Chief Complaint Orientated Cognitive Behavioural Therapy for Psychosis in Conditions of High Security: An Organisational Case Analysis.

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ABSTRACT.

Introduction.
Chief complaint orientated CBTp (C-Co) is a high secure (HS), context specific variant of individual Cognitive Behavioural Therapy for psychosis (CBTp) developed from the researcher's academic studies and own experience of psychosis. This research analysed the impact of C-Co on typically non-adherent, treatment resistant HS patients and on non-accredited C-Co nurse practitioners.

Methods.
A feminist facet-based methodological framework was adopted. A multi-component organisational case analysis of routinely gathered data, comprising eight discrete, innovative, award-winning research studies, was used to determine C-Co impact. A reflexive autoethnography of the researcher's first psychiatric assessment provided transparency. Modality fidelity and praxis competency were assessed to attribute causality. Descriptive single case analysis (n=1) provided an in-depth description of C-Co application. Group game development was used to consolidate and explore patient and practitioner experiences (n=15). A thematic analysis of supervision transcripts researched C-Co impact on practitioners (n=6). An exploratory, quasi-experimental, statistical analysis of repeat measures data was used to determine C-Co impact on patients (n=11). Descriptive analysis and statistics were used to determine dissemination strategy impact (n=22). Finally, a summative synthesis via triangulation was used to determine component convergent validity.

Results.
A high level of component convergent validity was achieved. C-Co had a positive and transient negative impact on patients and a positive and negative impact on practitioners. Component result dissemination resulted in national and international peer reviewed publications, conference presentations, awards, and collaborations.

Conclusions.
Although results may not be generalisable beyond the research samples, the research makes a significant and original contribution to professional practice and knowledge. C-Co is the only adapted, systematically deployed, individual HS CBTp approach, nationally and internationally, with proven efficacy with non-adherent, treatment resistant HS patients. This challenges HS medical model dominance, the hegemony of practitioner accreditation, and the norms of HS research methods. The deployment of C-Co across multiple HS sites and the further dissemination of component results are recommended.

ACKNOWLEDGEMENTS:

The researcher would like to acknowledge the patients and practitioners without whose involvement this thesis would not have been possible. The researcher would also like to acknowledge his doctoral supervisors Dr. Michael Townend, Prof. Chris Brannigan, and importantly Prof. Dawn Forman for their persistence and continued belief in him; to acknowledge Dr. Andy Benn, who supported and inspired the researcher for much of his career; to acknowledge members of the UK High Secure Hospitals CBTp Collaboration Group for their engagement in developing CBT for Psychosis across all UK high secure contexts; to acknowledge all those agencies, groups and individuals with whom the researcher has been fortunate to collaborate as part of his doctoral journey; to acknowledge members of his Trust Library Service for their guidance and support over the course of the doctorate, and to thank his *viva voce* examiners Dr. James Tapp and Dr. Andrew Dainty. Finally, but most importantly, the researcher would like to acknowledge and thank his wife and his children for their support, love, and enduring patience.

STATEMENT OF CONSENT:

All participants consented for the use of related materials. To comply with High Secure (HS) protocols (Sainsbury, 2018, Department of Health (DoH), 2019), only the minimum of materials necessary to illustrate germane points have been submitted. All additional materials are available for inspection in the HS area via prior agreement with the researcher.

DECLARATION OF INTERESTS:

A potential conflict of interest resulted from the researcher's remit to demonstrate efficacy of service delivery. This is further explored in the introduction to the thesis, within the results chapter and finally within the discussion chapter of the thesis. Nottinghamshire Healthcare NHS Foundation Trust provided part funding towards the doctoral course fees.

DISCLAIMER:

The views expressed within the research are the researcher's own and do not reflect the views of the institution or Trust in which the researcher is employed. Any misattribution of materials is entirely unintentional and will be addressed as a matter of urgency.

STATEMENT OF ATTRIBUTION FOR PUBLISHED PAPERS AND CRITERIA FOR THE INCLUSION OF PREVIOUSLY PUBLISHED WORKS WITHIN THE THESIS.

As a result of the active dissemination strategy expected of doctoral students during the period of study, the researcher achieved three peer-reviewed publications. These articles evolved from draft sections of the thesis and are listed below. Two of the articles were co-authored. Details of co-author contributions are given below and signed statements provided. These previously published works are referenced within the main thesis body, as is a section of the researcher's earlier MSc work. Advice was sought from the University College Research Committee about how these works might be appropriately incorporated. At the direction of the Committee, a summary, update, and critical appraisal of each is offered. Apposite permissions for reproduced materials were gained (Appendix 2) and an appropriate system of referencing and acknowledgment used. Full copies of published articles are provided within the appendices (Appendix 3). Credit for these earlier works (Slater, 2011; Slater and Townend, 2016; Slater & Painter, 2016; Slater 2020) in whole or in part is not expected as part of the thesis assessment.

1. Slater, J. & Townend, M. (2016). Cognitive Behaviour Therapy for Psychosis in High Secure Services: An Exploratory Hermeneutic Review of the International Literature. *Behavioural and Cognitive Psychotherapy***,** 44(6), pp. 652-67.

At the time of publication, Dr Michael Townend was a Senior Lecturer at the University of Derby and the researcher's First Supervisor. The review concept, strategy design, data gathering, data collation, analysis and interpretation were the researcher's own. Dr Townend contributed to the setting out of the submission, supporting the researcher through the submission process, and further developing the researcher's understanding of hermeneutic analysis.

Researcher contribution:	95%
Co-author contribution by Dr Townend:	5%
I acknowledge that the above statement represents my contribution to the published work and study output	

2. Slater, J. & Painter, G. (2016). Taking Steps: Using collaborative group game design to consolidate and evaluate experiences of individual chief complaint-orientated cognitive behavioural therapy for psychosis in conditions of high security. *The Cognitive*

Behaviour Therapist, 9(19), pp. 1-16.

At the time of publication, Mr. Glenn Painter was a Senior Occupational Therapist working in the same HS context as the researcher. Mr. Painter co-facilitated the CBTp Consolidation Group from which 'Taking Steps' emerged. The review concept, strategy design, data gathering, data collation, analysis, interpretation, and discussion were the researcher's own. Mr. Painter supported the cross validation of the data and was recognised as a co-author for his ongoing contribution to the CBTp Consolidation Group.

Researcher contribution:	100%
Co-author contribution by Mr. Painter:	0%
I acknowledge that the above statement represents my contribution to the published work and study output	

3. Slater, J. (2020). On being assessed…An autoethnographic exploration of being assessed by psychiatric services: A service user and nurse perspective. *Mental Health Nursing* 40(4), pp. 13-18.

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GLOSSARY OF ABBREVIATIONS.

AC	Approved Clinician
ACCS	Assessment of Core CBT Skills
AD4E	A Disorder for Everyone
AFC	Agenda for Change
APA	American Psychiatric Association
BA	Batchelor of Arts
BABCP	British Association for Behavioural and Cognitive Psychotherapies
BSc	Batchelor of Science
CASE	The HS Hospital's Clinical Audit and Service Evaluation Committee
CBT	Cognitive Behavioural Therapy
CBTp	Cognitive Behavioural Therapy for Psychosis
CBTp(f)	Forensic Cognitive Behavioural Therapy for Psychosis
C-Co	Chief Complaint Orientated Cognitive Behavioural Therapy for Psychosis
CUP	Cambridge University Press
DoH	Department of Health
DPrac	Doctor of Professional Practice
DSM-VTR	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision
GB	Great Britain
HEE	Health Education England
HRA	Health Research Authority
HS	High Security
HS-HVG	High Secure Hearing Voices Group
IAPT	Improving Access to Psychological Therapies
ICD-11	International Statistical Classification of Diseases and Related Health Problems, Eleventh Edition
LREC	Local Research Ethics Committee
MHA	Mental Health Act
MSc	Master of Science
NCCMH	National Collaborating Centre for Mental Health
NDip	Nursing Diploma
NICE	National Institute for Health and Care Excellence
NRES	National Research Ethics Service
NUSN	National User Survivor Network
OUP	Oxford University Press
PSI	Psychosocial Interventions for Psychosis
PTMF	Power Threat Meaning Framework
RC	Responsible Clinician
RCTs	Randomised Control Trials
REC	Research Ethics Committee
UK	United Kingdom
UoD	University of Derby
WHO	World Health Organisation

CHAPTER 1: INRODUCTION.

This doctoral thesis researches the impact of chief complaint orientated cognitive behavioural therapy for psychosis (C-Co), a high secure (HS), context specific variant of individual cognitive behavioural therapy for psychosis (CBTp). C-Co was developed solely by the researcher. It is unique to the researcher and represents an original contribution to HS CBTp practice. C-Co is the primary mode of therapy deployed by one UK HS hospital's CBTp service. It evolved from the researcher's own dissonant experiences of mental health services during an episode of psychosis, his earlier MSc studies (Slater 2011), applicable published and fugitive literature (Slater & Townend, 2016), and the prevalence of psychosis, treatment-resistance, and non-adherence in HS populations.

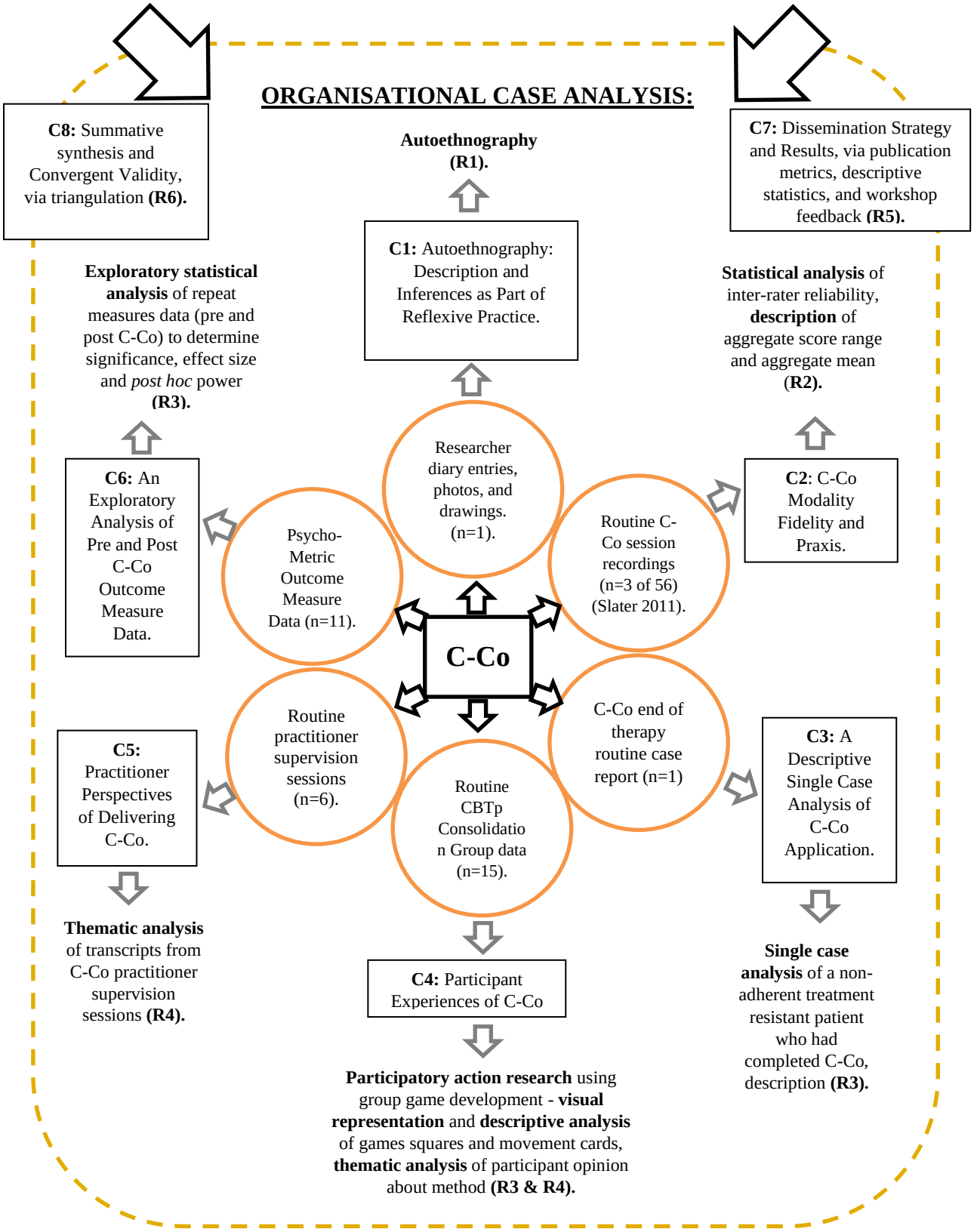
To research the impact of C-Co on direct participants who were patients and C-Co practitioners, the research uses organisational case analysis (Yin 2003, 2018) to provide a multicomponent, pragmatic analysis of C-Co data routinely gathered by the CBTp service. The primacy of any one methodological paradigm is rejected. Pluralist, pragmatic, and facet ontologies and epistemologies are instead embraced within a feminist methodological framework. The organisational case analysis is comprised of six primary (C1-C6) and two secondary (C7 and C8) research components. Positivist, constructivist, and critical realist lenses are used pragmatically to provide researcher transparency and to research each facet of routinely gathered C-Co data using pluralist, innovative methods (C1-C6). A further research component (C7) analyses the impact of result dissemination. Components C1-C7 include discussion, limitations, and recommendations sections. A final research component (C8) which is presented separately, analyses the level of convergent validity of the organisational case analysis as a whole, via a summative synthesis and triangulation of the results of the preceding research components. Table 1 provides an overview of each research component, its data, sample, method, methodological perspective, and linked research questions. Fig. 1 provides a schematic of the research strategy and illustrates how the research components and questions are linked to the analysis of routine C-Co data.

The dissemination of research component results (C1-C6) was extensive over the period of study and included peer-reviewed publications, conference presentations, interactive workshops, awards, and collaborations. Advice from the University College Research Committee was gained and followed on how to best integrate elements of published earlier works within the thesis without self-plagiarism.

Table 1: An Overview of the Research Components within the Organisational Case Analysis (© Slater).

Research Component (C):	**Data** (pragmatic):	**Sample:**	**Method** (pluralist):	**Methodological perspective** (feminist framework of parity):	**Research questions:**
C1: Autoethnography: Description and Inferences as Part of Reflexive Practice.	Researcher diary entries, photos, and drawings.	n=1 purposive.	**Autoethnography** used as a framework for reflexive practice to offer transparency of researcher motive and bias.	Constructivist.	**R1**: What impact has the researcher had on the research?
C2: C-Co Modality Fidelity and Praxis Competency.	Routine C-Co session recordings.	n=3 (of 56) random selection.	Using a standardised fidelity and praxis competence measure to independently rate 3 randomly selected session recordings. **Statistical analysis** of inter-rater reliability, **description** of aggregate range and mean.	Positivist.	**R2**: Does C-Co achieve modality fidelity and praxis competence?
C3: A Descriptive Single Case Analysis of C-Co Application.	C-Co end of therapy case report.	n=1 purposive.	**Single case analysis** of a non-adherent treatment resistant patient who had completed C-Co, description.	Critical realist.	**R3:** What impact does C-Co have on patients?
C4: Participant Experiences of C-Co.	Routine CBTp Consolidation Group data.	n=15 purposive.	**Participatory action research** using group game development - **visual representation** and **descriptive analysis** of game squares and movement cards, **thematic analysis** of participant opinion about method.	Critical realist.	**R3:** What impact does C-Co have on patients? **R4:** What impact does C-Co have on practitioners?
C5: Practitioner Perspectives of Delivering C-Co.	Routine practitioner supervision sessions.	n=6 convenience.	**Thematic analysis** of transcripts from C-Co practitioner supervision sessions.	Critical realist.	**R4:** What impact does C-Co have on practitioners?
C6: An Exploratory Analysis of Pre and Post C-Co Outcome Measure Data.	Routinely gathered pre and post outcome measure data.	n=11 purposive.	**Exploratory statistical analysis** of repeat measures data (pre and post C-Co) to determine significance, effect size and *post hoc* power	Positivist.	**R3:** What impact does C-Co have on patients?
C7: Dissemination Strategy and Results.	Publications, conference presentations, posters and workshops, awards, collaborations.	n=22 examples of research dissemination, n=31+10 workshop and peer review feedback responses).	**Descriptive analysis** of publication metrics and presentation attendance, **descriptive statistics** of number of publications, presentations, awards, and collaborations, **description** of feedback from workshops participants.	Positivist, critical realist.	**R5:** What impact has C-Co had via the dissemination of results?
C8: Summative synthesis & Convergent Validity.	The results of C1 – C7.	n=7 purposive.	**Triangulation.**	Critical realist.	**R6:** What level of convergent validity was achieved by the organisational case analysis?

Fig.1: A schematic of the organisational case analysis and research components linked to research questions (© Slater).



An exploratory review of national and international HS CBTp literature was first completed (see Chapter 2, and Slater and Townend 2016). Commensurate with the researcher's feminist methodological perspective, a novel iterative search strategy and hermeneutic analysis were developed, and both published and fugitive studies included. In the context of the individual HS CBTp literature the organisational case analysis is entirely unique and original in scope, method, ambition, innovation, level of patient non-adherence, and sample.

The research was categorised as service evaluation (Appendix 1) and met the criteria required for a practice-based doctorate (DPrac) set out by the University of Derby (UoD) (University of Derby, 2016). Commensurate ethics approval was received (Appendix 1).

In this chapter research details are provided and the meaning of key terms within the context of the research stipulated. The context, evolution and application of C-Co are described. An overview of the researcher's background in relation to the research is provided and a description of the research genesis presented. A justification for the research is given, followed by a synopsis of the remaining thesis.

1.1 Research Details.

A synthesis of research subject (C-Co), context (HS) and germane literature pertaining to HS applications of CBTp, was used to produce the research aim, questions, objectives, and components (Biggam, 2006; Punch, 2006).

1.1.1 Research Aim.

To analyse the impact of C-Co using organisational case analysis.

This describes the specific intervention that is researched for impact and the research method.

1.1.2 Research Questions (R).

R1: What impact has the researcher had on the research? C1
R2: Does C-Co achieve modality fidelity and praxis competence? C2.
R3: What impact does C-Co have on patients? C3, C4 and C6.

R4: What impact does C-Co have on practitioners? C4 and C5.

R5: What impact has C-Co had via the dissemination of results? C7.

R6: What level of convergent validity was achieved by the organisational case analysis? C8.

R7: What was the summative impact of C-Co?

R8: What were the research limitations of the organisational case analysis?

R9: What recommendations for future practice and research can be made?

R10: What impact has the research had on the researcher?

1.1.3 Research Objectives (O).

Chapter 1.

O1: To provide an overview of the research, research details, and thesis structure.

Chapter 2.

O2: To review the literature in relation to the provision of HS CBTp nationally and internationally.

Chapter 3.

O3: To discuss the methodological position of the research, describe the research method, and explore ethical considerations.

Chapter 4.

O4: To analyse the impact of the researcher on the research.

O5: To analyse C-Co modality fidelity and praxis competency.

O6: To analyse the impact of C-Co on patients.

O7: To analyse the impact of C-Co on practitioners.

O8: To analyse the impact of result dissemination.

Chapter 5.

O9: To analyse the convergent validity of the organisational case analysis.

O10: To determine the summative impact of C-Co

(Chapters 4 and 5 also address O11: To identify research limitations and make recommendations for further practice and research).

Chapter 6.

O12: To provide a summary of the research with which to conclude the thesis.

O13: To analyse the impact of the research on the researcher.

These objectives align with the research aim to analyse the impact of C-Co using organisational case analysis and are designed to achieve and analyse responses to the research questions.

1.1.4 Research Components (C).

C1: Autoethnography: Description and Inferences as Part of Reflexive Practice.
C2: C-Co Modality Fidelity and Praxis Competency.
C3: A Descriptive Single Case Analysis of C-Co Application.
C4: Participant Experiences of C-Co.
C5: Practitioner Perspectives of Delivering C-Co.
C6: An Exploratory Analysis of Pre and Post C-Co Outcome Measure Data.
C7: Dissemination Strategy and Results.
C8: Summative Synthesis and Convergent Validity.

The research components comprise the discrete elements of analysis within the organisational case analysis designed to answer the research questions (see Table 1 and Fig. 1).

1.1.5 The Meaning of Key Terms Within the Context of the Research.

Psychosis: Psychosis is defined by the dominant medical discourse as a disease and biomedical disorder involving a cluster of symptoms occurring across several diagnostic categories (American Psychiatric Association (APA), 2022; World Health Organisation (WHO), 2022). Symptoms include delusions, prominent hallucinations, disorganised thinking, disorganised speech, grossly disorganised or abnormal motor behaviour, and negative symptoms. Within the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-VTR) (APA, 2022) and International Statistical Classification of Diseases and Related Health Problems, Eleventh Edition (ICD-11) (WHO, 2022) symptom amelioration typifies recovery (National Institute for Health and Care Excellence (NICE), 2009; NICE, 2014). Randomised control trails (RCTs) have been used to promote antipsychotic medication as the most efficacious and primary means of amelioration (National Collaborating Centre for Mental Health (NCCMH), 2010; NICE, 2014).

These RCTs are heavily criticised for not considering longitudinal effects and for using small atypical concordant samples. Debilitating symptoms continue to be evident in a majority of cases and 20% of those treated with antipsychotic medication experience no amelioration (Kerwin &

Bolonna, 2005). A third of all patients intentionally subvert antipsychotic treatment or become actively non-adherent (Kerwin & Bolonna, 2005). In a study of 650 patients prescribed antipsychotics, 58% reported only negative experiences (Read & Sacia, 2020). Long-term use of antipsychotic medication is also linked to brain atrophy, lower rates of recovery and higher mortality (Haddad, Brain & Scott, 2014). According to patient report, side-effects are also considered to outweigh any short-term gains (Tiihonen, 2016; Tiihonen et al., 2016). A longitudinal study commissioned by WHO, found that people with psychosis in countries where antipsychotic medication was less available were more likely to recover, to recover earlier, to be employed, and achieve better qualities of life than people with psychosis in countries where antipsychotics were readily available (Filer, 2019a).

As a result, the primacy of the biomedical model and linked antipsychotic treatment is considered by some as damaging (Johnstone, 2000). Alternatives to the medical categorisation of psychosis like the Power Threat Meaning Framework (PTMF) (Johnstone & Boyle, 2018) and acceptance-based conceptualisations promoted by The Hearing Voices Network are increasingly gaining traction. Rather than "pathologise and medicate", these conceptualisations explore what may have happened to the individual culturally, societally, politically, and economically and argue that power imbalances and subsequent trauma offer a more valid aetiology for psychosis than a disease model. Redressing these imbalances via acceptance, understanding, and the support of self-actualisation offers a more complete and lasting resolution to psychotic experiences than pharmacological amelioration (Johnstone & Boyle, 2018).

The need to redress medical model dominance within mental health is also recognised within mental health legislation. Previously the sole prerogative of medical professionals, in 2007 changes to the Mental Health Act (MHA) (Great Britain (GB), 1983) legislated for non-medical healthcare professionals to train as approved clinicians (ACs). This enabled non-medical professionals to co-ordinate, lead and be legally responsible for a patient's mental health care and level of restriction for the first time (GB, 2007; DoH, 2007). Yet, despite research indicating that non-medical ACs increase care quality and are more financially viable (Wainwright, 2018), this change has been met with opposition, most notably from the medical profession (Oates et al., 2018). Over a decade since inception, non-medical ACs account for less than one percent of all AC's.

The HS context in which this research took place remains dominated by the medical classification and pharmacological treatment of psychosis. Commensurate with the researcher's feminist

methodological stance the researcher rejects the primacy of any one conceptualisation and treatment of psychosis. The research adopts instead a broader understanding of psychosis that incorporates both medical and non-medical conceptualisations and treatments to better evaluate C-Co impact from multiple perspectives.

CBTp: Founded on Beck's original cognitive model (Beck, 1976), CBTp is defined as a symptom orientated approach (Morrison et al., 2004). Beck's conceptualisation of psychosis remains medical and symptom based but also includes environmental factors and targets the resolution of distress as well as symptom amelioration (Beck, Rector, Stolar, and Grant, 2009). CBTp academics and practitioners have developed symptom-specific psychosis conceptualisations alongside linked evidence-based interventions (Morrison et al., 2004; Kuipers et al., 2006; Laithwaite et al., 2007). CBTp RCT research has subsequently targeted symptom amelioration to make a direct comparison with the efficacy of antipsychotics. Research evidence suggests that CBTp may be as effective at ameliorating symptoms of psychosis as antipsychotics (Morrison et al., 2018). Yet within legislation and NICE guidance CBTp is considered only an adjunct to antipsychotic treatment and is indicated for patients who are deemed treatment resistant to medication (GB, 2007; NICE, 2014).

Despite a strong evidence base, medical and patient opinion is critical of CBTp. Medical opinion suggests that CBTp has little consistent efficacy regarding symptom amelioration (Jones et al., 2004). Patient forums criticise symptom orientated CBTp for unhelpfully categorising patient experiences, for reinforcing medical compliance, and for failing to fully understand the patient narrative (National Survivor User Network (NUSN), 2018). Seminal figures in the development of CBTp have responded to these criticisms by stating that CBTp should evolve from being a quasi-neuroleptic and that distress reduction and increases in quality of life should be more apt determinants of CBTp efficacy than symptom amelioration (Birchwood & Trower, 2006).

As the field of CBTp has evolved, a synthesis has developed between an original emphasis on medically defined symptoms and symptom amelioration, with more transdiagnostic orientated methods, guided by a need to reduce distress and embrace the whole psychosis experience in addition to its constituent pieces (Barnard & Teasdale, 1991; Gumley, 1999; Ewers et al., 2000; Clarke, 2002; Barnard, 2003; Harvey et al., 2004). These refinements have led to a praxis which unites implication and emotion based interventions (Morrison et al., 2004; Gilbert, 2009) with more traditional cognitive and behavioural methods (Fowler et al., 1995). C-Co reflects these later refinements.

C-Co: C-Co is a context specific adaptation of individual CBTp developed by the researcher for deployment in HS contexts. It aims to overcome the adherence related barriers and treatment-resistance evident within HS contexts and offer a more universal recovery (Slater, 2011). It is targeted at patients who are non-adherent and treatment resistant but also offered to those who have stabilised on medication but may benefit from relapse prevention work. The context, evolution and application of C-Co are described below in section 1.2.

Non-adherence: Non-adherence in psychosis is medically defined as an intentional or unintentional refusal of pharmacological treatment and can be compounded by anosognosia (WHO, 2003). Non-adherence is considered the most common cause of treatment failure in psychosis and is a major obstacle to effective medical treatment (WHO, 2003). As few as 50% of individuals with psychosis comply with their prescribed medication regime (WHO, 2003). According to medical advocates of forcible medication-based interventions for psychosis, non-adherence is the biggest reason for poor outcomes, treatment failure and the harm of others by people with psychosis (Torrey, 2008). Seminal UK independent inquiries correlate non-adherence to a heightened risk of harm to self or others in people diagnosed with a psychosis (The Zito Trust, 1995). This correlation is particularly acute in forensic patient populations (Fazel et al., 2016). Yet implicit within this concept is the belief that medical diagnosis and pharmacological treatment are "always" valid and efficacious. Historical abuses within medicine like the categorisation of homosexuality as a mental illness and the use of frontal lobe lobotomy and ECT to treat schizophrenia belie these assumptions (Johnston, 2000; Read 2012; Sidley, 2015).

Non-adherence as a concept is also evident within CBTp. Beck et al. (2009) question whether talking therapies like CBTp can truly have an impact on psychosis given its genetic and biomedical aetiology. They suggest that psychotherapeutically adherent patients with insight, who are psychologically aware, actively seeking help, and willing to take responsibility for their own improvement are more suitable for CBTp. Crucially, however, and in contrast to medical non-adherence, they suggest it is the responsibility of the CBTp practitioner to surmount adherence barriers via the fostering of mutual respect and trust.

HS Hospital: There are various forms of forensic context in which mentally disordered patients are treated. A HS hospital is the most secure of these, and offers a range of physical, relational, and procedural measures to provide safe treatment for patients deemed to be at grave and immediate risk of harming themselves or others (Tilt et al., 2000). Patients are typically detained for treatment

under order of the courts or at the behest of the Secretary of State for Justice (GB, 1983; GB, 2007). There are four HS Hospitals within the UK. Whilst aligned with the Ministry of Justice, these hospitals sit within healthcare trusts and are subject to healthcare quality controls, guidance, and standards. This form of HS provision, incorporating local legal and healthcare responsibilities, with the remit to safeguard the public, promote patient recovery, and reduce risk to facilitate discharge to conditions of lesser security, is evident internationally (Tapp et al., 2013).

Organisational case analysis: Organisational case analysis is used to denote that the subject of the research incorporates a group of people who share experiences linked to a common organisation-based phenomenon (Yin, 2003). In this instance the subject of the research is C-Co and the patient and practitioner participant group the people whose shared experience is the provision of C-Co by the HS CBTp service. Organisational case analysis can use a range of data collection and analysis techniques to generate multiple methodologically diverse sources of evidence (Yin, 2018). Triangulation is used to orchestrate the convergence of these diverse sources into a germane aggregate. Case study may involve the use of both qualitative and quantitative methods facilitating the analysis of a wider range of case components, thereby strengthening outcome credibility (Gerring, 2007).

Impact: The Oxford English Dictionary (Oxford University Press (OUP), 2023) defines 'impact' as; *'the striking of one body against another; collision, chiefly in dynamics, in reference to momentum*,' and *'the effective action of one thing or person upon another; the effect of such action; influence; impression.'* In this instance the 'one body' or 'one thing' is C-Co and the 'another' are direct participants. The two meanings suggest different ontological and epistemological views of research causality, the former quantitative, the latter qualitative. By the adoption of a feminist methodology, this research incorporates components of both qualitative and quantitative ontologies and epistemologies, thereby embracing the definition of impact in its widest and most complete sense. The impact of the research on the researcher and the impact on others via result dissemination are also considered alongside the impact of C-Co on direct participants. It is important to note that the above definition does not stipulate the direction of impact, thereby inferring it may be positive, negative, neutral, or even multi-facetted.

Direct Participants: Direct participants refers to those individuals directly involved in the C-Co therapeutic process and includes both patients and practitioners. The term 'patient' is not without controversy (Johnstone, 2000); however, it aligns with the biomedical model that predominates

within HS hospitals and is the term most frequently used therein. The use of the term practitioner rather than psychotherapist donates the non-accredited status of the healthcare professionals trained to deliver C-Co. The impact of C-Co on indirect participants, like significant others, family, and carers, whilst important (NICE, 2014), was largely beyond the scope of this research but is considered within the dissemination results and discussion (Sections 4.8 and 5.9).

1.2 C-Co.

1.2.1 C-Co Context.

In the UK, psychosis guidance stipulates that all patients with experience psychosis must be offered individual CBTp focused on symptom amelioration, reducing associated distress, and enhancing adaptive coping (NCCMH, 2003; NICE, 2009; NICE 2014). This is a legal obligation as psychological therapies are considered treatment within the terms of the MHA (GB, 2007). In HS hospital populations, the high incidence of non-adherence and medication-resistant psychosis, linked to index offence severity (Taylor, 1998; Laithwaite & Gumley, 2007), underpin the chronic need for effective CBTp (Bartlett, 1993; Shah et al., 2009). Poor longitudinal outcomes after discharge and extremely high per capita financial investment, also indicate a moral and ethical obligation to deliver effective CBTp (Davies et al., 2007; Fazel et al., 2016).

Yet there is no one standardised CBTp approach or model (Clarke, 2001; Clarke, 2002; Wykes et al. 2008) and CBTp is considered one of the most difficult, complex and specialist CBT interventions (Kuipers et al., 1997; Clarke, 2002). High and low intensity CBT approaches in primary care have also fuelled debate about modes of CBTp delivery, however current research remains limited (Waller et al., 2013). HS patients are also less likely to engage in psychological therapies (Shah et al., 2009). Anecdotal opinion suggests that this may be because of the primacy in HS contexts of enforceable, injectable, pharmacological antipsychotic treatments over CBTp to address non-adherence (Mason, 1999; Adshead et al., 2005). The target HS population requiring CBTp comprises approximately 600 patients and is therefore also large.

The challenge for individual HS CBTp has been to translate a complex psychological approach into a complex environment, with scope to efficaciously treat complex psychotic experiences exacerbated by risk, non-adherence, and treatment resistance, whilst remaining financially viable and able to withstand rigorous evaluation.

1.2.2 C-Co Evolution.

In 2006 NICE funding was secured to develop a CBTp service in a UK HS hospital delivering individual CBTp. To meet population size and remain financially viable, an adapted approach was created for male patients that blended two strands of evidence: the use of CBT with treatment resistant, acute psychosis and psychosis experiences (Kuipers et al., 1997); and the use of CBT interventions for community-based carers and motivated psychiatric patients who had experience of psychosis (Turkington et al., 2006).

The former used dynamic idiosyncratic formulation and hypothesis led treatment delivered by British Association for Behavioural and Cognitive Psychotherapies (BABCP) accredited therapists. The latter was a modularised programme of standardised time-limited sessions, delivered by non-accredited practitioners trained to deliver the programme. The HS CBTp service aimed to achieve the former intervention approach delivered via the latter level of practitioner. The service started accepting referrals in 2007. Provision was based on nomothetic, symptom based CBTp approaches supervised by an external BABCP accredited psychotherapist with forensic experience and lead psychologist. The researcher was one of the services first practitioners. The researcher became manager of the CBTp service in 2008 and commenced a BABCP accredited MSc in CBT.

The researcher believed that adaptation of the service CBTp approach was needed to address chronic non-adherence and treatment-resistance and avoid treatment failure (Bentall & Haddock, 2000). Case analysis evidence indicated focussing on an agreed psychosis symptom combined with greater flexibility could mediate therapy barriers, but with only adherent HS patients. However, adherent HS patients represent the minority within high secure contexts (Ewers et al. 2000; Benn, 2002; Rogers & Curran, 2004). This earlier premise was therefore extended a step further with regards to non-adherent patients. It was from this subsequent extension, fused with the researcher's own experiences of alienation by healthcare services, and his MSc studies that C-Co emerged.

C-Co theorises that the barriers to efficacy with typical non-adherent treatment resistant HS patients can be addressed by initially focusing therapy on a non-symptom-based, co-established, chief complaint. The researcher subsequently used his MSc thesis as a pilot to explore and assess C-Co impact on psychosis and risk (Slater, 2011). This pilot evaluation indicated C-Co provided a subsequent platform for symptom-based interventions and increased the potential for recovery

among non-adherent HS patients (Slater, 2011). Following completion of the researcher's MSc thesis in 2011, C-Co became the primary intervention offered by the CBTp service.

1.2.3 C-Co Practice.

1.2.3.1 Referral.

Referrals were made by the multi-disciplinary team and responsible clinician. Criteria included treatment resistance and poor adherence with other psychotherapies. All referred patients were treated with antipsychotic medication as the primary mode of treatment, continued to experience residual psychotic symptoms despite that primary treatment, had histories of poor engagement with other psychotherapies, and histories of non-adherence with mental health services. A summary of the NICE guidance for CBTp (NICE, 2009; NICE, 2014) was given to potential referrers (Appendix 4).

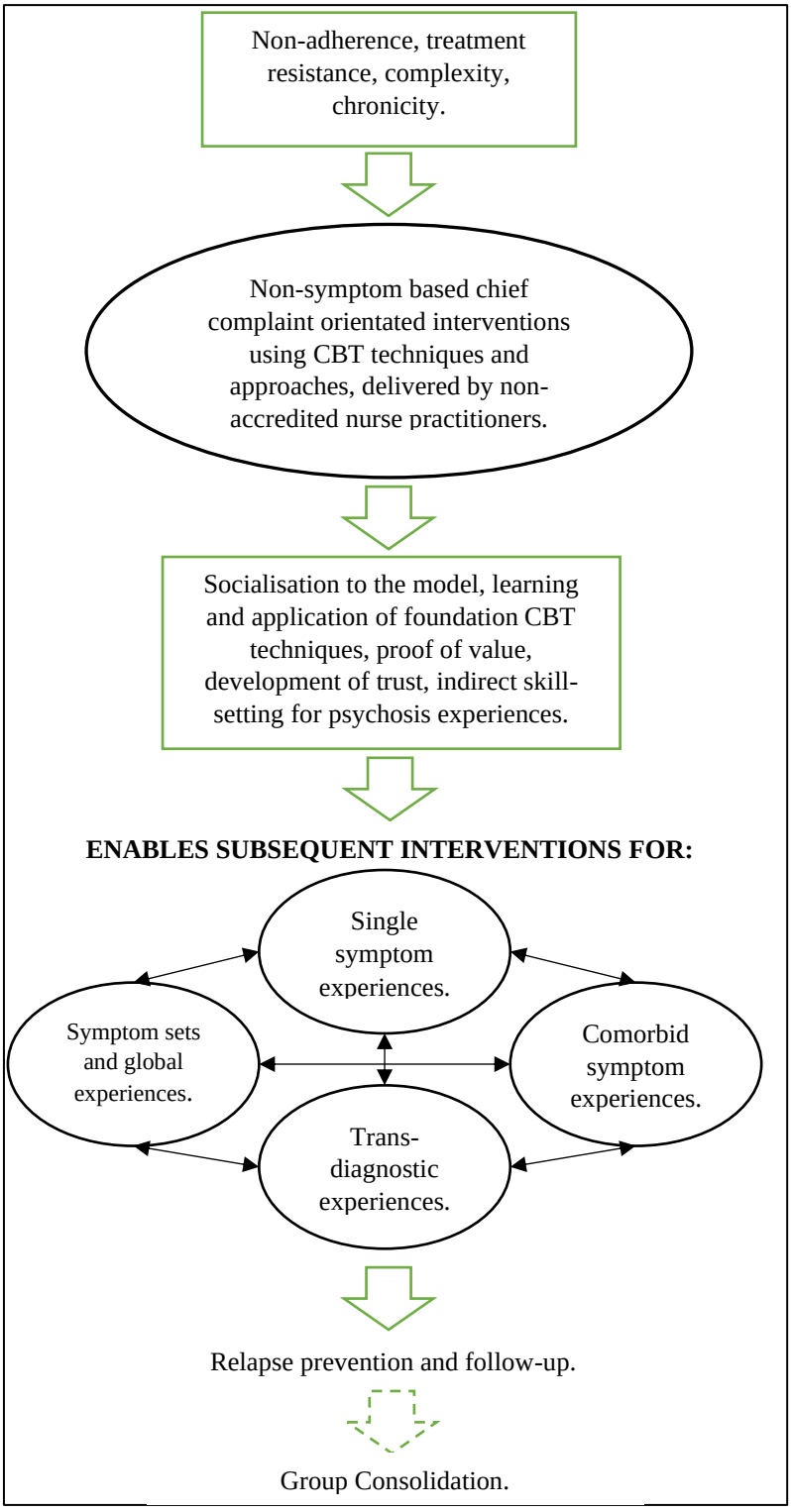
1.2.3.2 Application.

Fig. 2 offers a schematic of C-Co application. C-Co application includes CBTp components deemed essential within NICE guidance (NICE, 2009; NICE, 2014) (Appendix 4), but incorporates a crucial difference as the term "difficulties" is used interchangeably with the term "symptoms". A chief complaint orientation is initially adopted, and the patient asked what non-symptom-based difficulty they may want to change. Symptoms are not discussed. CBT techniques are then used to help the patient achieve change, removing insight and adherence barriers. Successfully resolving the chief-complaint using CBT techniques offers proof of value, surmounts adherence barriers, and enables the therapeutic alliance to develop. C-Co posits that whichever chief complaint the patient offers is affected by their psychosis experiences. Skill setting the patient to resolve their chief complaint also indirectly skill sets them to begin to resolve distressing and problematic psychosis experiences.

Proof of value and the development of a trusting relationship, during the chief-complaint stage of C-Co, leads to the sharing of symptom-orientated experiences which the patient may also want to address. Symptom based CBTp interventions are deployed, and effect co-evaluated. A relapse prevention pack is then co-developed with the patient and the patient's named nurse and follow-up offered to support its use. Patients are given the opportunity to attend a consolidation group to share and consolidate their experience of individual C-Co with other patients and practitioners. Extended

intervention periods are required due to the complexity of patient presentation and because of the holistic rather than single symptom approach C-Co adopts.

Fig. 2: C-Co Pathway Schematic.



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1.2.3.3 Mode of Delivery.

C-Co is delivered by non-accredited practitioners seconded to the CBTp Service one day a week. Practitioners are ward-based nurses ranging from Agenda For Change (AFC) bands 5-7. Each practitioner has a maximum caseload of three patients and receives an hour's one-to-one supervision from a BABCP accredited psychotherapist (the service lead) or Consultant Psychologist per practitioner day. All practitioners are provided an initial three-day training package and subsequent quarterly training and group supervision days. The quarterly training days are attended by all practitioners and the two supervisors. Training is delivered by the service lead. Manuals linked to each C-Co phase were developed as an additional source of guidance. Modality fidelity and praxis competence are regularly assessed via in vivo rating using the Revised Cognitive Therapy Scale (CTS-R) (Blackburn et al., 2001). Prior to changes in HS protocols this had been achieved via the rating of session recordings where consent had been gained (Sainsbury, 2018; DoH, 2019). Ratings are usually completed by the service lead (in vivo) or, for previous session recordings, the service lead and psychologist. This mode of manual development, training, supervision, delivery, and fidelity and competency monitoring was designed to comply with NICE criteria relating to the delivery of CBTp (NICE, 2014). The guidance does not offer an opinion on whether CBTp practitioners should be accredited or whether achieving accreditation qualifies a practitioner to competently deliver CBTp.

1.2.3.4 Routine Assessment and Evaluation.

The assessment and evaluation of C-Co impact over the course of therapy is written up in the patient's end of therapy case report based on patient feedback, changes in problem and goal statement ratings, MDT feedback regarding psychosis and risk, and pre and post subjective and objective outcome measure data. Outcome measures are first completed post C-Co phase to reduce masking effects, then post therapy and post follow-up. Whilst such measures have importance, their completion is not a pre-requisite for C-Co and patients can choose not to complete them. The CBTp consolidation group includes an evaluation of therapy experiences and includes practitioner perspectives. Practitioners also feedback their experiences via supervision and practitioner evaluation interviews. These routine formats for assessment and evaluation provide the data for the research components within the organisational case analysis (Fig. 1).

1.3 The Researcher in the Context of the Research.

Born in 1970, the researcher grew up in an armed forces context. The researcher attended boarding school from age 9 to 18 to offer stability of education. As his parents were often stationed abroad, he mostly resided with his grandmother when not at school. He achieved 11 O'levels, 2 AO'levels and 3 A'levels and, after spending a year out, studied a degree in history achieving a 2:1 specialising in the history of civil rights movements. On leaving university he was subcontracted to the military and worked abroad, before returning home to care for his grandmother who had Alzheimer's Disease. Following her death, the researcher began his training to become a psychiatric nurse, qualifying in 2000.

After qualification, the researcher worked in acute and community settings and obtained an honours degree in psychosocial interventions for psychosis (PSI) before moving into HS forensic healthcare. His first HS appointment was as a PSI Co-ordinator. He was promoted to team leader on the HS hospital's intensive care ward. In 2007 the researcher successfully applied to become a CBTp practitioner in the newly set up HS CBTp service and in 2008 accepted a Clinical Nurse Practitioner role to further develop and manage the service. He commenced a CBT MSc which he completed in 2011 with a distinction. The researcher was appointed as a Consultant Nurse in 2017, with special interest in the provision of CBTp to HS patients. In 2022, the researcher qualified and received approval as a Secretary of State Approved Clinician (GB, 1983; GB, 2007).

The researcher started voice hearing from an early age. These experiences became gradually worse during late adolescence, culminating in a psychotic breakdown in his mid-twenties following the death of his grandmother. His experience of psychosis and dissonant experiences of psychiatric services motivated him to become a psychiatric nurse and have influenced his career, his methodological perspective, and his need to develop better interventions for people who experience psychosis, including C-Co.

1.4 Research Genesis.

The research arose from a fusion of the researcher's sense of social justice, feminist methodological perspective and lived experience, with his professional role as the manager and developer of a HS hospital CBTp service. Organisational case analysis complements his feminist position as it ascribes equal merit and voice to a variety of research methods and forms of knowing. The subject

of the research, C-Co, evolved from the researcher's lived experience of psychosis and alienating experiences of psychiatric services. He believed less alienating and more useful healthcare engagement practices were possible. His sense of social justice led him to work in a HS context. HS hospital patients are vilified and demonised within the popular press and wider society, yet they are some of societies most neglected and damaged citizens. The requirement for psychiatric services to provide CBTp (NICE 2009; NICE, 2014) has enabled services like the HS CBTp service to exist as well as an obligation to analyse their efficacy.

1.5 Research Justification.

The impact of psychosis on the patient, their significant others, and society can be devastating. This impact is especially acute when patients experiencing psychosis harm themselves and others (MIND, 2010). The per capita healthcare cost of psychosis is one of the highest in healthcare provision. Whilst the research supports the need for HS adapted approaches like C-Co, very little is understood or known about their efficacy or the nature of the adaptations themselves. Research that adds to the understanding of adapted HS CBTp approaches and their impact is therefore justified.

1.6 Thesis Synopsis.

This section provides a synopsis for the remaining thesis chapters orientating the reader to its structure. Synopses of each chapter are given. Whilst much of the thesis is written from a third person perspective, there are elements within the discourse which lend themselves more pertinently to the use of a first-person narrative. To help facilitate dissemination, chapter and sub-section formats are guided by the editorial criteria of relevant peer reviewed publications (Cambridge University Press (CUP), 2023). To comply with HS security protocols and information constraints (Sainsbury, 2018; DoH, 2019), only the minimum of materials necessary to illustrate germane points are provided within the thesis. All additional materials are available for inspection in the HS area via prior agreement with the researcher.

1.6.1 Synopses of the Thesis Chapters.

Chapter 2: A Review of the Literature: This chapter was initially drafted in 2014 and formed the basis of a subsequent publication (Slater & Townend, 2016 – Appendix 3). This chapter and the published work identify and evaluate CBTp approaches used in HS hospitals in the UK and

internationally, thereby informing the development of the research aims, objectives and questions, whilst also facilitating a comparative analysis of results against the wider HS CBTp literature. A novel, iterative search strategy and hermeneutic source analysis were adopted to facilitate the inclusion of both published and fugitive studies to facilitate a more representative review.

Chapter 3: Methodological Perspective and Method: The research adopts a feminist methodology. This chapter explores the researcher's methodological perspective. It is informed by an introspective string shaped over the course of study, affording a deeper, more transparent insight into the researcher's methodological stance. The researcher asserts that any methodological stance is idiosyncratic, temporally, and contextually dependent, and therefore mutable. The method of organisational case analysis is then described and justified, and an overview of each research component provided, substantiating the pluralist, multi-method approach. Normative ethical considerations and descriptive actions undertaken by the researcher are then described guided by Beauchamp and Childress (2019) fundamental tenets for applied health research.

Chapter 4: Component Outcomes: In this chapter components 1-7 are addressed in turn. In each component section the component research method and application are described, and component specific ethical considerations explored. Results are provided and discussed, and limitations and recommendations given. Component 1: *Autoethnography: Further Exploration of the Researcher in the Context of the Thesis* provides an autoethnography of the researcher's experiences of psychosis as a reflexive means of providing researcher transparency. The autoethnography formed the basis of a published work (Slater, 2020 – Appendix 3). Component 2 then analyses C-Co modality fidelity and praxis competence. Component 3: *A Descriptive Single Case Analysis of C-Co Application,* uses descriptive single case analysis to illustrate an example of C-Co practice with a typical non-adherent, treatment resistant, HS patient, followed by Component 4: *Participant Experiences of C-Co*. This offers a summary and critical analysis of Slater and Painter (2016 – Appendix 3), which was based on the initial draft of this section. Additional data to that published in Slater and Painter (2016) is provided for further analysis and discussion. Component 5: *Practitioner Perspectives of Delivering C-Co,* provides a thematic analysis of transcribed C-Co practitioner supervision sessions and is followed by Component 6: *An Exploratory Analysis of Pre and Post Outcome Measure Data* which adopts an exploratory, quasi-experimental approach to the statistical analyses of pre and post, subjective and objective, repeat measures to determine significance, effect size, and *post hoc* power. Component 7: *Dissemination Strategy and Results* describes how component results were disseminated and with what impact,

Chapter 5: Summative Claims and Propositional Conflations: In this chapter Component 8: *Summative Synthesis and Convergent Validity* uses triangulation to determine the level of convergent validity of the organisational case analysis research components. Summative claims and propositional conflations are then discussed, facilitated by the level of convergence achieved. Limitations and recommendations regarding component 8 are then offered.

Chapter 6: Thesis Summary and the Impact of the Research on the Researcher: This chapter offers a summary of the thesis and concludes with the impact of the research on the researcher.

1.7 Chapter Summary.

This introduction chapter has provided details of the research, including research aim, questions, objectives, components, and definitions of key terms. Table 1 and Fig. 1 were used to provide an overview of each discrete research component and component integration within the organisational case analysis method linked to facets of routine C-Co data. An overview of C-Co evolution, practice, application, and routine forms of evaluation was provided alongside an exploration of the researcher in the context of the research, research genesis and justification. A synopsis of the remaining thesis chapters was then given. In the next chapter a summary and critical analysis of Slater and Townsend (2016) and an update to the published work is provided.

CHAPTER 2: A REVIEW OF THE LITERATURE.

2.1 Introduction.

This chapter was initially drafted in 2014. This draft later formed the basis of a subsequent publication (Slater & Townend, 2016, Appendix 3). Dr Townend's contribution to this work is detailed in the attribution statement at the start of the thesis. The aim of this chapter and the published work was to identify CBTp approaches used in HS hospitals and appraise approach impact, thereby offering context to, and informing the development of, the thesis aim, objectives, questions, and components (Biggam, 2008). It provides an exploratory review of the international literature relating to CBTp in HS contexts. Traditional positivist review frameworks yielded few results (Slater and Townend, 2016). A novel, iterative literature search strategy and hermeneutic source analysis were therefore adopted (Slater & Townend, 2016) facilitating the inclusion of fugitive and non-peer-reviewed publications alongside peer-reviewed texts. The review is provided in two parts. The first provides a summary and critical analysis of Slater and Townend (2016) and offers conclusions in the context of the thesis. The second part provides an update to the published work. To identify and analyse published and fugitive studies that may have been conducted since the earlier publication, it involves the reapplication of the novel search and analysis strategies used by Slater and Townend (2016). A chapter summary is then offered.

2.2 A Summary and Critical Appraisal of Slater and Townend (2016).

In their article Slater and Townend stipulated that their objectives were:

> *"1. To identify a wider body of HS CBTp studies.*
>
> *2. To analyse the identified studies with regard to application, impact and value.*
>
> *3. To offer a synthesised algorithm of HS CBTp intervention strategies according to perceived efficacy.*
>
> *4. To compare HS practices with non-forensic derived CBTp guidance."*
>
> - Slater and Townend (2016) p. 2.

The summary is organised according to these objectives.

2.2.1 Identifying a Wider Body of HS CBTp Studies.

As previous systematic literature searches adopting Cochrane search parameters had failed to identify a significant body of research evidence (Laithwaite, 2010; Jones, Hacker, Cormac, Meaden, & Irving, 2012; Tapp et al., 2013), influenced by Dewey's pragmatist concept of research inquiry (Morgan, 2014), Slater and Townend hypothesised that an exploratory review which included fugitive literature might yield additional studies with which to better understand CBTp application and impact in HS contexts (Pappas & Williams, 2011). This necessitated a more flexible review strategy with the capacity to identify, appraise and analyse published peer and non-peer reviewed articles alongside unpublished local studies. As review strategies that include fugitive literature are under-reported (Mahood, Van Eerd, & Irvin, 2014), Slater and Townend (2016) developed a novel approach that combined hermeneutic and iterative processes and offered rigour, flexibility, and transparency. A detailed schematic illustrating their strategy was provided (Fig. 1, Slater and Townend, 2016, p. 4, Appendix 3). Using this strategy of iterative encirclement, Slater and Townend (2016) were able to identify 14 sources (Table 1, Slater & Townend, 2016, p.5, Appendix 3). These sources indicated that CBTp interventions were provided to recently admitted, medium dependency, rehabilitation, and chronic long-term patients in HS contexts internationally, and included group and individual therapy, and CBTp linked milieus.

2.2.2 An Analyse of The Identified Studies Regarding Application, Impact, and Value.

2.2.2.1 Group CBTp.

Slater and Townend (2016) identified five studies relating to the provision of group CBTp in HS contexts internationally. Their interpretations of these regarding method, patient group, mode of delivery and main results were provided in Table 2, Slater and Townend, (2016), pp. 6-8, Appendix 3. Inferences in relation to these studies were then made (Box 1, Slater & Townend, 2016, p. 9, Appendix 3), and an appraisal offered. In their appraisal, Slater and Townend (2016) highlighted that the group interventions were primarily based on non-forensic derived protocols with various systems ensuring fidelity like supervision and guidance from protocol authors. Little significant change was reported in relation to positive symptoms of psychosis, a substantial discrepancy when compared to similar non-forensic based studies. Outcome congruence and evident levels of rigour led Slater and Townend (2016) to suggest that the lack of effect on positive symptoms may have been due to pre-group sample characteristics. These indicated that patients who engaged in the

groups were stable, adherent, were experiencing remission of positive symptoms, and had normal esteem and were therefore likely to experience only minor change. However, significant changes linked to negative symptom experiences, particularly affective flattening, alogia and anhedonia were evident within the group studies as were changes in social skills and reductions in negative coping.

2.2.2.2 Therapeutic Milieu.

Slater and Townend (2016) identified two studies relating to the provision of CBTp linked therapeutic milieus in HS contexts internationally. Their interpretations of these regarding method, patient group, mode of delivery and main results were provided in Table 3, Slater and Townend (2016), p. 11 (Appendix 3). Inferences in relation to these studies were then made (Box 2, Slater & Townend, 2016, p. 12, Appendix 3) and an appraisal offered. In their appraisal, Slater and Townend (2016) highlighted that the evidence provided by these studies, although anecdotal, gave the impression that CBTp linked milieus were less costly and more effective than group CBTp with reports of better coping, engagement, insight and goal attainment, further remission of positive symptoms, and reductions in high impact, high severity assaults. Other benefits included staff enhancement, the attainment of national nursing competency standards and compliance with core NICE guidance (NICE, 2009). Supplementation with one-to-one problem-solving interventions also led to reported reductions in negative symptoms. However, staff training, maintaining the milieus, and securing ongoing managerial support proved problematic.

2.2.2.3 Individual CBTp.

Slater and Townend (2016) identified seven studies, largely single case analyses, relating to the provision of individual CBTp in HS contexts internationally. Their interpretations of these regarding method, patient group, mode of delivery and main results were provided in Table 4, Slater and Townend (2019), pp. 14-16, Appendix 3. Inferences in relation to these studies were then made (Box 3, Slater & Townend, 2016, p. 17, Appendix 3) and an appraisal offered. In their appraisal Slater and Townend highlighted that the outcomes for individual CBTp, including those for severely chronic long-stay HS patients, were better than for groups and ward milieus and that patients who engaged in individual CBTp also experienced active symptoms profiles more than diagnostic norms, supporting specificity arguments. Nomothetic non-forensic derived protocols for individual CBTp resulted in treatment failure (Bentall & Haddock, 2000). Flexibility and sensitive

contextual and idiosyncratic adaptations enhanced efficacy with adherent HS patients and facilitated the subsequent use of symptom specific protocols (Benn, 2002; Rogers & Curran, 2004). Further adaptation, involving the initial provision of chief-complaint rather than symptom orientated therapy, led to the successful engagement of more typical non-adherent HS patients (Ewers et al., 2000; Slater, 2011). Protracted therapy periods greater than the norms suggested by NICE (2014) were evident as were a higher level of reported transient iatrogenic effects, albeit these were associated with and deemed indicative of change.

2.2.3. A Synthesised Algorithm of HS CBTp Intervention Strategies According to Perceived Efficacy.

Slater and Townend (2016) highlighted the need to consolidate and harmonise CBTp approaches across HS sites based on a deeper understanding of efficacy, and in the UK particularly enabling better alignment with NHS Commissioning Board stipulations for consistency and effectiveness across all HS locations (NHS Commissioning Board, 2012). Based on the outcomes of the literature review and in association with the UK High Secure Hospitals CBTp Collaboration Group, Slater and Townend (2016) tentatively offered an algorithm for effective evidence-based cross-site HS CBTp (Fig. 3, Slater & Townend, 2016, p. 18, Appendix 3).

2.2.4 A Comparison of HS Practices with Non-Forensic Derived CBTp Guidance.

Slater and Townend (2016) suggested that their algorithm compared favourably with but is crucially different from NICE guidance relating to CBTp (NICE, 2014). Although both support use across all presentations and stages of psychosis, support the efficacy of individual over group CBTp, emphasise the need for fidelity, and highlight the efficacy of multi-professional delivery, the algorithm offered by Slater and Townend (2016) stressed the need for context specific HS protocols with greater flexibility, sensitivity towards offence related factors, extended therapy periods, and chief compliant orientation, as well as symptom specific interventions, to manage typical non-adherence. Their algorithm also recognised the likelihood of transient iatrogenic effects as part of the change process as well as the important impact both group CBTp and CBTp linked milieus can have for HS patients.

2.2.5 A Critical Appraisal of Slater and Townend (2016).

Whilst the search strategy and analysis used by Slater and Townend (2016) is innovative and may offer a broader, more pragmatic, and potentially more representative review than a quantitative systematic approach, from a positivist methodological perspective little quantitative data is identified for analysis. The adopted approach may be considered purely theoretical and subjective in nature and is untested. One might question how likely it is that others may be able to replicate the iterative and hermeneutic approach used. When mapped against the most recent NICE (2014) CBTp guidance inclusion criteria, the studies identified by Slater and Townend (2016) would have been excluded as they lack quantifiable data. This means that only limited inferences can be made, with little generalisability. The results from the fugitive studies lack peer-review and therefore have indeterminate validity. The peer reviewed studies are limited in scope as they are largely qualitative and descriptive in nature and therefore also lack generalisability. Interestingly however, Slater and Townend (2016) achieved peer-reviewed publication in one of the leading CBT journals nationally and internationally. Not only was the review conducted to a sufficient standard to achieve publication, the subject matter, approach, findings, and inferences were deemed sufficiently important to publish. In addition, Slater and Townend (2016) did not make any claim that their inferences met positivist requirements for generalisation. They were instead transparent about their subjectivity and suggested that the dominance of positivist methodological approaches to literature review excluded potentially important praxis considerations and outcomes drawn from context based fugitive service evaluations and localised studies. As such Slater and Townend (2016) represents an original and important contribution to the HS CBTp literature.

2.2.6 Conclusions from Slater and Townend (2016) in the Context of the Thesis.

By developing a novel and exploratory review strategy, Slater and Townend (2016) were able to identify fourteen sources with applicability to the aims and objectives of this thesis. This was a higher number of sources than had been identified by previous or subsequent reviewers. Interpretation and appraisal of content helped determine the extent to which CBTp was an active and effective component of HS treatment provision in the UK and internationally. In relation to C-Co, the published review (Slater & Townend, 2016) supports C-Co's underlying premise that context specific variants of individual CBTp, that include flexibility of approach, chief-complaint orientation, and protracted numbers of sessions, alongside symptom specific CBT approaches to psychosis, may be warranted to maximise intervention efficacy with typically non-adherent, treatment resistant, HS patients. In

relation to this thesis the published review also highlighted directions and potential methodological approaches for further research. The review evidenced that more needs to be understood and disseminated regarding specific innovations in HS contexts that enhance CBTp efficacy, and that multi-component, pragmatic methodologies that offer a deeper, broader, praxis understanding, and evaluation have value and are warranted.

2.3 An Update to the Published Work Involving the Reapplication of the Novel Review Strategy Used by Slater and Townend (2016).

This section of the chapter offers an update to the published review. It adopts the same review strategy and inclusion criteria as the published review except for date range. The date range of the update was limited to studies completed after 2015, the upper cut-off of the published review. Only sources that described and offered an evaluation of a HS CBTp intervention were included. Those which offered only descriptions but no evaluation, were excluded. Within the published paper a systematic review of available databases was first used but yielded few results, a similar outcome to systematic reviews previously attempted by other researchers. As part of the update, it was important to determine if this was still the case. A systematic search guided by a pre-existing set of Cochrane Collaboration search parameters (Jones et al., 2004), the same as those first deployed by Slater and Townend (2016), was used across all accessible healthcare databases. This yielded two results that had direct relevance to HS CBTp interventions:

> Ferrito, M. And Moore, E. (2017). An exploratory study on the issues and challenges clinicians encounter in the application of cognitively behavioural therapy with mentally disordered offender patients. *The Cognitive Behaviour Therapist*, 10(19), pp. 1-17

And

> Slater, J. & Painter, G. (2016). Taking Steps: Using collaborative group game design to consolidate and evaluate experiences of individual chief complaint-orientated cognitive behavioural therapy for psychosis in conditions of high security. *The Cognitive Behaviour Therapist,* 9(19), pp. 1-16.

Ferrito and Moore (2017) used a semi-structured interview approach and thematic analysis to identify and better understand the challenges encountered by a sample of 6 clinicians delivering generic CBT approaches to patients with severe anti-social personality disorder and a high risk of violence detained in a HS UK context. This study was therefore excluded from the organisational case analysis as it did

meet the inclusion criteria of using HS CBTp with non-adherent, treatment resistant psychotic patients. Similarly, Slater and Painter (2016) reported on patient and practitioner experiences of HS CBTp, in this instance C-Co, rather than offering outcomes per se and was therefore also excluded from the literature review update. However, 'Taking Steps' was developed as part of this research and constitutes an important component within the organisational case study. A more comprehensive description of 'Taking Steps' and the impact of C-Co on patients and practitioners is provided within the Component Outcomes Chapter (Chp. 4).

As per the published review, reference lists of the identified papers were checked for further sources, and researchers and colleagues working in HS settings (nationally and internationally) were contacted to see if they were aware of any further research which met the inclusion criteria. This process continued until all possible leads were exhausted. Two unpublished fugitive studies were found:

> Cawthorne, P. 2019. *A process evaluation to determine the barriers and facilitators to implementation of a cognitive behavioural therapy for psychosis treatment programme in a high secure setting*, University of Stirling Faculty of Health Sciences and Sport; unpublished doctoral thesis.

And

> Yanovitch, M.A. 2019. *Investigation of burnout following a CBT for psychosis training for staff on secure forensic mental health units: A pilot study*, Palo Alto University; unpublished thesis.

Cawthorne (2019) used a retrospective review of case notes, interviews with clinicians, and a Delphi study to highlight barriers to the use of an adapted HS version of individual CBTp referred to as 'forensic CBTp' or CBTp(f), to better understand the limited efficacy of CBTp(f) (Cawthorne, 2003), limited patient engagement, and falling referral rates. This study and its linked pilot study (Cawthorne, 2003, discussed in Slater and Townend, 2016) are important in the context of the research. Other than those conducted by the researcher, Cawthorne (2003) and Cawthorne (2019) are the only other studies to investigate the impact of a systematically developed, specifically adapted, service-led individual HS CBTp approach. Whilst Cawthorne (2019) has relevance to later sections of this thesis, it offered no additional outcome data for CBT(f) efficacy beyond the limited results of Cawthorne (2003). Cawthorne (2019) was therefore excluded from the literature review update.

Yanovitch (2019) used focus groups and computerised self-report to determine the impact of CBTp training on perceived burn-out amongst social work and psychology staff on forensic mental health units in three California State hospitals. However, the study did not report on any specific patient outcomes of using individual CBTp. Training provision was low-intensity and psychosocial and recovery orientated as opposed to CBTp per se. Whilst some of the study sites had HS facilities, the studies seem to have taken place within the hospital rehabilitation units, an equivalent to low-secure UK provision. This study was therefore also excluded from the update. As an additional check, the researcher also approached his Trust Library Service to cross check his strategy application. The search provided by the library service (Thorpe, 2022) yielded no additional results to those identified by the researcher. No studies which met the review update criteria were therefore identified through re-applying the novel review strategy developed by Slater and Townend (2016).

2.4 Chapter Summary

This chapter was first drafted in 2014 which later formed the basis of a subsequent publication (Slater & Townend, 2016). The first part of the chapter provided a summary of Slater and Townend (2016) and offered conclusions in the context of the thesis. The second part of the chapter provided an update to the published work and involved the reapplication of Slater and Townend's (2016) review strategy to identify and analyse published and fugitive studies conducted since the earlier publication. No relevant studies were identified for analysis. The chapter provided evidence of CBTp being an active component of HS treatment provision in the UK and internationally. Outcomes also supported the underlying premise of C-Co as a potential means of enhancing CBTp efficacy in HS contexts through addressing barriers relating to non-adherence. However, the chapter also highlighted that HS CBTp studies are limited in number and often fugitive, supporting the assertion that more research is warranted and the justification for this thesis. In the next chapter the researcher explores the methodological perspective adopted by the research and provides details of the method used. Ethical considerations and actions are also explored.

CHAPTER 3: RESEARCH METHODOLOGY AND METHOD.

3.1 Introduction.

Methodology may be defined as the researcher's philosophical perspective and the associated ontological and epistemological assumptions made by the researcher in relation to the research (Howell, 2013). This research adopts a feminist methodology. The primacy of any one methodological paradigm is rejected. Pluralism and parity are embraced. The method of organisational case analysis is used to support this perspective (Yin, 2003; Yin, 2018). A facet-based theoretical framework is deployed to structure the organisational case analysis into discrete components for analysis facilitating greater objectivity (Mason, 2011). To determine C-Co impact and provide responses to the research questions, positivist, constructivist, and critical realist lenses are pragmatically used to provide researcher transparency (C1), to research each facet of routinely gathered C-Co data (C2-C6), to analyse the impact of result dissemination (C7), and to analyse the level of organisational case analysis convergent validity (C8) (Table 1, Fig. 1). Pluralist, innovative, and award-winning methods are deployed. In this chapter, the research methodology is first explored, informed by an introspective string shaped over the course of the research. The research method is described, and research questions and linked research components reiterated for context. Ethical considerations, commensurate actions, and approval are then discussed.

3.2 Research Methodology.

Whilst impoverished in comparison to works like Jack Kerouac's 'On the Road' (Kerouac, 1957), the introspective string below helped the researcher to better understand, evolve and transparently portray his feminist methodological stance in relation to the research. It helped him to appreciate more fully the crucial interconnectedness of epistemology and ontology with research questions, method, result analysis, and dissemination. The string was developed via an iterative process of encirclement using free association to shape content. Engaging in this form of reflexive insight development is a crucial part of enabling the researcher to better understand, clarify and portray their methodological stance (Lafrance & Wittington, 2019). Fine (2016) reminds us of the importance of deeper reflexivity when conducting research to promote growth and accountability. The string was started in the first year of the researcher's doctoral programme and evolved via several iterations as the researcher progressed through his postgraduate studies. It is still not the 'finished product' but offers a snapshot, the culmination of several moments in time, reflecting

some of the concepts the researcher has grappled with and attempted to resolve to better understand and convey his methodological perspective.

'Je pense, donc je suis' - I think, therefore I am… '*cogito ergo sum.'*

- Descartes (1637), cited by Dika (2023).

"11:03pm, what feels like a long time ago, sitting at a makeshift desk in that room in the house where we dump everything. I sit in the semi-dark room with the solitary company of my glowing computer screen – I'm not quite sure of the thoughts I'm thinking. Or how the thoughts that I'm thinking become the words that I'm writing, the words that get read, by you maybe, perhaps becoming your thoughts that are kind of my thoughts but are maybe different because you're thinking them? Does Descartes apply if it's my thoughts that you're thinking – wouldn't that make you me? But you can't be me as I'm somewhere else now, thesis hopefully finished. It's been a slog, juggling work, family, relationships, everything, despite the transformative experiences.

"My attention's is drawn to the flashing cursor on the screen - presumably it flashes to help you notice it, my behaviour directed by someone else's, but is my experience of the cursor the same as everyone else's…? The same as yours…? I notice I'm easily distracted - my dealer boots, snaffled in the sales, kind of think I look fab in them but too shy to really think that - I think it through some shyness 'filtery' thing. No idea why I'm shy, it's not very useful; memories go right back though, permeates, infiltrates, often without me noticing. Wonder how I'd see the world differently without it?

"I notice, deduce that my desk can't be level…Pen rolls off, hits the floor – cause and effect, so straight forward, easy to test, hypothesise, verify gravity, beautiful even. Comte would be pleased. I like the idea of an external world of measurable, observable, universal grand truths, it makes sense to me on some level, is useful, but I guess it depends on who's doing the observing and I feel lost applying the same simplicity to my internal world and to humans whose history repeatedly shows that we can corrupt and misrepresent the cause and effect we've observed, even justify atrocities however 'scientific' the claims. Head's filling but feels empty, desperate for the next helpful thought train to steam through my scrambled egg consciousness and make it onto the page. Weird how you can observe yourself observing.

"I imagine postmen and surgeons observe the colour red differently. Popper and Heidegger spring to mind, arguing about which colour perspective is right, about which colours are valid. But are you really seeing the world, really knowing it if you exclude different colours and colour perceptions? Almost instinctively I find myself defiantly opposed to colour-blindness, I'm fed-up of reading dominant 'gold-standard' research that doesn't speak to me, misses my experiences, seems to contribute to the marginalisation and control of the people I nurse. There is something powerful, more representative about not excluding colours, others' interpretations, feels like it fits with nursing, fits with psychotherapy. I've never given up on trying to see, understand, accept people who are different to me, which is essentially everyone, but it's not always harmonious – perhaps I should add 'idealistic', to the shy. Always advocated better for others. Maybe the thesis is a way of advocating for me, but hopefully helping to empower others, maybe that's where dissemination comes in. Middle daughter, bless her, a flowering artist, used to think the past was black and white…assumptions about colours in the old photos, she tells me now, with some authority, there only really three colours, what people see is just about how cleverly you mix them. I wonder about whether it's a good analogy for positivist, constructivist, and critical realist methodologies…

"I'm not sure about how I see methodology, about my 'mixing' of the colours, about whether they can be mixed, guess that's why I'm typing this, just seems to change, deepen, broaden. Lots to say, but it feels so complicated, multi-faceted, feel funnelled into taking sides, the conservative, or the revolutionary. It's like having to decide who you are, but bits of me are hidden and the definition fleeting, dependent on the 'when' and on who's doing the defining. Intuitively, emotionally I'm an iconoclast, but mentally there's a dilemma, do I conform to be heard. I struggle with the perceptions of inequality I hold, of feelings of being controlled. People experiencing mental health seem so marginalised, controlled, acutely so in high secure care, there's so much more we could do. That feeling comes back again, ingrained from my own first contact with services. It can be such a destructive experience psychosis, made more so in my belief by having to conform with a system of subjugation to get help, at least that was my experience. I just want to make it all better…a need to understand idiosyncrasies rather than slap on the cuffs of a generic fix.

"Middle daughter once asked her mum which came first, mummies or daughters. My wife: "It's a bit like the chicken and egg sweetheart". Paradox – a quizzical, beautiful, vulnerable look on my daughter's face, then simple acceptance. Darwin might have a slightly longer explanation. My other daughter chimed in, "Doesn't matter, shops sell both!" I think she meant chickens and eggs, far more pragmatic, different epistemologies, ontologies. I love both, value both, gain from their

differences. But they'll bicker like mad over who's right, vie to be Foucault's dominant discourse, sometimes fiercely, maybe Kuhn's right, maybe it's just human nature, but I want us to all have a voice, to be heard…it feels important in some way to at least try, although I'm not 100% sure it's possible.

"I hear the third child's breathing on the monitor. It relaxes me, tells me he's safe. Everything else is quiet, still. The next Train à Grande Vitesse is arriving…maybe it's more je suis, donc je pense, I am, therefore I think…'donc' I add words to this thesis…maybe it's an endless paradoxical string of therefore I am, therefore I think, therefore I am, therefore I think…..just different sides of an endlessly flipping coin, dependent on who is doing the flipping and when! Wohooo, wohoooo or whatever noise French trains make to French people…who communicate in Latin."

The researcher first became aware of feminism from his mother. Age seven, he remembers his mother holding a weekend 'coffee morning', an activity where she would invite other armed forces housewives to drink coffee and socialise. Whilst he would generally play with his toys or watch TV and not be a direct part of such events, he remembers one of the guests stating that, "wives should stick together." Curious, after the event, he asked his mother why. The event occurred at the height of second-wave feminism and the organised feminist activism of the 1960s and 1970s, and whilst the researcher doesn't fully remember his mother's response, he does remember her saying, "boys are more privileged than girls," and remembers his own intuitive sense that this disparity seemed odd.

During his first degree, when he studied 20th century civil rights movements, the researcher became more aware of feminist theory, its influence, and importantly forms of feminist scientific inquiry. He was particularly struck by the seminal academic works of Helen Longino published during his degree. The perspective Longino espoused in *Science and Social Knowledge* (Longino, 1990) proved formative in that it established feminism as both a philosophy and a research methodology as per its application in this research. It provided the researcher with a gynocentric theoretical framework that offered meaningful insights and new perspectives into societal privilege, inequity, and paternalism. It gave context to his mother's earlier remarks, and the almost emotional and intuitive presuppositions he held and that had been nurtured within him about gender inequality and the moral and ethical justification for redress. It offered a meaningful theoretical framework from which to contextualise the resurgence of feminist activism from the 1960s to the time of his studies. Importantly, Longino also suggested a relevance for feminist theory beyond that of a purely

gynocentric context and the author was struck by how the tenets of discrimination, oppression, patriarchy, and objectification, that underpinned inequality within feminist theory, also had application to other civil rights movements, like the black civil rights movements that were evident over a similar epoch in America. In his writings and speeches Dr King acknowledged the important 'education' he received from female black welfare activists alongside the critical importance of figures like Rosa Parks and the duality of the inequality she experienced as both a black person and a woman (Washington, 1986). Whilst the influence of theology and religious non-violence have been central to civil rights, the acceptance of women's rights as civil rights and the early removal of gender distinction within many civil rights movements denotes a shared purpose and theoretical principles at a time when most western societal structures remained wholly androcentric. This wider application is embraced by more recent feminist scholars who argue that to only associate feminism with the rights of women is both simplistic and reductionist (Lay, 2007).

Whilst completing his MSc, the researcher revisited Longino's work. He realised that this and works by other feminist academics provided a theoretical framework that articulated and helped him to better understand and conceptualise his dissonant experiences of psychiatric care, his journey into psychiatric nursing and HS services, and his need to challenge the inequalities he perceived were due to the dominance of medical discourse. His doctoral studies afforded the researcher a further opportunity to explore and revisit feminist theory. As with the civil rights movements of the 20th century, the mental health civil rights movements of this century like A4D and Mad Pride, of which the researcher has been part, share the theoretical principles of earlier movements, incorporating feminist theory linked to inequality, discrimination, patriarchy, and dominance.

However, the criticisms that apply more widely to feminist theory also apply to its adoption within a civil rights context like mental health. The diversity of diagnosis, disparities of service provision, division of opinion relating to activism, polarisation of perspective between reforming the existing system or creating a new one, the lack of sufficiency regarding idiosyncratic individual patient experience, and the complexities of how mental health is perceived across cultures, and societal and economic contexts, are but a few (Lay, 2007). As with gynocentric experience, the application of feminist theory to mental health inequality, also fails to provide a monolithic universal explanation of that inequality. Different constructs of domination, like the dominance of the medical model within mental health provision, require a unique matrix of understanding in addition to that of any intersecting oppression (Collins, 2000).

Much of the published literature relating to mental health 'inequality', links this to societal and economic theories of disadvantage and references a 'mental health burden' rather than exploring the possible impact of a dominant medical discourse and a failure to apply alternate means of evaluative scrutiny within healthcare (Johnstone, 2000, Filer, 2019a). This perspective is adopted by most western governments when developing theories about how to address mental health inequality and reduce this 'burden' (Department for International Development, 2020). This is counter to the researcher's presuppositions about mental health service provision and how services might be improved. Supported by the myriad of available anecdotal patient testimony, works by non-medical mental health professions and academics, his own previous scholarship, and experiences of being a mental health professional and patient, the researcher presupposes that mental health services might have greater impact via reform that explores alternatives to the dominant medical discourse and views impact from alternative standpoints to those adopted by the medical profession. This presupposition differs from the more radical perspectives within feminist and patient movements. These perspectives advocate that an entirely new system of service provision is required, in contrast to the researcher's belief that reform from within will redress inequality and improve intervention impact. Standpoint feminist research methodology and scientific enquiry aligns with the presuppositions held by the researcher.

Within her seminal works, Longino described how feminist theory could be adopted as a research methodology and form of scientific inquiry. Rather than promote the primacy of any one methodological perspective or even a distinctively female way of knowing, Longino (1990; 1993) argued for pragmatic paradigmatic pluralism and the parity of different ontologies and epistemologies. She argued that research data of any kind is neutral and that its relevance and value are subjectively and societally constructed. As Schutte (2000) later asserted, 'the nature of knowledge is not culture-free but is determined by the methodologies and data legitimated by dominant cultures,' (Schutte, 2000, p.40). Longino argued that the scrutiny of data, or subjects of research like C-Co, from multiple standpoints, using multiple methodological lenses and methods, embracing quantitative and qualitative methods equally, enhanced objectivity, facilitating convergence or flux within what is societally known. Excluding certain standpoints in deference to others caused bias and inequality and lessened objectivity (Longino, 1993). This aligns with the researcher presuppositions regarding inequalities of discourse and research paradigms within mental health. Longino (1990) advocated for the democratisation of dialogue to constructively explore dissonant interpretations of data and mutually identify areas for additional scrutiny, thereby iteratively facilitating closer and closer approximations to a convergent objectivity.

It is important to offer a distinction between pluralist, pragmatic, and feminist methodologies. Whilst these methodologies intersect, and feminist researchers highlight that pluralism and pragmatism are valuable forms of scientific inquiry, feminist philosophers are critical of both as they fail to espouse the democratisation of knowledge integral to feminism. They argue that without the centrality of democratic parity, pluralism and pragmatism perpetuate oppressive, androcentric interests and dominant perspectives. They highlight that seminal male philosophers, who advocated for pragmatic pluralism, failed to appreciate how their own freedoms to express and hermeneutic context intersected with and reinforced the oppression of others (Whipps & Lake, 2024). Whilst feminist methodology integrates pragmatism and its emphasis on pluralism, it views these through the lens of hermeneutic and social contexts and systems of oppression that marginalise other equally important voices and ways of knowing. It explores and exposes the facets of dominance that perpetuate oppression, that preclude flux across multiple realities and prevent inclusive problem-solving and creative discourse. This rejection of universal truth, in deference to multiple realities and the democratisation of these, has led to the labelling of feminist methodology as purely qualitative and lacking generalisability. It has led to criticisms regarding a failure to truly integrate and afford equal status to quantitative methodology. Quantitative empirical feminist research is critiqued on the basis that its design is to seek data with which to challenge the dominant quantitative discourse using its own paradigm and is therefore inherently bias (Whipps & Lake, 2024).

Whilst epistemologically and ontologically the research incorporates several elements of feminist research theory, the researcher rejects the assertion that feminist research must be purely gynocentric. Activist feminists assert that feminist research must be gynocentric and lean towards a more empirical methodology that can infiltrate and directly challenge mainstream, dominant ‘gold-standard’ discourse (Jessica Taylor, 2022). Any deviation is perceived as an anathematic, androcentric influence. Yet other feminist researchers argue that this stance betrays the wider application and value of feminism. They assert that gynocentric feminism has enabled a select group of privileged, white, middle-class European and American women to prioritise their agenda above the universal needs of all women and argue that true feminism has value for all oppressed and marginalised groups (Kendall, 2020). People experiencing psychosis and patients detained in conditions of HS are examples of these groups. The central tenants of standpoint theory, social justice, social constructionism, postmodernism, and relativism within the latter feminist research perspective deeply appeal to the researcher. Empirical, activist feminism, and gynocentrism seem

counterintuitive to these tenants via the exclusion of other ways of knowing, other methods of deriving knowledge, and other marginalised groups (Belle & Doucet, 2003).
The presuppositions held by the researcher feel more intuitively and conceptually methodologically aligned to the research perspective of standpoint feminism. It posits that there is no such thing as a neutral detached observer or single lens or method through which knowledge can be scrutinised or created (Longino, 1993; Hicks, 2011). Being answerable and open about how one sees one's reality is crucial and integral to this methodology (Hekman, 1996). Ontological value is assigned to the voices of marginalised groups and people, to transparency and to the plurality of standpoints, offering an epistemological starting point for considering ways in which experiences are shaped by a multiplicity of social lenses including, race, sexuality, health, disability, age, social class, and gender (Anderson, 2011). Research evidence is used to challenge epistemic injustices and confront oppressive systems and power structures (Hundleby, 1997; Fricker, 2007; Egbert & Sanden, 2019).

The primary intention of this feminist methodological perspective is to promote ways of understanding that enable and empower people on the margins of society whose voice has been silenced by the dominant discourse or research paradigm (Fricker, 2007). This methodology embraces a pragmatic approach, facilitating the exploration in-situ of the subject of research, in this instance the 'real-world' delivery of C-Co by a HS CBTp service (Anderson, 2011). It encompasses the understanding of that subject from multiple methodological perspectives using multiple methods matched to the real-world data, without the exclusion or control of potentially relevant factors. It also embraces the potential for fragmented, de-synchronous outcomes, thereby removing any pretence of there being only a single truth or way of knowing (Longino, 2002). Research aim, objectives, questions, method, and research components align with this position in that they allow the inclusion of and attribute value to multifaceted, different forms of knowledge derived by different methodological perspectives and research component methods. Aligned to the research methodology, organisational case analysis offered a parsimonious means of framing these considerations and ensuring a cohesive focus for abductive analysis and discussion (Yin, 2003).

The researcher's feminist methodological perspective is evident and further justified within the introspective string. This is further explored in the context of the research. In attempting to better understand and portray his methodological stance, the introspective string demonstrates that the researcher has grappled with the concepts of what it means 'to be' and to know, of subjectivity, objectivity, of irrealism and realism, of personal idiosyncrasy, of the impact of time and place, of accountability, of cause and effect, of how knowledge is disseminated between humans, of the

primacy of some dialogues over others, of how knowledge is derived, of how perceptions differ, of inequality and control, and of corrupt science. References are made to the works of Descartes, Popper, Heidegger, Comte, Darwin, Kuhn, Foucault, and Dewey, alongside attempts to make sense of existentialism, rationalism, empiricism, relativism, and power within the researcher's everyday experiences and within the context of the research. Positivist, constructivist, and critical realist methodologies are likened to primary colours, the mixing of which might develop new ways of creating and understanding knowledge.

The radical scepticism asserted by Descartes (Dika, 2023) suggests that very little can be perfectly or absolutely known in a manner which is incapable of being doubted. Anything that is in anyway probable and therefore uncertain is not perceived as 'true' knowledge. The "fluctuating testimony of the senses or the deceptive judgment of the imagination" is rejected and "certain and evident cognition" afforded primacy (Dika, 2023; Machamer & Adams, 2014). Descartes' method of enumeration, using contingent and necessary propositions, is elevated above syllogism as a means of discovering the 'simple natures' or pure, absolute knowledge: I know that I exist; I know that I think; knowing that I exist is a thought; I think therefore I am (Dika, 2023). With regard to the human sciences, using Descartes, one might reach the irrealist, solipsistic, constructivist conclusion that nothing is really known beyond the subjective cerebral lens of the consciously realisable self, that all understanding is seen through and indeed derived from that lens, and that very little can be absolutely known or be 'true' as our cognitions invariably yield only probable insights and are rarely free from the influence of our senses and imagination.

Descartes' assertion (Machamer & Adams, 2014) that little if anything can be absolutely known as true is shared by the researcher at both a subjective and societal level. Within the string the researcher questions what is really known, in what ways you as the reader exists, how knowledge is conveyed and whether a cognition or a flashing cursor, or the results from the thesis research, can be truly experienced in the same way by two different people or the same person at different times or indeed should be for research to have value. Based on his own lens, the researcher grapples with the rationalist notions of 'certain and evident cognition,' of being able to bracket out the effects of the senses or imagination, of time and context, of our known and unknown character traits, such as shyness, and of our pasts and projected futures.

The researcher wonders instead whether 'I am, therefore I think' might be a more representative phrase, in that there is a possibility that what we perceive as cognitively known may derive from the

sum of who we are and may therefore be inexorably influenced by emotions and imagination in ways too subtle to counteract via a research process of conscious bracketing. In turn, the metaphor of an endlessly flipping coin is used to suggest that who one is, how one feels and imagines, the context in which one believes one exists, may subsequently be influenced by, and evolve in some way because of the things one thinks and vice versa. These considerations within the introspective string demonstrate that constructivist methodology is valued by the researcher. In the context of feminist methodology, constructivist methods can facilitate the reflexive analysis needed to demonstrate researcher transparency, uncover bias, and understand the experiences of people in marginalised groups. A constructivist methodology and method are therefore used in research component 1: *Autoethnography: Description and Inferences as Part of Reflexive Practice*, to provide researcher transparency.

The perspective that accessible cognition is a product of but may also influence a deeper less accessible multi-faceted process of being is central to most evidence-based psychotherapeutic perspectives, including CBTp. But, like the design and influence of the flashing computer cursor referred to in the introspective string, these psychotherapies adopt a more realist and subjectivist or critical realist methodological position. Freud's psychoanalytical model theorises that perceptions of internal and external stimuli are sorted and censored by hidden memory subsystems prior to appearing as conscious accessible thoughts (Goleman, 1997). Beck theorised that accessible cognitions were automatic responses to internal or external stimuli shaped by schemas derived from earlier experiences (Beck, 1976). Seminal neurological studies indicate that much of how we respond to external, or realist stimuli is independent of consciously realisable subjective cognition (LeDoux, 1996; LeDoux, 2003; Marteau et al., 2012). The considerations within the introspective string, in conjunction with his psychotherapy specialism, demonstrate that the researcher ascribes value to critical realism as well as constructivism. A critical realist methodology and methods are adopted in research components 3, 4, 5, 7 and 8 (Table 1).

From a critical realist perspective, the researcher also concedes that he may have no influence over how you or any other reader subjectively value the external stimulus of this research. The researcher believes that how external stimuli like this thesis are understood and valued by others is entirely subjective and dependent on the who, when and perceived context of the receiver. The researcher believes that the receiver's subjective perspective if expressed and shared creates a new external stimulus with the potential to create flux within what may be societally known, understood, and valued from the initial stimulus. Aligned to his feminist methodological perspective, the researcher

believes that his transparency (Component 1) and the research dissemination strategy (Component 7) offer the most salient means of facilitating potentially constructive dialogue and therefore flux within and a re-construction of what is societally, externally known and more specifically known in relation to the research subject of C-Co.

Like the observable effect of his pen rolling off the researcher's sloping desk in conjunction with the theory of gravity, the considerations within the introspective string demonstrate that a realist ontology combined with an objectivist epistemology also have value to the researcher. Whilst this positivist methodological perspective has limited value to the researcher regarding his subjective internal world, its methods and results have value in testing and further developing theoretical hypotheses of more universal cause and effect. Positivist methods are therefore deployed in research components 2, 6 and 7. In component 2: *C-Co Modality Fidelity and Praxis Competency*, positivist methods are used to attribute causality of C-Co impact. In component 6: An Exploratory Analysis of *Pre and Post C-Co Outcome Measure Data*, an exploratory, quasi experimental, statistical analysis is used to determine significance, effect size and *post hoc* power to test what the impact of C-Co on patients might be. Similarly, in component 7 positivist publication metrics are used to determine dissemination impact. The introspective string and research components therefore demonstrate that the researcher ascribes value to multiple methodological perspectives including constructivism, critical realism, and positivism, and commensurate methods, which aligns with his feminist research methodology.

The introspective string also demonstrates that the researcher is conflicted by the pressure he feels within the context of HS psychiatry to assign primacy to positivism. In keeping with his feminist methodological stance, the researcher rejects the dominance of one methodological perspective over another. In the same way that the researcher's children 'bicker' to be the dominant discourse, it is evident that proponents of some discourses and perspectives, of certain ways of knowing and knowledge, deliberately and systematically pursue dominance and influence by controlling, discrediting, or excluding other forms of knowing whilst promoting their own (Khun, 1962; Foucault 1997). By being in a position to influence knowledge construction, value and any disseminatory discourse, those with power may inadvertently (or indeed deliberately) reinforce and perpetuate their own dominance and ideals (Palys, 1997).

Critics argue that such dominance may be evident in the field of psychiatry where empirical positivist knowledge and the 'gold standard' RCT (NICE, 2014) may serve to perpetuate the

dominance of the medical model and pharmacological treatments, to the detriment of other health interventions (Mantzoukas, 2008). According to the NICE Glossary, ‘gold standard’ research is ‘a method, procedure or measurement that is widely accepted as being the best available to test for or treat a disease’ (NICE, 2024). It could be argued that the term ‘widely accepted’ is a social, consumerist construction where professionals and not patients are the consumers. Whilst proponents of the RCT gold standard in psychiatry argue that it reduces bias and is the only means by which results might be generalised, critics suggest the consumerist nature of health research and inherent power imbalances between those treated and those offering treatment, result in publication, method and methodological biases. These biases preclude other ways of knowing and treatments that may result in improved outcomes, and paradoxically also limit a deeper understanding of the constructionist reality of healthcare interventions (Frieden, 2017). Some critics go so far as to argue that this dominance, in combination with professional hegemony, has been used to justify what many now perceive as ‘abusive’ practice (Sidley, 2015).

The destructive procedure of lobotomy as a first-line treatment for a wide range of mental health presentations gained considerable traction during the last century due to the dominance of a spurious positivist scientific evidence-base and continued to be used long after it was established to be wholly iatrogenic (Sidley 2015). Pharmacological psychiatric treatments for the ‘scientifically determined’ ‘disease’ or ‘aberration’ of homosexuality are also still afforded credibility and coercively imposed in many counties. Within western cultures ‘schizophrenia’ and psychosis continue to be perceived as genetic medical diseases despite no genetic markers or determinants ever having been proven and a wealth of trauma research, both qualitative and quantitative, strongly indicating a more nurture-based aetiology (Read & Dillon, 2013). Despite little established validity or biological testability, the DSM-VTR, a construct of a handful of predominantly white, male, upper-middle class Americans, which pathologises almost every facet of human behaviour and experience as a disease to the exclusion of other forms of interpretation, continues to have an almost universal dominance (Filer, 2019a). The influential pharmaceutical industry, worth trillions of dollars, dominates the provision of ‘cures’ for these diseases via evidence from RCTs despite a wealth of evidence, including RCTs, that suggests limited effect (Reissegger et al., 2021).

Psychiatry has also used its dominance to justify and perpetuate racial and gender discrimination (Segrest, 2020). Diagnoses like drapetomania and dysesthesia aethiopia and the current disproportionate incarceration of people from black and ethnic minorities in psychiatric hospitals supports this assertion. Similarly, the distress experienced by women because of misogyny, rape, or

androcentrism is all too often pathologised and pharmacologically silenced because of medical psychiatry's dominance, rather than really understood and heard (Taylor, 2022). Psychiatry has also used empirical evidence to justify the mass euthanasia of psychiatric patients. Between 1934 and 1945 German psychiatrists used pseudo-scientific evidence to justify the systematic murder of 300,000 psychiatric patients from asylums across Germany and its occupied territories.

The examples above give weight to the researcher's feminist methodological position in that data is neutral and that most, if not all, of what is accepted as 'known' or valued as knowledge is a societal construction, is in constant flux, and is hermeneutically dependent. The researcher believes that 'facts' or 'truths' are synonymous with 'best guess' however sophisticated, and are subject to political, social, and economic interpretation, bias, and corruption. All systems by which knowledge is derived are mutable, facilitating the refinement and convergence of earlier 'best guesses' into more potentially representative or perhaps more palatable forms of knowing. The degree of credibility afforded this knowledge is entirely hermeneutically dependent and subject to change.

Societal knowledge about the scientific benefits or dangers of smoking tobacco or ingesting refined sugar are particularly apt examples of this process of flux. One only needs to look at 'TikTok' or 'Facebook' and their influence on what is perceived to be true. The Oxford English dictionary now includes the phrase 'fake news' in deference to societal modes of knowledge construction (OUP, 2023), and the BBC has a 'misinformation' correspondent and a service dedicated to verifying information (BBC, 2023). Aligned to his feminist methodology, the researcher believes that what is known, by whatever route it is known, even if it is considered at a particular juncture to be absolute and dominant, remains vulnerable to further processes of construction and deconstruction via subjective, societal, and hermeneutic interpretation and scrutiny. The researcher believes that the feminist methodological scrutiny of a subject from equally valued, multiple methodological standpoints, using multiple methods, explored within a context of constructive, democratic dialogue, is the only apposite means of achieving true objectivity and the only means to reduce and challenge the propensity of dominant discourse misuse.

In this section of the methodology chapter the researcher has described and defended his feminist methodological perspective. An introspective string, developed over the course of study, was used to help the researcher better appreciate and convey his methodological position, affording greater reflexivity with which to promote growth, accountability, and transparency. The string conveys the concepts and real-world perspectives and considerations that the researcher has grappled with to

reach his standpoint feminist position. The string and subsequent discussion convey the value the researcher attributes to different way of knowing and knowledge creation and how constructivism, critical realism, and positivism all have value within the feminist paradigm, as well as how paradigm dominance has led to the subjugation of marginalised groups. The discussion and string also illustrate the researcher's perspective that data is neutral and that all of what is known or perceived to have relevance is socially constructed and in flux and that democratic dialogue is a pre-requisite to true objectivity. In the next section of the methodology chapter, the researcher illustrates and discusses the primary and secondary methods adopted by the research and research components.

3.3 Research Method.

Aligned to the research feminist methodology a facet-based organisational case analysis was used to analyse routinely generated C-Co data to provide a pragmatic, multi-component, and multi-method analysis of C-Co impact regarding the research questions (Fig. 1). The organisational case analysis is comprised of 8 research components (C1-C8, Table 1). Facet theory and techniques propose that the subject of research is like a cut gemstone with multiple facets, each of which may offer insightful flashes of perspective depending on what light, or method of scrutiny, the facet is exposed to (Mason, 2011).

The different formats of data that are routinely gathered as part of C-Co application may be considered its facets; the different research component methodologies and methods of analysis a way of directing light at that facet; the refracted reflection the results; an analysis of convergent validity a means of better appreciating the whole gemstone, affording significantly greater objectivity (Table 1). Fig. 1 illustrates this perspective. At its centre is C-Co (the gemstone) surrounded by facets of routine data. The sample size for each facet is provided. Arrows from each facet point to the research component within the organisational case analysis that is specific to that facet and further arrows to the methods deployed within that component and the research questions linked to it. Two additional arrows at the top right and left of the schematic illustrate 2 further research components that were applied to the whole C-Co gemstone - C7: *Dissemination Strategy and Results*, and C8: *Summative Synthesis and Convergent Validity*.

The types of sampling used for the different components and for patients and practitioners involved in the research are provided below:

- Autoethnography: materials were purposively sampled from the researcher's possessions and reflexive research journal to convey researcher transparency.
- Modality Fidelity and Praxis Competency: random selection – 3 C-Co session recordings were randomly selected for independent CTS-R rater assessment from 56 recordings.
- Patients: purposive sample – of the patients engaged with the HS CBTp service, only patients who had been considered non-adherent prior to engaging in C-Co, who continued to experience distressing residual symptoms despite the prescription of antipsychotic medications (treatment resistant), and who had not been in receipt of any other psychotherapies during the provision of C-Co were included in the research.
- Practitioners: convenience sample – C-Co practitioners who were delivering C-Co and gave consent were included in the research.
- Dissemination: convenience sample based on the number of examples of research dissemination and on people who provided workshop and peer review feedback responses.

3.4 Research Component Details.

Component 1: Autoethnography - Description and Inferences as Part of Reflexive Practice.

The researcher initially kept a diary to aid reflexive practice and protect against self-verification. This evolved into an autoethnographic account of the first time he was assessed by psychiatric services. It facilitated a greater depth of understanding regarding the researcher's motivation in the context of the research and provided researcher transparency.

Linked research question:

- R1: What impact has the researcher had on the research?

Component 2: C-Co Modality Fidelity and Praxis Competence.

Fidelity and competency testing using the CTS-R to rate recorded sessions were a routine part of C-Co delivery. To explore modality fidelity and competency, this research component aimed to replicate the approach adopted by Slater (2011) in which randomly selected recordings of C-Co

sessions were independently rated by BABCP accredited CBT psychotherapists using the Revised Cognitive Therapy Scale (CTS-R). Policy changes regarding the recording of HS patients and other context related difficulties precluded this aim. The data from Slater (2011) is therefore re-examined in the context of the research to determine new insights and causality.

Linked research question:

- R2: Does C-Co achieve modality fidelity and praxis competence?

<u>Component 3:</u> A Descriptive Single Case Analysis of C-Co Application:

Case data pertinent to case description is routinely gathered as part of C-Co delivery and presented within the case report completed at the end of therapy. This component of the research includes a case description of C-Co application with a purposively sampled typical HS patient (n=1). It builds upon routinely gathered data by adding more depth regarding praxis to offer a deeper description of C-Co application with a typical patient in a HS context. Emphasis is placed on the chief-complaint orientation stage of C-Co. This research component did not gather case data in addition to that generated as part of routine practice.

Linked research question:

- R3: What impact does C-Co have on patients?

<u>Component 4:</u> Participant Experiences of C-Co - Visual Representation and Thematic and Descriptive Analysis of Data.

Participant (patient and practitioner) experiences of C-Co are routinely evaluated and consolidated as part of the HS CBTp service's consolidation group. Participatory action research (PAR) was used as a means of researching these experiences. Generated data was subject to visual, descriptive, and thematic analysis (n=15). This provided data about and an analysis of participant experiences. The research component did not gather any data in addition to routinely gathered evaluation data.

Linked research questions:

- R3: What impact does C-Co have on patients?
- R4: What impact does C-Co have on practitioners?

<u>Component 5:</u> Practitioner Perspectives of Delivering C-Co - A Thematic Analysis of Practitioner Interview Data.

Practitioners are routinely interviewed as part of C-Co supervision to evaluate their experiences of delivering C-Co. Themes are verbally identified and agreed and used to support their development and that of the CBTp service. Several practitioners consented to have their interviews recorded and transcribed as part of this research component and for the anonymised transcriptions to be made subject to a more rigorous process of thematic analysis and dynamic participant validation. The sample size (n=6) was established from the number of practitioners who had experience of delivering C-Co and consented for their information to be used within this thesis. The resultant themes offered an insight into deliverer experiences and reflections of C-Co. This research component did not generate practitioner data in addition to that already generated as part of routine clinical care but did apply a more robust method of analysis to that data.
Linked research question:

- R4: What impact does C-Co have on practitioners?

<u>Component 6:</u> An Exploratory Analysis of Pre and Post Outcome Measure Data – A Quasi-Experimental Statistical Analysis of the Data. Subjective and objective psychometric outcome measures are routinely used in the early stages of C-Co, post therapy, and longitudinally at the 6-month mark following therapy to assess patient progress and the maintenance of gains. This research component did not generate data in addition to that which was routinely gathered. The parametric quality of the data was determined, and an appropriate within-subjects statistical analysis applied using SPSS (n=11).

Linked research question:

- R3: What impact does C-Co have on patients?

<u>Component 7:</u> Dissemination Strategy and Results.

The researcher was encouraged throughout his doctoral research to adopt an active approach to dissemination. Commensurate with the research methodological perspective a pluralist, multi-method dissemination strategy was adopted. The application of this strategy led to published works, national and international conference presentations, awards, and collaborations. These are analysed for impact using a descriptive analysis of publication metrics, presentation attendance and app downloads, descriptive statistics regarding number of publications, presentations, awards, and collaborations, and descriptions of feedback from workshop participants and academic peer reviewers.

Linked research question:

- R5: What impact has C-Co had via the dissemination of results?

<u>Component 8:</u> Summative Synthesis and Convergent Validity.

The research used triangulation as a secondary research method to offer a germane multi-modal summative analysis of C-Co impact in keeping with the method of organisational case analysis. Whilst this generated new insights and knowledge, the process did not involve the generation of additional clinical data.

Linked research questions:

- R6: What level of convergent validity was achieved by the organisational case analysis?

3.5 Ethical Considerations.

According to the HRA (2023) all health research must be guided by ethical principles in all its aspects and must have gained and be able to demonstrate approval from any commensurate ethics committee or any other relevant body. It is also crucial that patients, staff, carers, and the public are given the opportunity to safely and ethically engage in health research, including the design, management, application, and dissemination of research (HRA, 2023). People and ethics should be at the heart of health research (HRA, 2022) and the subjection of health research to a rigorous analysis of propriety using ethical principles is fundamental in reducing healthcare abuse (Shamoo & Resnik, 2009). Within the field of applied health ethics respect for autonomy, non-maleficence,

beneficence, and justice represent the fundamental tenets of any such analysis (Beauchamp & Childress, 2019). The consideration of these tenets importantly immerses the researcher in a deeper subjective and objective analysis of the propriety of their research as opposed to a dichotomous, solipsistic, unconstrained choice between potentially biased perceptions of right and wrong (Ellis, 2007). However, despite the equal ranking and importance of the individual principles, health professionals demonstrate a significant bias towards non-maleficence above the other principles (Page, 2012). Ellis (2007) suggests that the absence of a single, definitive ethical principle or framework with application to all health research contexts and all health research methodologies, perpetuates the generic pervasiveness of non-maleficence as an over-arching tenet. This section begins to explore some of the more generic normative ethical considerations and descriptive actions that were undertaken by the researcher in relation the research as a whole. It offers the framework by which later component specific ethical considerations are explored (Holloway & Galvin, 2017). As the reader is not yet immersed in the specific research components, to afford a more representative context and avoid repetition, a more in-depth exploration of component-specific ethical considerations is offered later within each discrete component section.

3.5.1 Normative Ethical Considerations.

3.5.1.1 Respect for Autonomy

Respect for autonomy can be defined as an active process that ensures people engaged in research are supported to make their own decisions in relation to the research (Beauchamp & Childress, 2019) and incorporates important concepts such as informed consent, the right to withdraw, and anonymisation of data. To avoid repetition and offer context, considerations regarding respect for the autonomy of patient, practitioner, and public participants is addressed within specific component sections mapped against the guidance offered by Beauchamp and Childress (2019).

3.5.1.2 Non-maleficence.

Established by the Nuremberg Code and further established by the World Medical Association's (WMA) Declaration of Helsinki (WMA, 1964-2024), non-maleficence may be described as the requirement to avoid harms resulting from research (Beauchamp & Childress, 2019). It must involve careful, dynamic consideration of the potential and actual risks research may involve to participants including the researcher (Holloway & Galvin, 2017). Although some of the ethical

considerations that underpin the concept of non-maleficence may more generally apply to the introduction of novel medical interventions and procedures (Ellis, 2007), it is important that consideration of non-maleficence is also extended to research that evaluates existing practice. Researcher intent is integral to these considerations as are the safeguards of independent scrutiny of that intent via commensurate ethics committees. C1 and consultation with and approval from the Trust Research Management and Governance Department, HS hospital's Clinical Audit and Service Evaluation Committee (CASE) and the University of Derby Health and Social Care Research Ethics Committee, reflect the researcher's intent not to cause harm. Although emotionally engaged and invested in the subject of the research, the transparency and self-exploration offered in C1 reflects the researcher's intent not to cause harm which his respect for participant autonomy further reflects. This is evident via the process of anonymisation detailed within the 'Ethical Considerations' section of each component.

3.5.1.3 Beneficence

The concept of beneficence incorporates not only the intent to produce benefit from the research but also the consideration of these benefits against risks. Both deontological and utilitarian considerations are important components of this consideration. Deontological benefits to the researcher included the potential gain of a doctorate. Benefits also included satiating the needs within the researcher to develop more effective interventions for typical non-adherent HS patients with experience of psychosis, to give voice to a marginalised group, to demonstrate transparency, and to challenge the dominant medical dialogue inherent in HS care. However, there were also risks to the researcher. These included the risk to his family, the risk to his professional standing, the risk of labelling and alienation via the exposure of his own mental health experiences and health dissonance. The mediation of these risks and cost benefit analysis involved careful *a priori* consideration of what impact the research might have on the researcher and the subsequent a *posteriori analysis* and conclusions drawn in section 6.5 The Impact of the Research on The Researcher.

From a utilitarian perspective the researcher's intent was to advance an understanding of the interventions which supported progress for non-adherent typical HS patients experiencing psychosis. The impact of psychosis on the patient, significant others, and society, especially when this involves harm to themselves or others, can be devastating (Mind, 2010) The intent to reduce this impact through more effective psychotherapies was therefore beneficent. Importantly the

research also focussed on exposing potential iatrogenic impacts on both patient and practitioner participants with the beneficent aim of better understanding these and developing theories and models of how such effects might be reduced in the future. The adopted multi-modal dissemination strategy and the results of this strategy also demonstrate a beneficent intent to cause flux in what is known about HS care provision and psychotherapies and therefore influence the development of more effective interventions. Similarly, the researcher's philosophical stance of feminism incorporates an inherent beneficence by the intent to empower marginalised groups like HS patients to have a voice and be heard. One criticism and risk might be that the research fails to optimise its beneficent intent as the results can be considered to lack generalisability. However, the researcher challenges this perspective as this privilege's (delete apostrophy) certain dialogues and narratives over others which have equal importance and ontological and epistemological value, if considered as part of a democratic discourse (Longino, 1993).

3.5.1.4 Justice

The ethics of justice are integral to feminist philosophy and to health research. Within both society and the research literature, non-adherent HS patients experiencing psychosis lack true representation. Headlines like 'Schizophrenic Killer' (BBC, 2017) skew public perceptions and instead promote and reinforce marginalisation and vilification and emphasise incarceration over effective proactive and reactive treatments. The concept of health dissonance that is explored with the autoethnography highlights the discord evident between service users and providers and the impact of the dominant medical dialogue on patient perceptions. Giving voice to and empowering the treatment perceptions of non-adherent HS patients experiencing psychosis and the practitioners who support their progress aligns with both justice and feminism. Respect for the disability and vulnerability of HS patients and those with experience of psychosis is evident throughout the thesis. It would be 'unjust' not to empower this group to have a voice and to offer engagement in research evaluating the impact of interventions on them. Integral to the concept of justice is research dissemination. A feminist, multi-modal dissemination strategy was developed with this concept at its core as is detailed in the dissemination component section (C6).

3.5.2 Descriptive Actions.

As the thesis research is part of ongoing service evaluation within mental health services it fits within existing NHS ethical guidelines. The research site had approval for research and evaluation

purposes to use anonymised data generated as part of routine clinical care including the retrospective use of anonymised outcome measure data. This approval is linked to the need to evaluate service impact as an integral component of service development. The Health Research Authority research decision tool (Health Research Authority (HRA), 2014) categorised the research as a service evaluation that did not require LREC (now REC) approval. This outcome was supported by the Trust's Research Management and Governance Department. Permissions and guidance regarding the research were also sought and gained locally via submission to the HS hospital's Clinical Audit and Service Evaluation Committee (CASE) and from the University of Derby Health and Social Care Research Ethics Committee. Supporting materials are provided in Appendix 1.

Informed consent was sought for components 2 to 7 from patients and responsible clinicians and practitioners and for component 7 this was also sought from workshop attendees and academic peers. Participants were also offered the opportunity to withdraw their consent and data prior to the analysis stage of individual components. All data has also been anonymised. Although component 1 involves only the researcher's own reflections, all third-party references have been anonymised, unless explicit consent was provided. The disclaimer at the start of the thesis also stipulates that any opinions offered are the researcher's own and are not those of the Trust for whom he works or HS research context. The research complies with the requirements of the Data Protection Act 2018 (GB, 2018) as well as related National Health Service, local Trust and University of Derby policy and guidelines.

All thesis research data was stored in the secure area of the hospital (in this instance either a locked filling cabinet within the hospital psychology department or on a secure HS server password protected by the researcher). All materials (transcripts, outcome measure responses and interview, case, and questionnaire data) used within the thesis have been anonymised in accordance with the conditions of use to protect confidentiality. Data has only been kept for as long as is deemed appropriate for the research or as was deemed appropriate within the terms and conditions of the CBTp service. In accordance with local HS policy relating to patient and staff data, no primary data is reproduced within the sections of this thesis but is available for inspection and review within the HS area via arrangement with the researcher.

3.6 Chapter Summary.

In this chapter the researcher has stated and substantiated the feminist methodological perspective adopted by the research. An introspective string developed over the period of research was used to aid the illustration of this perspective and offer a deeper insight into the researcher's thought processes, observations, influences, and considerations. The researcher hopes that by sharing his introspection in this format it offers the reader a more transparent insight into the feminist methodological stance he has adopted. The belief that methodological stance is mutable was also explored, alongside the aim of creating flux in what is known from multiple perspectives. Research method was then described, and ethical considerations, permissions, and commensurate actions stated. In the next chapter component outcomes are offered. Discrete sections for each research component are provided. These sections contain a description of the method used, sampling, mode of analysis, mode of application and component specific ethical consideration. Within each component section the results from applying the research method for that specific component are provided and then discussed. Component specific limitations and recommendations are also provided within each component section. The summative synthesis via triangulation of discrete component outcomes (C8) is provided in a separate Chapter 5.

CHAPTER 4: COMPONENT OUTCOMES.

4.1 Chapter Introduction.

In the previous chapter the researcher described and justified the feminist methodological position of the research. The method of research, organisational case analysis, was then explored and illustrated using facet theory and details of each discrete component of research given. Ethical considerations were also explored. In this chapter component outcomes are offered. Discrete sections for each research component are provided. These sections describe the component method in more detail, its sampling and mode of analysis, and component-specific ethical considerations. The results from applying the research method for that specific component are provided which are then discussed in the discrete component section and limitations and recommendations given. These sections contain further information about the feminist methodological influences for each specific component. Component 8, the summative synthesis via triangulation of discrete component outcomes (C1-7) is provided separately in Chapter 5. Section format within the Component Outcomes Chapter was guided by the editorial criteria offered by relevant peer reviewed publications to aid dissemination. The initial drafts of two of the sections (4.2 and 4.5) became the basis for subsequent publications (Slater & Painter, 2016; Slater, 2020).

4.2 Component 1: Autoethnography: Description and Inferences as Part of Reflexive Practice.

4.2.1 Introduction to the Autoethnography.

The autoethnography was first drafted in 2017 in response to Research Question 1: *What impact has the researcher had on the research* and formed the subsequent basis of a conference presentation (section 4.8.3.2) and illustrated publication (Slater, 2020). A full copy of Slater (2020) is provided in the appendices with permission from the publishers and referred to within this result section (Appendix 3). The researcher asserts that all research lacks complete value neutrality as the values of the researcher and research context knowingly and unknowingly affect the research. To attain true rigour, research must therefore contain a reflexive exposition proffering transparency about researcher bias and trustworthiness (Holloway & Galvin, 2017). Whether this is offered as a simple declaration of interests, or a more elaborate exposé is dependent on paradigmatic perspective. Proponents of reflexive-researcher-practice argue such transparency enriches both research process and product (Hek & Moule, 2006). Motivation may be defined as: *the reason or reasons why*

somebody behaves or acts in a particular way; their desire and willingness to act in that way; and the justification held by the individual for those actions (OUP, 2023). In the context of a feminist methodology, providing researcher transparency by exploring and declaring researcher motivation via a process of reflexive practice is crucial (Longino 1993).

4.2.2 Aim.

To provide transparency by illustrating the researcher's motives in the context of the research.

4.2.3 Method.

Autoethnography can be used as an effective constructivist research method for reflexive practice, thereby offering a potential insight into the researcher's motivation, and underlying emotional schemas regarding the research, allowing both reader and researcher to be more conscious of the bias the research has been subject to, thereby offer transparency regarding impact. This process of self-study and self-examination in the context of one's research is an important facet of feminist methodology (Taylor & Coia, 2019). Autobiographical literary expression can be used within a feminist methodology to explore the filters a given context or experience might create on those who experience it, to offer a narrative that may have been overlooked or previously presented through a patriarchal lens, and to offer a concrete and tangible insight into the seminal experiences of the researcher that may influence the research (Chapola & Datta, 2023). It can offer both a sense of reunion and release, helping the feminist researcher to better appreciate and convey the emotional, societal, and hermeneutic schemas that have informed their journey to begin the research (Taylor & Coia, 2019). In this instance the experience became the first time the researcher was assessed by psychiatric services.

4.2.4 Data Collection.

Over the course of his doctoral studies the researcher purposively amassed evidence that he felt might help deepen his understanding of what motivated him regarding the research, what influenced and biased his actions and evidence which might help him convey this to others and offer transparency. He wrote down linked feelings, recorded actions and logged any memories that were triggered. He trawled old personal drawings, photographs and objects that resonated with the

purpose of his exploration and his attempt to convey a deeper understanding through a written narrative of his motives and bias. This in turn sparked further feelings and actions and memories. This iterative process, illustrated by the photographs, drawings, and objects he had found, led to a first-person account of the first time the researcher was assessed by psychiatric services. The narrative became both research process and research product in which researcher had become both story and storyteller (Altheide & Johnson, 2011).

4.2.5 Data Analysis.

Whilst the researcher did not set out specifically to use auto-ethnography as a means of offering transparency and of better appreciating his motives and bias in relation to the thesis, the auto-ethnographic process emerged as the most apt and congruent means of achieving this within the framework of a feminist methodology. Autoethnography offered a broader cultural, political, and social exploratory framework with which to analyse ego-dystonic, de-synchronous events at a deeper personal level than other modes of reflexive practice, in this instance a particular event that the researcher came to appreciate had been fundamental in motivating him to complete the research, despite the fact the event occurred several decades ago (Ellis, 2004).

4.2.6 Ethical considerations.

The existing guidance regarding the ethics of autoethnography is limited and contradictory, with few practice examples (Altheide & Johnson, 2011). Tolich's (2010) Ten Foundational Guidelines is one of the more established and recognised guiding ethical frameworks when engaged in autoethnographic research and proved integral to the development of the raw and final narratives. *A priori* consent was not possible during the evolution of 'On Being Assessed' as the researcher was not aware during the early development of the raw narrative who else it might involve or in what capacity. Yet, an autoethnographer should always assume that anyone mentioned within the text will one day read it (Ellis, 1995). A process of *a posteriori* consultation and consent seeking therefore proved a more apposite means of ensuring participant autonomy regarding ethical considerations.

Other than his assessor, the researcher was able to consult and seek consent from everyone referenced within 'On Being Assessed'. Although attempted, the researcher was not able to find contact details for his assessor to gain their consent. Whilst the researcher has taken steps to ensure

his assessor's anonymity and thereby mediate possible vulnerability, the impact the autoethnography may have on the assessor should they read or become aware of it is unknown. It may make for uncomfortable reading and evoke distress. It may not. The researcher feels it important to assert that he has no blame or anger towards his assessor. The process of developing and analysing the narrative has led him to conceptualise his assessor as the product of an era of psychiatry that the researcher hopes to have helped healthcare move away from. 'On Being Assessed' is the researcher's reflection of that era rather than of the assessor. The autonomy of the assessor will also be respected by the redaction in the published thesis of the photograph of the unit where the researcher was assessed. For this reason, the photograph was also not included in the published article of 'On Being Assessed'. By ensuring that the assessor has not been named, that certain details and descriptors have been changed, and identifying information such as the unit photograph are redacted from the published thesis, the researcher hopes via this process of anonymisation to empower his assessor to make his own choice about whether he makes known his role in the autoethnography or indeed doesn't, thereby fully respecting his autonomy.

The researcher's parents and sibling are also referenced and therefore their autonomy to consider. The initial sharing of the autoethnography with them caused unexpected angst and their emotional responses ranged from anger, shame and dismissiveness to guilt and reluctant acceptance. Whilst there is nothing within the auto-ethnography they can dispute, given their absence from the researcher's life for much of this period, it made for uncomfortable reading about subjects they felt were better left in the past. To ensure his parents' and sibling's anonymity and respect their autonomy it was agreed that family photographs would be redacted from the published thesis and excluded from the published article. Whilst it was agreed that these photographs could be included for presentation purposes, it was agreed that the researcher would offer no handouts of presentation slides and would ask attendees not to take any photographs of slides during any presentation.

There is also the researcher's own vulnerability and the vulnerability of those people he now shares his life with, primarily his wife and children, to consider. The researcher and his wife discussed in depth the impact publication, conference presentation, and the inclusion of the autoethnography in the thesis might have on both them and their children. For the researcher there was a lot of shame linked to his experiences of psychosis. His desire to have people read the autoethnography could perhaps be conceptualised as an almost cathartic means of stating that he was no longer ashamed. It may have benefit for other healthcare professionals and healthcare users to hear. The involvement in or impact on children of research is especially important to consider (Savin-Baden & Howells

Major, 2013). Whilst as adults the researcher and his wife were able to express emotionally what they envisaged might be the impact on themselves, and rationalise the costs and benefits, their young children were less able to and were not of an age where they were legally able to provide informed consent. The researcher was able to helpfully consult with his wife about the inclusion of a photograph of his family as part of the epilogue to 'On Being Assessed'. To protect his children's vulnerability and ensure their and his wife's autonomy it was agreed that this photograph would be redacted from the published thesis and excluded from the published article but included for presentation with the same conditions as for other family photographs. Whilst there was a potential that dissemination via presentation could have adverse consequences for his children and wife, no adverse effects materialised in relation to them from either the conference presentation or publication of 'On being Assessed'.

One potential way of mediating the vulnerability to all those affected and to ensure autonomy, was to redact the entire autoethnography or parts of the text alongside certain photographs from the published thesis, an option the researcher's doctoral mentors explored with him. The researcher's wife proved a deeply important point of consultation with these concerns. Her love, support, encouragement, and sage direction are the primary reasons the researcher chose to disseminate the autoethnography first to trusted colleagues and subsequently via international conference and journal publication. The feedback the researcher received has helped to further assuage some of the ethical considerations revealed through the application of Tolich's Guidelines, helping to reconcile both deontological and utilitarian perspectives. However, to respect the autonomy of those involved in the autoethnography or who might be impacted by it, several photographs are redacted from the published thesis and were not included in the peer reviewed publication.

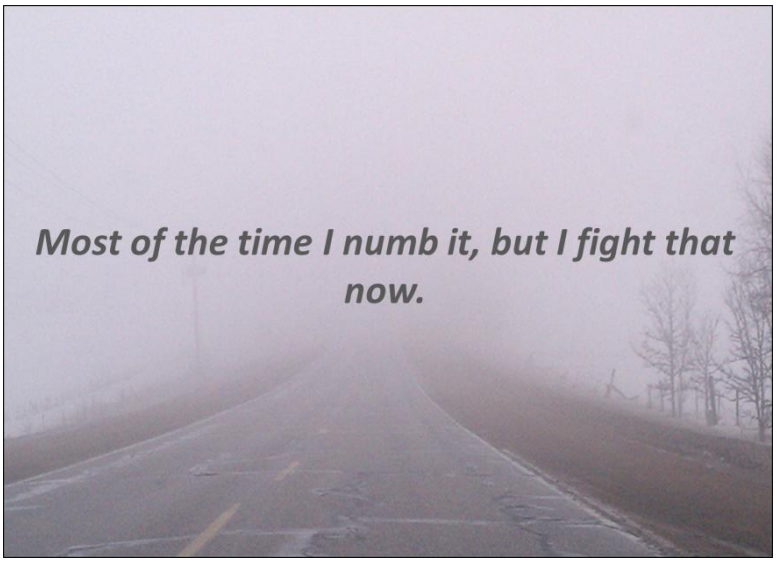
4.2.7 Results.

Whilst consideration was given to referring the reader to the published article within the thesis appendices and offering a summary of 'On Being Assessed' within the main body of the thesis, the published version is not representative of the 'final version' that evolved as the researcher's doctoral studies progressed. Whilst the text remained the same and apposite, the final version of 'On Being Assessed' includes greater illustration and importantly an epilogue. These additional elements are central to fully conveying the researcher's motivation and transparency regarding the thesis subject and of conveying the bias the thesis may contain. This 'final' version of Taking Steps was therefore provided within the main body of the thesis text for the viva. Reproduced illustrations

from earlier published works by the researcher are attributed accordingly and the text appropriately cited. Permission from the publishers were gained for this purpose (Appendix 2). All other images are reproduced under fair use and there is no intentional copyright infringement. Where copyright could be established this is recognised.

4.2.7.1 *'On Being Assessed'.*

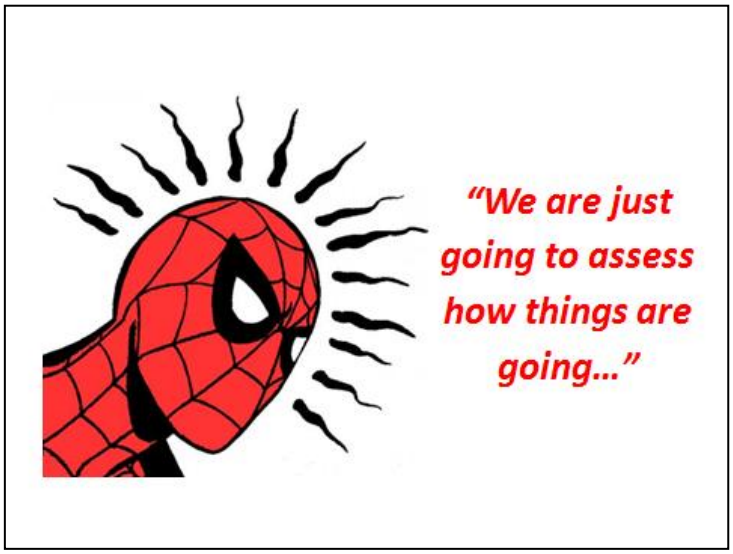
"It could have been two decades ago like it was, or right now. It's me as I was then and me as I am now. It feels like I'm twenty-something, 23, 24 maybe, but it doesn't seem to want to stick anywhere. Like driving a familiar road in thick fog – you're just not quite sure it's familiar. Most of the time I numb it, but I fight that now and try to feel it as it was, but I'm pretty good at blocking it out. It still hurts, leaves me seething at how alienating it all was.



"I'm sitting on a row of trendy chairs; brown suede with dulled chrome sides, in a well-lit reception area, some of the chairs look stained with spilt coffee. I'm on my own. Waiting. I can't remember why I was there. I recall a 'chat' with an eccentric but kind GP. I remember the dark afternoons.

Photo of the psychiatric unit where the researcher was assessed with the words 'I'm on my own now' – redacted

"The Day Centre receptionists are talking about me, scrutinising me, mocking me. A steroidal goliath of a nurse stands in front of me, leads me to a small room, claustrophobic and restrictive. Cattle-like I comply. Spidey sense tingles, spikes. Concede control or have it taken. He's big enough to stop me if I try and leave. 'We're just going to assess how things are going for you….Is that OK…?'



© Marvel.

"'I need to know if you are taking any illicit substances?' I answer 'No'. Paranoia protecting me. People give drugs a bad press. I'm deeply sorry if that's offensive, if they've consumed someone you love, if drugs delivered on promises no one else could. For me they delivered on a promise of emptiness, of no voices, no persecution, no fear.

Photos of the researcher with the words ‘I need to know if you are taking any illicit substances’ – redacted

“Drugs connected me with people. I found acceptance at a time when I needed it most, and for that I’m grateful. It gave me a kind of invisible uniform, an outlook that others recognised and accepted. I once took some drugs in an airport toilet with a woman I’d just met. We both knew we used, she was carrying, I had the right gear, we got busy. Connection. People, other people don’t get it, demonise it. Drugs never intensified my paranoia; it was already intense.

A photo of the researcher with the words ‘Are you gay?’ – redacted

“‘I need to ask, are you gay? Studies have shown that men who are struggling with their sexuality are more likely to kill themselves.’ Had my first ever boy crush on the Black Cat, me and Peter Parker lusting after the same impossible fantasy woman, classic – still feel the tingle. I answer

‘No’. It’s a year or so earlier, I’m sitting under a tree on the Dutch boarder, with long, strong branches that are just the right height. I’m not yet at my lowest ebb, that came later. But I’m sitting beneath the tree and there’s a beautiful field of winter corn in front of me. It’s that kind of anaemic gold you get as the light quality drops and the leaves turn auburn and fall unwitnessed. I’ve worked out how to tie a noose, a proper drop noose with coils, like on the cowboy films. I didn’t use the noose, figured the kind of brain that could work out how to make a noose from just seeing one stood a chance, the tiniest of chances, of figuring a different way out.

A photo of the researcher, age 6, with his sister and dog, with photographs of front covers of ‘The Amazing Spiderman’ with the words ‘Connection, protection’ – redacted

“‘Do you hear voices that no one else hears? Are you distressed by anything you hear but others might not?’ Yes, but I don’t know that yet, don’t know that the Whisperers aren’t real. Don’t get that there are ‘normal’ and ‘abnormal’ people, a them and an us. Spidey sense kicks in: ‘Don’t say anything! DON’T say anything!’ Age 6 I remember my dad, huge and omnipresent in his combats ordering me my first issue of The Amazing Spiderman, the simple buzz each week of hearing the letter flap slam shut and the drop on the mat, knowing the next instalment was here. Connection. Protection. Dad gave me his helicopter headset once whilst he was away. I broke it pretending to be him, playing. He looked disappointed but not angry. That sense of disappointment I took and filled the vacuum of his absence with, it threads and binds my memories, it squashes, pinches, flattens me, even now.

That sense of disappointment I took and filled the vacuum of absence with.

"'She' gently nudged her way into my life when I was 9. She's the clearest and most consistent. She still calms me. I'd started boarding school. Mum and Dad had been posted to Africa. The move trashed the bond I had with them, with my family. For most of my adult life I've tried to reclaim that bond.

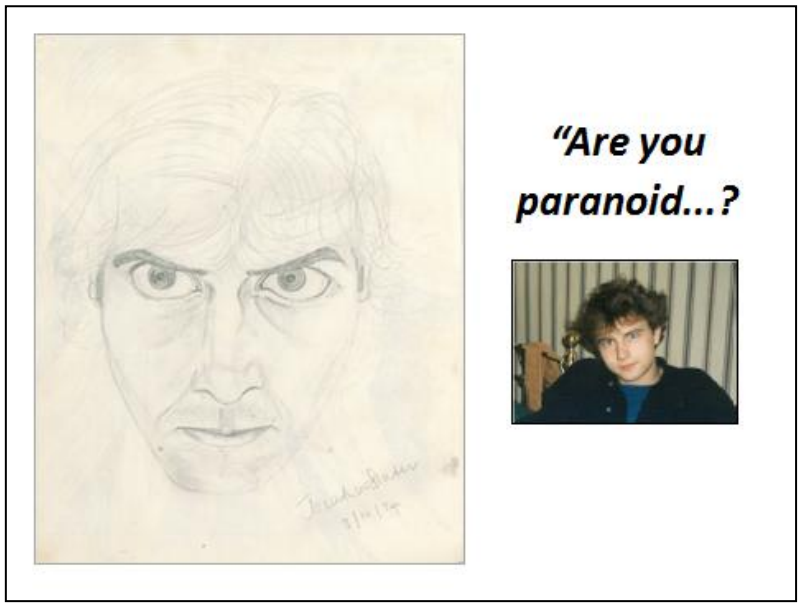
**A photo of the researcher shortly after starting boarding school
and a photo of his grandmother,
with the words 'She?' – redacted**

"I was in a dorm with other boarders; one boy rocked every night, crying until he was asleep, another traumatized, spoke quietly and infrequently, prey for the older boys, another just stared at everyone. You numb yourself, try not to auto-destruct through self-blame. I wanted to please, knew my parents needed me to say I wanted to go, said I did, it made it easier for them. Shame covering a

layer of loss, covering an embryonic kernel of self-hatred. I was waking up. She said simply and quietly, 'Time to get up.' And She was beautiful and loving, and like my grandmother who made me feel safe. That's how She made me feel; comforted, prioritised, loved.

- Picture reproduced with permission from © Slater 2020, p. 12 (Appendix 3).

"I was around 16 or 17 when the Whisperers came, but it's hard to tell because for a long time I didn't realise they weren't real. I was still at boarding school. At first they were the voices of people I knew, heard just out of earshot, down a corridor, outside a door, in a kitchen in a house I was walking by. And then came the voices of people I didn't know, in an office I could see into the window of, of people on trains behind me or at the end of the carriage, of people in the street, all picking at my paranoia, playing on my self-doubt, crushing what esteem I had left. At its worst the Whisperers were constant and unyielding, 24/7. I remember in my early 20's stumbling around a housing estate hearing the Whisperers from every kitchen, every living room, destroying me. She tried to drown them out by speaking loudly, but just added to the cacophony. It was untenable. Blunt or combust.



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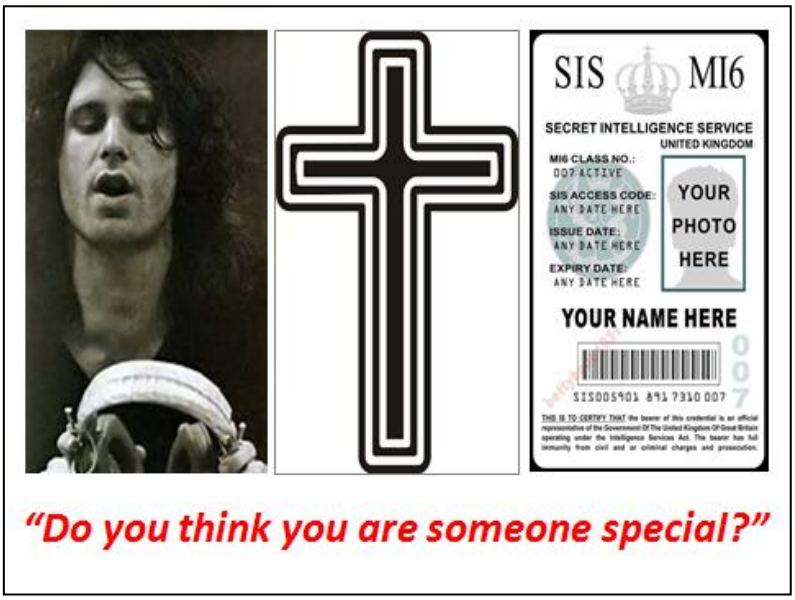
"'Are you paranoid?' Yes, deeply, but I don't really know that yet either, don't know that it's a formal condition, a 'disease' with a global healthcare industry geared up to ameliorate every part of it. 'Do you believe that people want to harm you in anyway?' Other people make me anxious, I hide away, I feel ashamed, I believe other people see it, know it, hate me for it.

"'Do you have unusual beliefs, beliefs that are different from other people? Do you think you are someone special?' At my core is the belief that I'm not as special as I would like to be to the people I most want to be, but allowing myself to see that, to feel it and embrace it as part of the journey, that's a long way off from this moment.



"In the meantime, I make do with the odd fleeting belief that I'm Jim Morrison, or God, or undercover. God evaporated pretty quickly, felled by experimentation and reason; if I was really God I could walk on water, I tried, I couldn't, still can't, ergo I'm not God, first victory for CBT. Jim fell prey to the same process of evaluation. I 'knew' the truth, tested it. But being undercover, I couldn't let go of. It explained the withdrawal, gave purpose to the paranoia, proved I was special in some way. It's about percentages and tipping the see-saw, we all have, need fantasies, how much we inhabit them and how much we are willing to step out of them depends on our vision of everything else. The things I saw were a lot worse. My assessor never asked about that, never knew that I saw cameras in the corners of rooms, felt I was being watched, manipulated, worn down.

"'You seem to be holding back a little.' I am. I feel funnelled, by a warped unfamiliar dialogue. Only choice is to dip below the radar, drop-out, withdraw. His questions are clinical, invasive, disconnected. He just seems to expect answers. Heart thudding, wants to break out. I want to say I'm confused. I remember staring at the carpet, at the varnished, worn striated wooden arms of his chair, wondering how many other people had faced these questions. Self-preservation urged me to begin to clip my responses, control my movements, close down the questions, anything to stop me from becoming my own Judas.

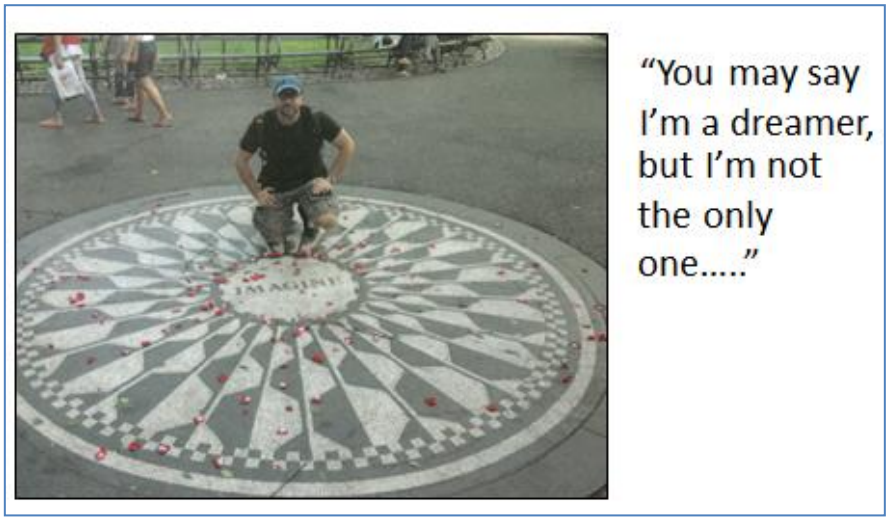
- Picture reproduced with permission from © Slater 2020, p. 12 (Appendix 3).

"'Time to go!' she says. Cuts through my fear, his questions. Elegant, straight forward, no guile, no judgement, just a simple fact. Time to go. I get up and go. Feels like I'm going to be grabbed, but

I'm not. Something about writing to my GP, referring me on, checking if my address is right. I get past the brown chairs, out the door, breathe. Two weeks later he moved into the flat above mine, my assessor. Life is determined to throw shit coincidences your way – I didn't get that then. I could hear him thudding about. I didn't dare leave my flat after that, sometimes I didn't dare to even move from one room to another."

- Slater, 2020, pp. 11-13.

4.2.7.2 *'On Being Assessed'* - Epilogue…



© Slater.

"Imagine a different way of engaging with people who experience psychosis …"

**A photo of the researcher's wife and children,
with the words 'My girls, my boy, my soulmate' – redacted**

"Imagine different outcomes…"

4.2.8 Discussion

"You may say I'm a dreamer, but I'm not the only one."

- Lennon (1971).

The aim of this research facet was to offer transparency regarding researcher bias, providing a response to the first research question of *'What impact has the researcher had on the research?'* Researcher transparency is defined as the obligation to make apparent any bias that may influence the application and the subsequent interpretation of the research by the researcher. It is central to ethical practice and trustworthiness (Savin-Baden & Howell, 2013). Autoethnography was used to facilitate and illustrate a deeper understanding of researcher bias, thereby providing transparency in the context of the organisational case analysis. No other HS CBTp research offers this depth of transparency making the organisational case analysis unique. The autoethnography exposes the non-adherence and health dissonance experienced by the researcher. It exposes his opposition to the dominant positivist paradigm evident in psychiatry and it establishes that he is not value neutral in relation to the research. In this section the potential impact of researcher bias on the research is explored.

The concept of patient non-adherence is a central to C-Co and the organisational case analysis. The experience of being assessed, illustrated by the autoethnography, led to the researcher's non-adherence and to a deep, felt sense of empathy with and anger on behalf of other psychosis patients similarly alienated. The autoethnography brought to conscious awareness and illustrated that the experience of engaging with psychiatric services was both de-synchronous and ego dystonic for the researcher, bringing into being his fundamental belief that services could be better. This belief is the central tenet of the organisational case analysis. Themes which emerge from the autoethnography that support the researcher's felt sense of alienation and subsequent non-adherence include the emotional distress caused by trying to remember that period of his life; the sense of disempowerment, alienation, and dissonance; the sense that hope was absent from the assessment process; of developmental trauma being unimportant to his assessor; of being unhelpfully categorised; and that the importance of attachment, connection, and meaning within psychosis did not seem relevant to the assessment process. These themes, brought into awareness by the autoethnographic process illustrated that in the context of the research the researcher was himself a non-adherent psychotic patient.

The term ‘health dissonance’ was developed by the researcher as part of disseminating ‘On Being Assessed’ (Slater, 2017). The term consolidates and illustrates the themes and biases linked to the non-adherence the autoethnography exposes. Dissonance can be defined as a lack of agreement or harmony between people (OUP, 2023) and health dissonance the discord the researcher felt when first engaging with mental health services leading to his non-adherence. C-Co evolved as a means of reconciling dissonance and to reduce the impact of non-adherence. The concept is therefore central to C-Co and the organisational case analysis. It incorporates the alienation, anxiety, self-censorship and ultimately disengagement provoked by the level of dissonance between the researcher and the culture, politics, and process of psychiatric assessment at that time illustrated by the autoethnography.

The autoethnography also illustrated the transgressions against dominant psychiatric positivist perspectives that had lain deep within the researcher but had been silenced to conform and progress (Spry, 2011). It exposes the researcher’s almost diametrical opposition to the damaging dominance of the positivistic and scientific ontologies that are afforded most relevance and value within psychiatry (NICE, 2014). It exposes the need within the researcher to ensure that other voices, other more ‘real-world’ pragmatic perspectives of HS CBTp impact are captured and evidenced alongside more dominant empirical determinants. It exposes the need to give voice to those typically excluded from the dominant positivist discourse of psychiatric care like HS patients. The autoethnography therefore gives context to and provides an insight into the genesis of the researcher’s feminist, pluralist, facet-based methodological stance, and his opposition to the dominant discourse within psychiatry.

The non-adherence, health dissonance and opposition to the dominance of psychiatric medical discourse exposed by the autoethnography indicates that the researcher is emotionally and conceptually driven and biased. It demonstrates that in the context of the research the researcher is by no means value neutral and may lack impartiality and objectivity. However, transparency has been the researcher’s aim, not impartiality and objectively, and this has been achieved. He does not believe that impartiality is a realisable tenet and rejects notions of bracketing out bias. He asserts that all research and researchers are biased in ways that are too subtle and embedded to truly bracket. The metaphor of an endlessly flipping coin, the re-appraisal of Descartes ‘truths’ to better convey the interdependence of who we are with how we think, the depth of reflexive analysis and time needed to unearth a fraction of the researcher’s potential biases, and the methodological perspective that research only offers closer and closer approximations to the truth, support this

assertion. The autoethnography therefore exposes that the researcher is bias in the context of the research. What impact this has on the research is important to determine as is who is best placed to determine that impact.

It would be paradoxical for the researcher to elucidate what impact his bias has had on the research given that he is already bias. The researcher has instead laid bare his bias on the page, welcoming the reader to subsequently interpret and determine for themselves about how this may detract from or indeed enhance the validity and authenticity of the research. Congruent with his methodological perspective, the researcher embraces this vulnerability and risk as a means of empowering the reader to make a deeper determination about the value of the thesis to them. The flux this may create in what is perceived to be known or not known about C-Co and HS CBTp, the potential democratic debate and dialogue thereof, and how this may or indeed may not influence others in their provision and expectations of healthcare services for psychosis, is integral to the researcher's methodological perspective and has underpinned the thesis dissemination strategy. The researcher believes that the transparency 'On Being Assessed' extends is crucial to this flux, empowering the reader to reach their own informed determination of bias, which superficial bracketing prohibits.

Yet, the autoethnography also exposes that the researcher's bias is juxtaposed with and tempered by an almost Socratic curiosity to better understand how providers refine health services for psychosis to make them more effective from multiple perspectives. The very emotions that underpin the researcher's bias also preclude any consciously realisable drive within the researcher to make the evidence 'fit'. The emotions that underpin this curiosity, that drive the need to find better ways of working, and the need for integrity and honesty within this process are laid bare within the autoethnography. The epilogue to 'On Being Assessed' portrays this sentiment (section 4.2.7.2). The two, very personal images depicted offer an anecdotal but importantly real example that there are different, more hopeful, and more efficacious ways of conceptualising, understanding and engaging psychosis and that hope cannot be built on false pretence.

4.2.9 Limitations.

There are several limitations to the autoethnography. The autoethnography exposes assumptions made by the researcher that health dissonance results in non-adherence and that change within mental health care provision is needed to address dissonance. The growing abundance of mental health user testimonies within published literature (Flier, 2019a) and the researcher's own

engagement over the last two decades with user organisations supports these assumptions. However, such accounts remain predominantly anecdotal. As happened at conference, the autoethnography was critiqued as purely 'anecdotal' and therefore of no consequence, although the researcher asserts that the process of ethical consultation used during the development of autoethnography mitigated against this (Savin-Baden & Howell-Major, 2013). User accounts also suggest health dissonance is caused by much broader cultural, systemic, societal, economic, and historical factors rather than solely by service provision. It may also be erroneous to assume that the reasons for health dissonance in HS populations are comparable to those within non-HS populations. Little is specifically known about the factors which have contributed to and underpin non-adherence within HS populations beyond what is known from the outcomes of independent inquiries, nor whether the causes of non-adherence are uniform across diagnoses in HS populations.

As a subjective and purely anecdotal account of being assessed by psychiatric services, the experienced conveyed in the autoethnography cannot be generalised. Whilst, Slater (2020) does not make any claims regarding representativeness, making clear that this was his experience and his alone, the autoethnography in both the published article and thesis remains temporally located several decades ago and may also be anachronistic within any wider context beyond that of the organisational case analysis. Its impact on future healthcare guidance may therefore be limited. This limited impact may also be true for readers, including the intended audience of nurses, some of whom may subscribe to a more quantitative methodology. The existing guidance regarding autoethnography application is limited and contradictory. The autoethnography also exposes assumptions made by the researcher that health dissonance results in non-adherence and that change within mental health care provision is needed to address dissonance when there may be other important variables that impact non-adherence.

4.2.10 Recommendations.

Several recommendations can be made. Greater transparency about the researcher in the context of the research is needed and recommended within the HS CBTp literature. Quantitative and other qualitative researchers may hopefully be inspired by the transparency achieved within the organisational case analysis to examine, appreciate, and convey their own bias more robustly. Some of the assumptions held by the researcher that the autoethnography exposes, particularly regarding non-adherence and health dissonance, need to be formally researched to better appreciate and

understand the concepts and their impact on patient engagement and recovery. This research is recommended.

4.2.11 A Summary and Critical Appraisal of Slater (2020).

The focus and purpose of Slater (2020) are immediately different to that of the evolution of 'On Being Assessed' regarding the context of the research and researcher transparency. Whilst Slater (2020) provides background in the context of his doctoral studies and explores ethical considerations, the focus of the article is primarily to convey to other nurses an experience of being assessed with the purpose of creating flux in relation to their knowledge of how it might feel to be assessed by them from a patient perspective. Slater (2020) urges the nursing readership to pause and reflect on their own practice, on how susceptible this might be to the influences and dominance of other healthcare professions like pharmacological psychiatry, and on how the vagaries of healthcare provision may be more vulnerable to hermeneutic context and hegemony than evidence.

The article introduces the nursing readership to the concept of health dissonance as a means of conceptualising patient non-adherence and suggests that nurses have a duty to deploy their practice imaginatively and creatively to try and address and overcome this. Illustrations within the article are limited in comparison to the final version provided in the thesis, and there is no epilogue within the published article. This may have affected the impact of 'On Being Assessed' on the reader, possibly limiting it as the epilogue coveys hope and recovery.

4.2.12 Section Summary.

In this component of the thesis the researcher engaged in a reflexive research process to provide transparency regarding researcher motivation and bias. This resulted in an autoethnography of the first time the researcher was assessed by psychiatric services. 'On being Assessed' offers transparency regarding the researcher in the context of the research, achieving its aim. It indicates that the researcher is emotionally invested in the research and may lack value neutrality, which may impact the research. The researcher rejects that research can be completely value neutral through processes like bracketing, instead asserting that the values of the researcher affect the research in subtle ways that may not be consciously realisable. The process of autoethnography facilitated a more rigorous means of researching and illustrating transparency regarding researcher bias and trustworthiness when interpreting C-Co impact, and of affording greater insight into what drives the

researcher and the potential effects this may have had on the research. Limitations and recommendations for future research are also offered. A summary and critical appraisal of Slater (2020), a published work relating to the autoethnography, was also provided. The next section of this chapter analyses C-Co modality fidelity and praxis competence.

4.3 Component 2: C-Co Modality Fidelity and Praxis Competence.

4.3.1 Introduction.

This aim of this research component was to provide a response to Research Question 2: *Does C-Co achieve modality and praxis competence.* It aimed to do this by replicating the positivist approach and statistical method of analysis adopted by Slater (2011) to test C-Co fidelity and competence. Greater restriction and changes in the policies and guidance relating to recording HS patients which included the destruction of pre-existing recordings and the removal of video recording devices (Sainsbury, 2018), changes in personnel, the lack of available BABCP accredited therapists with the requisite experience not already affiliated with or indeed trained and supervised by the researcher, precluded conducting the research in the intended manner. The CTS-R data from Slater (2011), a research study conducted in the same HS context with the same subject of C-Co, was therefore revisited, summarised, and critically analysed using new lines of inquiry for inclusion and consideration within the context of the organisational case analysis.

To attribute causality to the organisational case analysis results, new emphasis was placed on determining whether the data from Slater (2011) proved that C-Co was CBT and controversially whether non-accredited C-Co practitioners achieved praxis modality competence (Kuipers, 2011; Waller et al., 2013,). The delivery by non-accredited practitioners is an important facet of C-Co to consider which was not explored by Slater (2011). The use of the CTS-R to determine whether C-Co can be specifically categorised as CBT was also not fully explored. The outcomes offered by Slater (2011) remain a crucial and relevant part of evaluating the impact of C-Co from a newer multi-modal perspective rather than from the single case analysis offered in Slater (2011). Causality is an important conceptual and ontological component of feminist methodology and links to the Cartesian duality first postulated by Descartes (Thaliath, 2008). However, unlike Descartes assertion that causality must be free from the deceptive judgement of the senses and imagination, within a feminist methodological framework, using positivist methods to establish causality is not an ‘end in itself’ or privileged above other lenses by which the subject of inquiry is scrutinised.

Instead, causal pluralism, based on viewing a subject through multiple lenses, via multiple components of study as are within this doctoral thesis, is embraced and valued, with convergence offering greater objectivity and causal attribution (Crasnow, 2016).

CBT as a modality, encompasses a wide variation of empirically tested intervention protocols which are subsequently further adapted and refined due to praxis considerations (Grant et al., 2008; Townend and Grant, 2016). These adaptations can be dependent on context and work conditions as well as patient and therapist experiences, characteristics, and culture (Kendall et al., 2008, Rathod et al., 2015). As evidenced within the research literature review, these adaptations are relevant in HS contexts yet their impact on modality fidelity is not reported (Slater & Townend, 2016). Fidelity to the treatment model and the competent application of modality specific techniques are fundamental to effective CBT (Muse & McManus, 2013).

Despite interest and research into the development of other fidelity measures (Muse & McManus, 2013; Muse et al., 2022), including disorder specific measures (Gordon, 2006; Roth & Pilling, 2007), the CTS-R remains the most reliable, valid and widely used measure of CBT fidelity and praxis competence (Bennett-Levy & Beedie, 2007). It is comprised of 12 items relating to fidelity. It achieves a high degree of validity and reliability (Blackburn et al., 2001; Weck et al., 2015). A 0-6 Likert scale is used to rate each item (0 indicating incompetence and poor modality fidelity, 6 indicting the highest level of competency and modality fidelity). An aggregate score of ≥36 demonstrates modality fidelity and praxis competence (Blackburn et al., 2001).

4.3.2 Aim.

This aim of the component was to analyse C-Co modality fidelity and non-accredited C-Co practitioner praxis competence, and attribute causality to the results obtained by the organisational case analysis.

4.3.3 Research Component Questions.

1. Is it possible to adapt an established high intensity therapeutic approach for delivery in a high secure context and maintain modality fidelity - is C-Co CBT?
2. Can the impact of C-Co be attributed to CBT?

3. Is it possible for non-accredited nurse practitioners to achieve modality fidelity when delivering high intensity CBT approaches like C-Co?

4.3.4 A Summary of Slater (2011).

4.3.4.1 Method.

A qualitative descriptive research method was adopted by Slater (2011). By being able to describe C-Co session CTS-R scores, Slater (2011) aimed to identify whether modality fidelity was achieved and whether causation could be attributed to CBT. In the context of the thesis, this also facilitates the exploration of the impact of non-accredited practitioners. The application of this method involved the random selection of C-Co session video recordings which were then subject to CTS-R ratings for competency and fidelity by 2 independent raters. Statistical analysis was then used to determine the level of rater correlation and descriptive statistics used to illustrate results. To rate C-Co practitioner competence and provide supervision material C-Co sessions were video-recorded as part of routine care.

4.3.4.2 Sampling.

A set of 3 recordings (from 56) were selected using an internet-based random number generator.

4.3.4.3 Data collection.

The 3 recordings were then independently assessed by two raters using the CTS-R. Both raters were BABCP accredited and had experience of forensic healthcare and were made aware of the treatment approach.

4.3.4.4 Data Analysis.

Slater (2011) used a two tailed Spearman's Rho (ρ) to determine the level of correlation between rater scores for individual CTS-R component categories across the three randomly selected session recordings (Field, 2000) and descriptive statistics were used to calculate the aggregate range of scores and aggregate mean score.

4.3.4.5 Ethical Considerations.

Slater (2011) reported that his research had been subject to peer, academic institution, departmental, and employer ethics review as well as being favourably adjudicated by a national ethics panel, ensuring that ethical principles were adhered to. The research was classified as service evaluation and commensurate ethics permission sought and gained. Adherence to the HS site policy for recording patient sessions support compliance with ethical standards (Sainsbury, 2018).

Patient anonymity was respected via several processes and actions. All patients subject to recordings were made aware prior to any recording of potential uses including service evaluation. Written consent and responsible clinician agreement were also sought and gained. Continued consent was checked at both the start and end of any recorded session and the patients were given the opportunity to withdraw their consent from the recording or any previous recordings at any time. As the recordings were made as part of routine practice to assess practitioner competence, only practitioners were seen in the recordings. To further protect patient autonomy and anonymity patients remained off screen and only their voice was captured. References to any identifying information, like a patient's name or details that might offer an insight into the patient's identity were avoided, and recordings deleted if this was in anyway compromised. In addition, the randomly selected recordings were not viewed other than by the two independent CTS-R raters bound by patient confidentiality requirements.

Of relevance was also how practitioner autonomy might be respected regarding independent assessor scrutiny. One of the conditions of service that practitioners consented to was that, with requisite permissions, their *in vivo* or recorded practice may be subject to CTS-R scrutiny by the service manager, lead psychologist, or independent assessors to support the development of praxis competency and model fidelity, inform service training, and support service evaluation. Explicit within the conditions of practitioner service was that any recorded sessions scrutinised by independent assessors would be randomised, that any data viewed by independent assessors would be anonymised, and that the assessors would be bound by confidentiality criteria. Their informed consent to these conditions as an important safeguard against maleficent practice, and one that also promoted more beneficent psychotherapy provision, was crucial in respecting practitioner autonomy during the evaluation of competence and model fidelity, as was the anonymisation of results.

Session recordings on DVD were held in a locked filing cabinet in the researcher's office and destroyed once used for the agreed purpose. Similarly digital recordings were stored on a password protected drive that was only accessible to the researcher and were deleted once used for the agreed purpose.

4.3.4.6 Results.

Slater (2011) provides raw item and aggregate scores assigned to each randomly selected session tape by individual raters. There were no missing variables, and all items were scored. There was a high level of inter-rater reliability (ρ = 0.711 significant at the 0.01 level). The aggregate score range of 44-59 and aggregate mean of 49.7 demonstrated that C-Co practitioners achieved praxis competence (≥ 36).

4.3.5 The Results of Slater (2011) in the Context of the Organisational Case Analysis and the Component Research Questions.

Whilst the results of Slater (2011) demonstrate that C-Co practitioners achieve praxis competence, the aggregate score range and aggregate mean score of above 36 also demonstrate modality fidelity indicating that C-Co achieves the modality criteria to be categorised as CBT. In the context of the organisational case analysis this is an important result as it facilitates the attribution of causality. As the patients who took part in the organisational case study were not engaged in any other additional form of treatment over the course of C-Co, any impact, positive or negative, can therefore be attributed to C-Co as CBT. This result also demonstrated that HS context specific adaptations can be made to CBTp without compromising CBT modality fidelity. In addition, as C-Co practitioners are non-accredited, the results from Slater (2011) show that non-accredited C-Co practitioners also achieve and exceed the minimum required CTS-R scores needed to demonstrate CBT praxis competence. The responses to the component specific questions and Research Question 2 are therefore as indicated below:

Component Specific Questions:

1. Is it possible to adapt an established high intensity therapeutic approach for delivery in a high secure context and maintain modality fidelity - is C-Co CBT? -**YES.**
2. Can the impact of C-Co be attributed to CBT? – **YES.**

3. Is it possible for non-accredited nurse practitioners to achieve modality fidelity when delivering high intensity CBT approaches like C-Co? – **YES.**

Research question 2:

Does C-Co achieve modality and praxis competence – **YES.**

4.3.6 Discussion

The aim of this research facet was to use routine C-Co session recordings to analyse C-Co modality fidelity and praxis competency providing a response to the second research question of *'Does C-Co achieve modality fidelity and praxis competence?'*. The cognitive therapy rating scale (CTS) (Young & Beck 1980) and the later revised cognitive therapy scale (CTS-R) (Blackburn et al., 2001; James et al., 2001) provide the benchmark for assessing fidelity and competence in CBT (BABCP, 2023). Fidelity can be defined as the extent to which a psychotherapeutic modality is delivered as intended and competence as demonstrating a required level of modality knowledge, theory, and praxis application (Goodyer et al., 2017). Competence confers fidelity (Goodyer et al., 2017). In relation to the organisational case analysis, fidelity facilitates causal attribution, and competence the capability of C-Co practitioners. Context-related barriers precluded the application of this research component as intended. Data from an earlier work by the researcher, Slater (2011), was referenced instead.

Slater (2011) remains the only HS CBTp research to have quantified modality fidelity and competence using the CTS-R and is therefore seminal in its contribution. The aggregate range of CTS-R scores (44-59) and aggregate mean of 49.7 reported by Slater (2011), demonstrate that C-Co is CBT (fidelity) and that C-Co practitioners achieve praxis competence in delivering CBT. Any claims of C-Co impact determined by the results of the organisational case analysis can therefore be attributed to CBT. This attribution is further strengthened by the purposive sampling adopted; patient participants had all been considered non-adherent prior to engaging in C-Co, continued to experience distressing residual symptoms despite pharmacological treatments, and had not been in receipt of any additional interventions during the provision of C-Co (see section 3.4).

Slater's (2011) use of the CTS-R to measure the competency of non-accredited CBT practitioners is unique in the context of HS CBTp research and forms a novel, potentially controversial, narrative.

Formative CBTp literature categorically states that only accredited therapists with at least three years' experience of delivering CBT post qualification are sufficiently competent to deliver CBTp (Kuipers et al., 1997). The competence achieved by C-Co non-accredited practitioners reported by Slater (2011) directly challenges this stipulation. It is useful to highlight that the NICE CBTp guidance (NICE, 2009; NICE, 2014), BABCP directions, HS CBTp literature (Slater & Townend, 2016), and CTS-R developers (James et al., 2001) do not explicitly stipulate that HS CBTp should only be delivered by accredited psychotherapists or that the CTS-R cannot be used as a valid measure to rate the competence of non-accredited HS CBTp practitioners. Slater (2011) is also unique as no other HS CBTp research has quantified modality fidelity and competence using an accepted and standardised approach. C-Co therefore remains the only HS CBTp approach that can categorically claim to be CBT and claim that its practitioners achieve praxis competence in respect of CBT. The work undertaken by Slater 2011 therefore sets a standard for quantifying the psychotherapy genus of individual HS CBTp delivery and for rating praxis competency.

4.3.7 Limitations and a Critical Appraisal of Slater 2011.

Whilst Slater (2011) used a statistical analysis to determine significance and inter-rater reliability, the results regarding competence remain descriptive. Power is not achieved. As such it may be problematic to make any robust claims beyond the context of the research and the research subject of C-Co. The results can also be considered limited in the absence of replication or further research. Considerably more session recordings would need to be randomly selected from a larger sample and rated to facilitate more definitive, generalisable claims. Due to context requirements, raters were also not 'blind' to the subject of research or context in that they were informed of the approach and had experience of forensic contexts. Blind ratings may have enhanced validity. Specific C-Co modality fidelity and practitioner praxis competence was not assessed.

The uniqueness of Slater (2011) also weakens comparison with other HS CBTp studies whose claims of fidelity and competence remain comparatively superficial. Most HS CBTp studies also failed to stipulate whether their practitioners were accredited or non-accredited which may further limit comparisons. The CTS-R is also limited in scope when applied to the more advanced level of CBT praxis necessary in HS contexts. It only rates a minimum level of CBT adherence and competency and does not measure fidelity to modality adaptations. How HS CBTp approaches might differ from or indeed exceed these minimum requirements is beyond the scope of the CTS-R. Unless there are significant changes in HS directions and policy, further independent CTS-R rating

of C-Co modality fidelity and practitioner praxis competence which might add to the outcomes of Slater (2011) remains unlikely. However, despite these limitations, it is important to assert that the results reported by Slater (2011) remain the only quantifiable fidelity-based data derived from an approved competency measure to have been disseminated about any HS CBTp approach nationally and internationally and remain seminal.

4.3.8 Recommendations.

Several recommendations can be made. The development of a measure that specifically quantifies C-Co fidelity and praxis competence, potentially used in vivo with the CTS-R, is a practice recommendation. The broader adoption of quantifiable methods of fidelity testing within other HS CBTp research to strengthen claims relating to causality is recommended. Further exploration and standardisation of alternative means of measuring fidelity and competency within national and international HS CBTp research is also recommended. Whilst alternatives to the CTS-R like the ACCS (Assessment of Core CBT Skills – Muse et al., 2022) have failed to gain traction, these may prove better suited to and more permissible within the HS environment and may be justifiable as a necessary adaptation and more robust alternative to inferred fidelity and competence.

4.3.9 Section Summary.

This aim of this research component was to provide a response to Research Question 2: *Does C-Co achieve modality and praxis competence* by replicating the research approach adopted in an earlier study conducted in the same HS context involving C-Co (Slater, 2011). Greater restriction and changes in the policies and guidance relating to recording HS precluded this. The data from Slater (2011) was therefore revisited and new lines of inquiry pursued in the context of Research Question 2 and specific research component questions. This facilitated the conclusions in the context of the organisational case analysis that C-Co achieves CBT modality fidelity despite context specific adaptation, that C-Co non-accredited nurse practitioners achieve CBT praxis competence, that C-Co can be categorised as CBT, and that any impact resulting from C-Co can be attributed to CBT. Limitations and a critical appraisal of Slater (2011) were provided, and recommendations offered. The next section of the Component Outcomes chapter uses single case analysis to provide an in-depth analysis of C-Co praxis and impact with a typical treatment resistant non-adherent HS patient.

4.4 Component 3: A Descriptive Single Case Analysis of C-Co Application.

4.4.1 Introduction.

A description of the development of C-Co and a schematic of its application was provided in the introduction of the thesis (Chapter 1). Based on the patient's end of therapy routine case report, this component of the organisational case analysis provides a single case analysis of the application and impact of C-Co with a typical, treatment resistant, non-adherent HS patient. It provides a response to Research Question 3: *What impact does C-Co have on patients?*

4.4.2 Aim

The aim of the single case analysis is to prove a rich, immersive, intimate description of 'real-world' C-Co application and impact to contribute to both academic and practical knowledge about the application of CBTp in HS contexts.

4.4.3 Method.

This component adopts a critical realist methodology and uses a qualitative, descriptive, critical, single case analysis (n=1) method to illustrate an example of C-Co practice (Yin, 2003). This method aligns with the researcher's feminist methodology as it offers a description of a phenomenon as experienced by someone who has lived it, privileging that experience on an equal plane with other forms of knowing, and facilitating insights into the experience of individuals, in this instance a HS patient, whose voice might otherwise be marginalised (Hankivsky, 2014).

Proponents of single case analysis consider the approach an essential component of qualitative psychotherapy research and are often purposefully confined to an individual subject (Hecker & Kalpokas, 204). Seminal examples like those conducted by Freud (1906) and Beck (1952) are often cited. The research method enables the intricacies and complexities of 'real-life' psychotherapy practice that might otherwise remain hidden, to be revealed offering insightful contributions to both academic and practical knowledge via a process of analytic generalisability (Yin, 2018). It can also be deployed in contexts like HS where it may be problematic to conduct quantitative, randomised experiments (Benn, 2002; Cherry 2024). If adding to a set of existing or future single case analyses of the same phenomenon, a single case analysis may also become part of a multiple case analysis or case series, offering an ever-developing holistic understanding of the phenomenon and compensate against context related barriers to quantitative research (Hecker & Kalpkas, 2024).

Critics of single case analysis suggest the method lacks statistical generalisability and scientific rigor, is wholly subjective and susceptible to researcher influence and bias, is difficult to replicate, and may lack representation and transferability regarding any wider body of subjects exposed to the same intervention (Gering, 2007; Cherry, 2024). However, Yin (2018, p.264) warns that viewing single case analysis through an 'out-dated' paradigmatic hierarchy of quantitative above qualitative methodologies constricts the true potential and value of case analysis and suggests that case series also have value as a purely qualitative method of research.

The methodological lens through which a researcher views single case analysis, the propositions they hold, and the purpose they assign are crucial determinants in deciding the type of single case analysis subsequently deployed (Yin, 2018). Case analyses may be categorised as exploratory, explanatory, or descriptive (Yin, 2018). Additional qualifiers like single, holistic, multi-case (or case series), instrumental (or critical or crucial) and intrinsic may also be applied (Yin, 2018; Stake, 1995; Gerring 2007).

The propositions held by the researcher and the aim of the single case analysis suggest that a descriptive case analysis may be most appropriate for the purposes of the research and the feminist research methodology. The propositions held by the researcher, as discussed in Chapter 3, include the belief that political, social, historical and personal contexts are intricately woven into and affect healthcare provision and research, that health dissonance, including that experienced by the researcher, is a manifestation of discord between service-users and health providers based around medical model dominance, that HS patients are marginalised, vilified, and have little voice, that HS research is largely targeted at atypical adherent HS patients, and that psychotherapy adaptations are required in order to effectively and meaningfully engage typical non-adherent HS patients in psychotherapy. Whilst the case analysis is also part of testing the theory that psychotherapy adaptations are required to engage typical HS patients and references the use of objective measures to determine impact and might therefore also have been considered explanatory and exploratory, its primary purpose is to illustrate in depth the practical application and impact of C-Co based on data gathered as part of routine service provision. The qualifier 'single' might also apply in that the analysis is confined to a single subject, however, it might also be considered as part of the larger body of case analyses conducted in HS contexts. The qualifier of 'case series' or multi-case' might also apply if a comparison proved apposite. The thesis descriptive single case analysis might also be considered 'critical' or 'crucial' as it represents a more typical sample of the target population – a

non-adherent HS patient with psychosis - rather than less typical adherent patients on which the bulk of individual HS CBTp studies seem based.

After gaining commensurate permission, the procedure for applying the chosen method included purposive sampling, and descriptive data collection from the patient's C-Co case report and other materials developed as part of therapy. A process of cross-validation in which case description content was carefully considered with James, his responsible clinician and MDT, was utilised throughout the research process to offer authenticity and to respect James'ss autonomy via his full inclusion in the research process. The findings were then analysed against the current HS literature. As there is no one defined procedure for descriptive single case analysis the researcher developed the adopted procedure and format from guidance offered within seminal case study literature and the procedures referenced in existing HS case analyses (Benn, 2002; Gerring 2007; Yin, 2018)

4.4.4 Sampling.

Purposive sampling was used to ensure 'fit' (Taylor, 1998). According to Gerring (2007), purposive selection rather than randomisation is more suited to single case analysis. This involves ascribing which characteristics within a population are typical, in this instance non-adherence and treatment resistance, and selecting the case according to the adopted research subject, C-Co (Flyvberg, 2006). The 'case' was therefore purposively selected from patients who had completed C-Co and who were also considered non-adherent and treatment resistant. Not all patients referred to the CBTp service for C-Co could be considered typical as a minority were adherent and had responded to treatment with antipsychotic medications. This distinction and focus on a non-adherent patient represents a departure from most previous literature within the field and suggests that the adopted sampling process may have the potential to offer instrumental results.

4.4.5 Data Collection.

The patient was referred by his MDT. Therapy was delivered by a non-accredited, nurse practitioner, supervised by an accredited BABCP supervisor and via a practitioner peer supervision group. Outcomes were evaluated as per the HS CBTp service's approach. Descriptive data is provided within the single case analysis. Outcome measure data has been incorporated within Component 6*: An Exploratory Analysis Pre and Post C-Co Outcome Measure Data.* The descriptive data was collected from the patient's routine C-Co case report completed at the end of

therapy (see Section 1.2.3.4 Routine Assessment and Evaluation) and other materials produced during-Co by the patient such as drawings made by them to convey impact, illustrations of formulations and conceptualisations, game squares produced by the patient during the consolidation group, tables of comparative pre and post problem and goal statement ratings, lists of cognitions and beliefs, as well as practitioner descriptions of interventions and the processes involved.

4.4.6 Data Analysis.

A descriptive analysis of the data is provided to illustrate C-Co praxis application and impact, and in particular the chief complaint orientated stage of C-Co. Descriptions of the patient's experience of engagement, chief complaint orientation, symptom specific interventions, risk, relapse prevention, and consolidation are described and impact illustrated to offer the reader a sense of C-Co application and the impact of this on the n=1 subject.

4.4.7 Ethical Considerations.

The HRA Decision Tool was completed to categorise the research (HRA, 2014). The outcome indicated the research should be categorised as service evaluation involving routine clinical practice. No data other than that developed as part of routine care was included in the case analysis. A formal review of the proposed research by the local Research and Ethics Governance group, Trust Governance and Research Lead and University Ethics Committee supported this categorisation. Guidance, support, and permissions commensurate to this categorisation were sought and gained. Consent was sought and gained from both James and his Responsible Clinician. Data within the research has been anonymised. For the purposes of cross-validation this case description, analysis and interpretation of impact were also validated as representative by the patient and patient's MDT.

In exploring ethical considerations, it was paramount to consider James's vulnerability not only as a psychiatric patient but also as a HS patient. He could therefore be regarded as particularly vulnerable regarding ethical considerations. Although the report on which the case analysis was based was produced as part of routine care, the research categorised as service evaluation, data anonymised, and consent sought and gained from both James and his Responsible Clinician, careful additional consideration was still required as to how James's autonomy might be fully respected regarding the level of detail offered. Content was therefore carefully considered with James, his

responsible clinician and MDT, not only to offer authenticity and to respect James's autonomy via full inclusion in the research process, but also to consider elements James might wish to be included but that might compromise his autonomy. A pertinent example of this was the deeply personal and cathartic account written by James of his index offence which James wished to be included verbatim (see 4.4.8.5). Sensitive, compassionate discussion was required with James alongside consultation with James'ss Responsible Clinician and with the researcher's university mentors. Via a cost benefit analysis with James, the researcher and James were able to co-agree that the account contained information that may compromise James's anonymity. Of note is that James was also able to recognise that the inclusion of the text might impact the autonomy of his index offence victims and families. The researcher and James agreed that a brief description of the progress made regarding risk would suffice. This was supported by James's Responsible Clinician and by the researcher's university mentors.

It could be argued that due to the nature and degree of his psychosis, on commencing C-Co he may not have had capacity to consent to involvement in research. One might also argue that even when James subsequently engaged during the chief-complaint phase of C-Co, and indeed once therapy was completed and he might be deemed to have capacity, the inherent power-imbalance between users and providers of healthcare interventions, amplified by the conditions of detention HS patients are subject to which HS professionals are not (like having keys), may have impacted James's ability to weigh up when considering whether to give his consent. James's initial perception that you had to be 'whiter than white' to progress in HS care and the subsequent reattribution of this belief to one of needing to engage and mediate symptom experiences may also have influenced his provision of consent. Important safeguards like timing of consent and RC and MDT consent in addition to James'ss consent were therefore important ethical safeguards, as was the need to fully anonymise data and engage with James in a collaborative, dynamic process of cross-validation and cost benefit analysis. This process was most evident regarding information relating to James's index offences which James consented to include within the research. Via a collaborative process with both James and his RC and MDT, it was possible to determine what information to include and importantly what information to exclude to protect his anonymity and respect his autonomy. This also served another important, non-maleficent ethical imperative which was to protect the families of the victims James had harmed. Details such as James's name, some of the background information, and details of some of his symptoms (particularly voice content linked to his index offences) were therefore either changed or excluded to protect his anonymity and limit any harm the text of the single case analysis might cause him or others.

4.4.8 Results.

4.4.8.1 James.

James was a 38-year-old white male. He was in receipt of no other therapies or additional treatments. His previous limited engagement with psychotherapies was considered superficial with few reported gains. Whilst James complied with a medication regime which included anti-psychotics, he was considered treatment resistant in that he continued to experience high levels of residual psychotic symptoms. As his psychosis symptoms had only partially remitted and were believed to link to his risks, he continued to be detained in HS conditions. At the time of engagement in C-Co he had been detained in conditions of high security for almost a decade.

4.4.8.2 Engagement.

A total of 71 scheduled sessions were offered over a period of 2 years. These lasted between 10 minutes and 1½ hours. James attended all these plus 8 follow-up sessions (monthly for six months then three monthly). Follow-up sessions were also attended by James's named nurse. James was initially very hesitant about engaging.

4.4.8.3 Chief Complaint Orientation.

James's initial response to being visited by the practitioner was "Fuck off, all you see me as is a bag of symptoms." This subsequently became his chief complaint! Short (10 minute) sessions were initially used to begin to explore James's chief complaint with him and to support engagement at James's pace. He engaged in an initial assessment and formulation of his chief complaint resulting in the collaborative development of a linked working hypothesis (see 4.4.8.3.4) alongside a plan to resolve and test out the complaint using modality techniques. Linked to the complaint was a firmly held perception by James of needing to be "whiter-than-white" to progress, and a belief that his current coping strategies (a programme of off-ward activities) were adequate to maintain his sense of wellbeing.

4.4.8.3.1 Chief Complaint Statement.

When asked what problem he wanted to change at the start of the chief-complaint stage of C-Co, James said, "*Who cares? No one wants to know. You have to be whiter than white here. You can't ever understand. Nothing changes. All you* [the ward team and practitioner] *see is a bag of symptoms. I've got everything I need to cope".* This was written down and became his chief-complaint statement. A cost benefit analysis was completed highlighting greater benefits to resolving the chief-complaint than costs.

4.4.8.3.2 Chief Complaint Problem and Goal Statements.

Components of the chief-complaint statement were co-developed into problem statements and rated for conviction (patient and practitioner 0-8 where 8 = maximum conviction in belief and 0 no conviction) and frustration (patient only, 0-8 where 8 = maximum associated frustration and 0 no frustration) – Table 1.

Table 2: Problem Statements on Commencement of the Chief Complaint Orientation Stage of C-Co (© Slater).

Belief.	**Patient.**	**Practitioner.**	**Frustration.**
Who cares? No one wants to know.	8	2	8
You have to be whiter than white here.	8	2	8
You can't ever understand.	8	2	8
Nothing changes.	8	0	8
All you see is a bag of symptoms.	8	2	8
I've got everything I need to cope.	8	2	0

Two goal statements were also developed: 1. *"I want people to see me as me,"* 2. *"I want to progress."* Each statement was then rated for level of attainment (0-8 where 8 = full attainment and 0 no attainment) - Table 2:

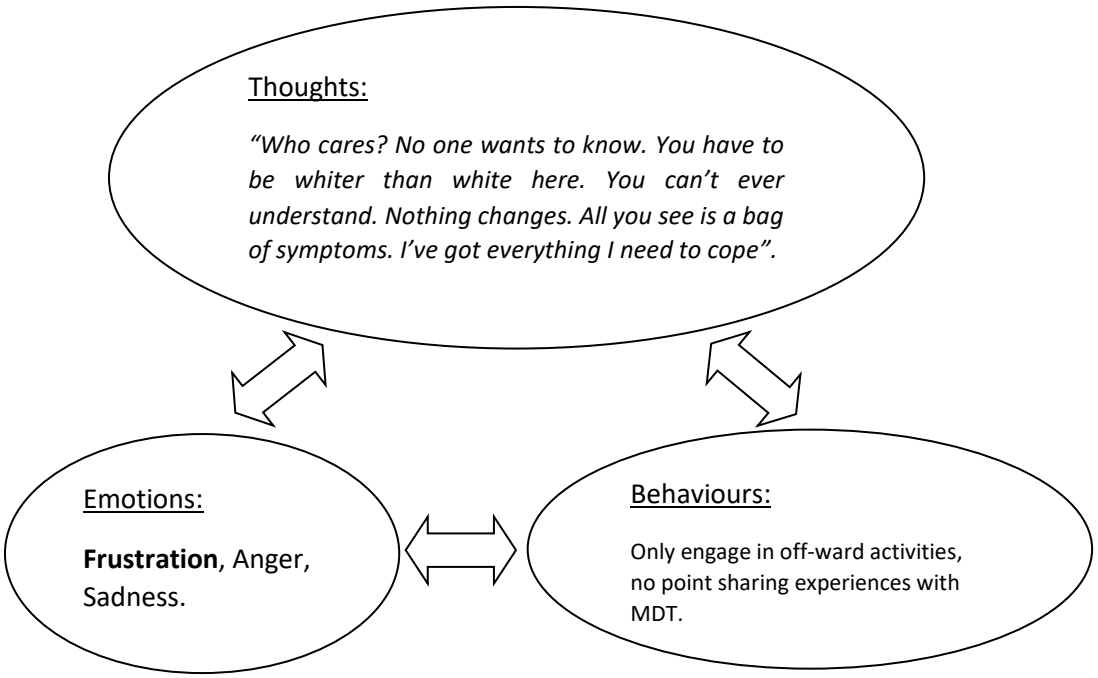
Table 3: Goal Statement Achievement on Commencement of the Chief Complaint Orientation Stage of C-Co (© Slater).

Level of attainment.	**Patient.**	**Practitioner.**
I want people to see me as me.	0	2
I want to progress.	0	2

4.4.8.3.3 Chief Complaint Formulation.

The formulation of James's chief complaint is illustrated in Fig. 3.

Fig. 3: An Illustrated Formulation of James's Chief Complaint (© Slater).



4.4.8.3.4 Chief Compliant Working Hypothesis.

"How I think, feel, and behave are connected. If I change one of these the others may change."

4.4.8.3.5 Chief Complaint Interventions.

Surveys: James wrote a statement down about himself that he felt no-one knew and was not related to 'symptoms'. He predicted that people would immediately judge it to be written by a 'paranoid schizophrenic murderer'. All the psychologists, department practitioners, ward staff and MDT members were approached to see if they would like to be part of an experiment. They were given the statement and asked to state what diagnosis the writer might have. Responses were anonymised. There were 19 respondents, all bar one of whom said it was impossible to make any conclusions based on the information provided including whether the writer even had a diagnosis or whether they had caused harm to another person. Only one recipient stated that they thought it would be

schizophrenia given the likelihood of the statement being made by a patient within a high secure forensic hospital. This led James to reconsider his statement that all people saw was a bag of symptoms. It also began to change his perception of how he might progress and that potentially this could involve being more open about his experiences.

Connecting with inspirational others: At the behest of his C-Co practitioner James agreed to attend an off-ward talk facilitated by members of the Hearing Voices Network, organised by the CBTp Service. Whilst James had stated following his index offence that he was experiencing voices, linked to his belief that you had to be 'whiter than white' to progress, he had subsequently denied any further voice experiences. Whilst James said very little during the open discussion session of the talk, he revealed to his practitioner that the talk had had a profound effect on him as he was exposed to voice hearers who, whilst still experiencing voices, had also built successful careers and in James's words, lived 'normal lives'. James began to reconsider his statement about needing to be white than white to progress. The experience also began to change his perception of how he might progress and that this could involve being more open.

Behavioural Experiments: Options for how his MDT might see him differently were explored. James opted to put a presentation together for co-delivery with his C-Co practitioner about an aspect of himself that he did not consider symptom related. For several years prior to his index offence James had been a proficient BMX racer, winning a number of trophies. The 10-minute presentation detailed how James had become interested in BMXing from a young age, the different BMXs he had owned and his successes, photos of which were shown as part of the presentation. James predicted that others would not be interested and would be dismissive of such experiences.

The presentation was first delivered to another C-Co practitioner, then James's named nurse and ward manager, and then his MDT. Each participant was not given any information about the subject of the presentation before being exposed to it. None of James's predictions were realised, quite the opposite. All participants fed back how interesting the presentation had been and how amazing his BMXing achievements were. Interestingly, some members of his MDT who had known James for a considerable part of his decade plus admission, including his responsible clinician, said that this was the first time they had learnt about his interest and achievements in BMXing. James subsequently further reappraised his belief about being seen as a bag of symptoms as well as his goal statement attainment. This also led to James independently testing additional negative assumptions as James

began to share other things about himself with his named nurse and MDT. James also began to share symptom experiences with his C-Co practitioner, including his experience of voices.
A Bleak Winter: James was reliant on off-ward activities to maintain his sense of wellbeing. An outbreak of diarrhoea forced his ward into quarantine for a period of two weeks prior to the Christmas period. During the Christmas period off ward activities were shut down for a week. James described this three-week period without activities as his 'Bleak Winter,' stating that he had become extremely down and anxious. Through guided discovery, this led James to realise how vulnerable his wellbeing was without additional alternative means of coping to off-ward activities.

Thought Challenge Records: Using data from the above interventions, thought challenge records were used to reattribute the beliefs linked to his chief complaint and generate more balanced beliefs.

4.4.8.3.6 Impact of the Chief Complaint Orientation Stage of C-Co.

Each problem and goal statement were re-rated for conviction and attainment. Ratings are provided in Table 4 and 5 below. There was also evident increased trust and engagement. James had also become socialised to the modality, learning, and applying foundation CBT techniques. He had experienced proof of value in the approach and was becoming more socially integrated. Over the course of the chief-complaint stage of C-Co he had also began to share symptom orientated experiences and was beginning to explore whether similar techniques could be used to address these.

Table 4: Problem Statement Ratings Post Intervention (© Slater).

Problem Statements			
Belief	**Patient**	**Practitioner**	**Frustration**
Who cares? No one wants to know.	2	2	2
You have to be whiter than white here.	2	2	2
You can't ever understand.	4	2	2
Nothing changes.	4	0	3
All you see is a bag of symptoms.	2	2	3
I've got everything I need to cope.	3	2	5

Table 5: Goal Statement Ratings Post Intervention (© Slater).

Goal Statements:		
Level of attainment	**Patient**	**Practitioner**
I want people to see me as me	5	2
I want to progress	3	2

4.4.8.4 Symptom Specific Work.

Formal assessment at this juncture suggested a complex and chronic psychosis presentation involving linked experiences of hallucinations, depression, persecutory delusions, anxiety, poor self-esteem, high interpersonal sensitivity, superficial engagement with services, and continuing risk.

4.4.8.4.1 Risk and Symptom Conceptualisations.

A risk formulation and personalised symptom formulation were co-constructed. These are illustrated below in Fig. 4 and Fig. 5.

Fig. 4: Risk Formulation (© Slater).

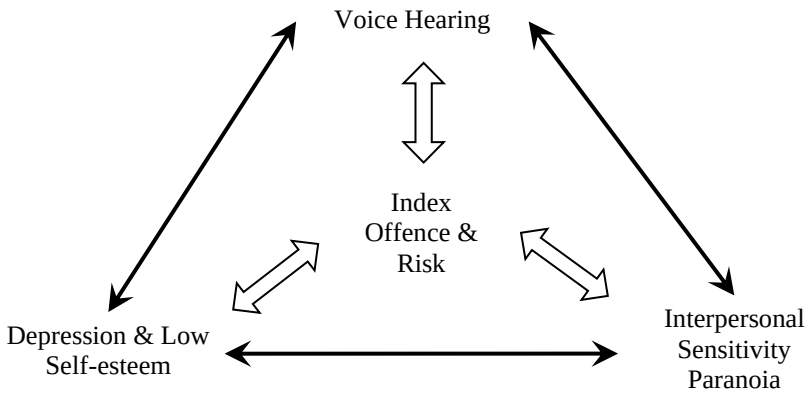
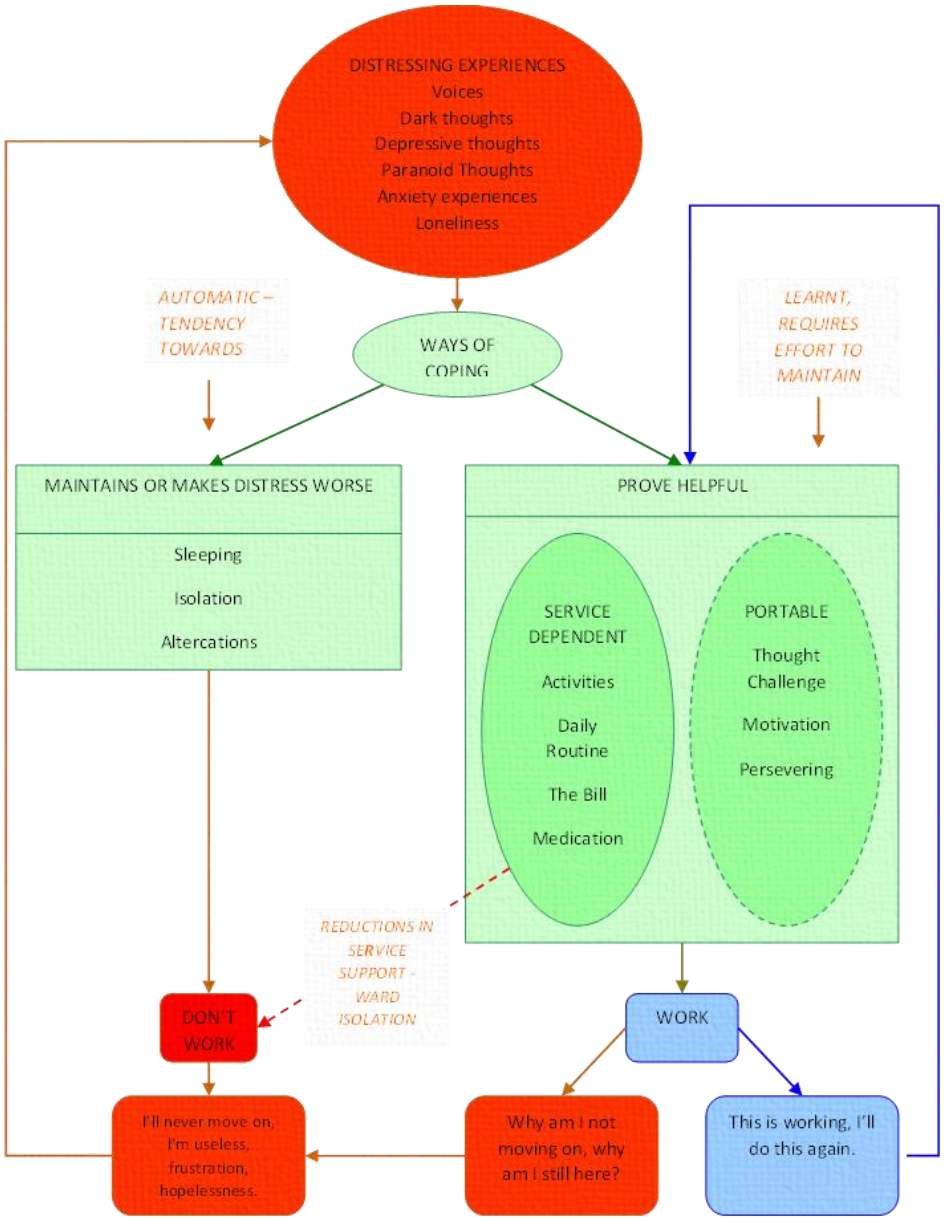


Fig. 5: Personalised Symptom Formulation – Referred to by James as ‘a simplified model of myself’ (© Slater).

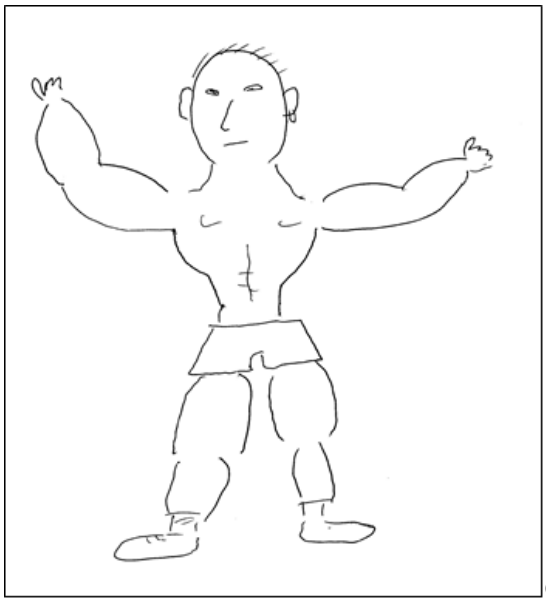


4.4.8.4.2 Voice Hearing.

Description: Voices were mood congruent, generally malevolent and perceived as omnipotent. Voice content was abusive and derogatory and included commands to be violent. James described being distressed by 70% of voice content and that challenging voice content rarely diminished distress. Hallucinatory experiences lasted 10-20 minutes, occurred 4-5 times a day and happened most days. On occasions the intensity of these experiences was such that James said he felt like putting a nail through his head to relieve the pressure. James described experiencing two voices, voice A, the most dominant and distressing, and voice B. James described A as a ‘big bloke’, as

nasty and threatening. He said that A had threatened to kill him and liked bullying him and trying to control him because he found it amusing. He said that A tried to stop him from doing the things he wanted to do and had the power to come and go from James's life at will. James said he was fearful that if A went away something worse would replace him. Below is James's illustration of A prior to commencing the interventions stage of symptom specific therapy (Fig. 6). James described voice B as indistinct, almost out of earshot, quiet but there. He was not distressed by voice B, and it was co-agreed to focus the voice hearing work on voice A.

Fig. 6: James's illustration of 'A' prior to commencing symptom-specific therapy.



© James.

Coping: Prior to the introduction of an effective anti-psychotic James said his voice hearing had been constant and he had been unable to 'ride out' periods of high intensity. Medication therefore provided a considerable but ultimately partial source of coping. To cope with the experience's medication failed to ameliorate, James would sometimes act on some of the non-violent commands. He would also try and ignore the voices or aggressively challenge them by telling them to 'F off'.

Interventions: the following interventions were used with the aim of reducing the impact of voice hearing on James

- Positive reinforcement: Encouraging James to bring A to the session agenda and positively reinforcing this through praise.
- Voice Diary: designed to identify and keep track of voice frequency, intensity and content.

- Voice Challenge Records: Designed to offset abusive and derogatory voice content via the collaborative identification of James's strengths and abilities.
- Mindfulness: this allowed James to observe, but not invest in cognitive events which might usually have triggered a voice hearing experience.
- Voice Dialogue: Initially James was asked to challenge A to do everything James feared A was capable of. Understandably, James was initially quite reluctant and avoided the task. Possible alternative challenges were identified and role-played. James then engaged in voice triggering activities (for example watching TV) and was supported in having adaptive dialogues with A, an example of which is given below (Fig. 7). These dialogues culminated in James challenging A to do his worst which A was unable to do.

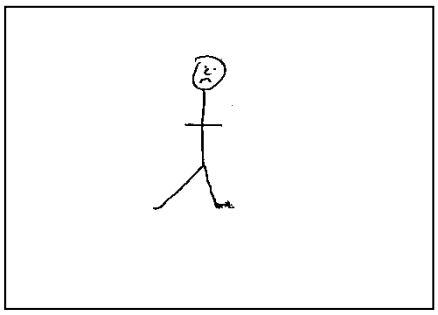
Fig. 7: An Example of a Voice Dialogue Exercise Used in Therapy (© Slater).

Voice Dialogue Exercise (35 minutes):
James and his practitioner engaged in a voice triggering activity – watching TV. Shortly after James turned the TV on A told James to change channel. A running dialogue between practitioner, James, and A then ensued in which James would share what A was telling him and James and his practitioner would formulate a response to A's demands. James responded to A's command to change the channel by asking A what he was going to do if the channel wasn't changed. A became quiet. A little later A told James to change channel again. James responded by asking A what he was going to do if the channel wasn't changed. A stated that he would cause the TV to break down during one of James'ss favourite programmes later that evening. We agreed that this would form part of a behavioural experiment. James reasoned that if nothing happened later then A was incapable of causing things to happen and if something did it was more likely due to a system glitch. A then voiced that he liked a particular programme. James changed channel. A instructed him to turn back. James responded by telling A to do it himself. A was unable to do so. Given that James also liked the programme he said to A he would turn back, but only if A remained quiet for at least five minutes. A agreed but started talking once the channel was changed. James turned to a channel he knew A would not like. The same agreement was brokered, but once again A broke this so James turned back to previous channel. He

agreed to give A one last chance. A remained silent for the agreed period. The TV also did not break down during James's favourite programme later that day.

Impact: James's conviction that A was able to hurt him or make him do things reduced to zero and remained at zero. James also no longer believed that A's derogatory and abusive comments were true. James was bemused at A's lack of power and seemed to become more invigorated by each new challenge to A's omnipotence. James described the experience as one of the best he had ever had and seemed elated by the newfound freedom he described. Below is James's illustration of A following the work (Fig. 8). However, this later also caused James considerable anguish as it had been A's instructions he had fearfully followed during his index offences, instructions he now realised he may not have had to follow.

Fig. 8: James's Illustration of 'A' Following Interventions.



© James.

4.4.8.4.3 Depression and Low Self-Esteem.

James was preoccupied by a multitude of negative self-evaluative beliefs, examples of which are given below in Table 6. These were accompanied by chronic low mood or blunting and were substantially reinforced by negative voice content and persistent negative attention and recall biases.

Table 6: Examples of the Negative Self-Evaluative Beliefs Held by James (© Slater).

• Its ok to let people take advantage of you, keeping the peace is more important. • I'm worthless.	• I have no control. • I'm not good enough. • I'd be better off dead.

• I'm evil. • I'm horrible. • I'm a murderer. • I just want to die. • I'm unlovable. • I carry a huge burden of guilt. • My life is dull. • I wake up to the same experiences every day. • Nothing is going to change. • Psychosis has ruined my life.	• My parents never hugged me. • I'll never move on. • I'm to blame. • Emotions frighten me. • I'll never be able to be myself or get on with my life. • If I start to feel good about myself, it means that I don't care about what I did. • I'll never recover. • I was never loved. • People will fear me if I become unwell.

Coping: James had repeatedly declined anti-depressants. He instead coped by resigning himself to the 'truth' of his beliefs or by isolating himself in his room where he would ruminate and mull over the beliefs. Both strategies had a negative impact on his mood, motivation, and quality of life.

Interventions: the following interventions were used with the aim of reducing the impact of depression and low self-esteem on James:

- Pie chart: James was asked to complete a pie chart. The chart was divided into segments each representing a year of James's life. He was asked to black out years where there was overwhelming evidence to support his negative self-evaluations. James was only able to colour about a ¼ of the chart. This had a powerful effect and led to recognition by James that he could be biased in his self-perception and that these biases influenced his actions and feelings.
- Black dot exercise: A small black dot was drawn on a piece of white paper. James was asked what he could see. He said a black dot on a piece of white paper. He was then asked to focus on the black dot, after 30 seconds he was asked what he could see. He said all he could see was the black dot. James then said that the exercise demonstrated that by focussing on the smaller number of negatives in his life the positives blurred out of focus.
- Positive Data Log: this was designed to develop positive bias and enhance positive recall and memory retrieval. It involves identifying a positive event each week and exploring that event using a 5 Aspects template. As expected, James initially found the task difficult and tended to avoid it. Entries were over-general and sparsely populated. As a result, we completed an entry for a negative event which James fully populated and compared this with his positive entries.

On seeing the bias James then hypothesised that if he could create the same bias towards positive events his quality of life and symptom experiences may improve. Subsequent entries became more and more populated. Once he had completed 10, these were bound resulting in what James and his named nurse had come to refer to as a 'light bulb' moment. James suggested that it was evidence that there were positives in his life and that he was increasingly able to identify, enjoy and remember these. James continued to complete the log throughout the remainder of therapy and as part of his relapse prevention pack.

Impact: Positive self-image and self-evaluative comments: As the negative self-evaluative bias lifted, James became surprised at how many positive events he started to notice and enjoy. Comments by staff and friends that he seemed to 'be coming out of himself' aided this process.

4.4.8.4.4 Wider Engagement, Interpersonal Sensitivity, and Paranoia.

On assessment it was apparent that James's engagement with services was superficial, that he had a high level of interpersonal sensitivity and that he held various negative and paranoid perceptions about engaging with others, a list of which is provided below:

- James experienced a sense of constant vulnerability to being teased or mentally bullied by others, and therefore constant anxiety (history of being bullied, difficulties at school, teased about liking a girl).
- He had a fear of blushing around others and being made to look stupid.
- He ruminated about social interactions and tended to catastrophise potential outcomes.
- He believed others were too busy to help him.
- He believed other people, particularly staff couldn't be trusted.
- He believed he didn't deserve help and that it was better to deal with things on his own.
- James felt that health services had a duty to make his life interesting and was angry that it didn't.
- He felt to talk about his worries was selfish.
- He thought if he talked about his problems he would be punished.
- He felt constant anxiety when in the company of others.
- He believed he had to be whiter than white and that if he showed active symptoms or relapse, he would get in trouble, and it would set his progress back.
- Everyone will think I'm stupid, I'll not be good enough if I say something.

- I'm hated.
- I can't get close to people.
- It's better not to get involved with others.
- I don't fit in.
- I feel indifferent towards people.
- People expect me to know why my index offence happened and I don't.
- I'm in a catch 22: if I say nothing, they think I'm masking, if I told people about all of my experiences people would be shocked, either way I stay in a high secure hospital.
- I deserve to be spoken to abruptly by others.

Coping:

James coped by limiting his involvement with other patients whilst on the ward and with his MDT. His engagement with the MDT was superficial and he managed his presentation to the team in a manner that limited any indication that he may be experiencing active symptoms. He did engage in off ward activities, but only those which involved individual activities like wood working or one-to-one education support.

Interventions: the following interventions were used with the aim of reducing interpersonal sensitivity and paranoia and increasing wider engagement:

- Thoughts Diary: This helped identify associated beliefs and triggers.
- Completion of the Maastricht Paranoia Questionnaire (Escher et al., 2004) this provided a thorough analysis and mapping of James's paranoia which helped him develop insight into the pervasive nature of his experiences.
- Weighing up the evidence: This was used to challenge James's perceptions of how he believed others responded to him. For example: a positive data log entry, following a visit from friends, demonstrating he was accepted by others was used to contrast with his perceptions of being unloved by family members. This produced a cathartic response from James and a succession of cognitive links culminating in a belief that he may have been loved by his family and was indeed 'loveable' but that negative bias and paranoia had blinded him to this.
- Behavioural Experiments: These involved testing out his negative predications and delusional beliefs regarding how others would respond to him. James was initially avoidant of these experiments, however, gradual exposure via role-play and practice sessions resulted in full engagement. None of his negative predictions were realised, leading to James believing that his

paranoid and maladaptive assumptions about others were in error. Experiments involved taping a session, asking staff for help and support and reddening his face to observe others' reactions to his manufactured blushing.

Impact: A considerable reduction in paranoia, interpersonal sensitivity and associated anxiety was achieved. James described that learning to 'let go' of his paranoia had been a relief and that he now enjoyed sharing information and showing who he was to people. He said that testing out his predictions had helped him develop a more positive perception of others and allowed him to be himself around others. It also resulted in better abilities to rationalise and challenge negative paranoid assumption about others. Although James subsequently believed that a lack of communication harmed rather than helped his progress and was more confident and comfortable discussing his experiences with others, he regretted that he had not made this realisation earlier during his admission.

4.4.8.5 Risk.

On initial engagement, James was ambivalent about what should be covered in therapy sessions. His understanding of therapeutic process was poor, and he lacked insight into the degree of work needed to produce meaningful change. He resisted even minor exploratory conversations around the risks his psychosis presented. He often became irritated and described any such conversation as 'too intense'. He also struggled to grasp conceptualisations of symptom maintenance and retention of session content was poor. He believed others were responsible for his progress and were not doing as they should. He lacked assertiveness and coped with conflict by 'bottling up' his aggression, a strategy that had had tragic past consequences. He denied being 'angry' yet held a keen sense of being unjustly treated by others which he ruminated over frequently. James's perception of proactive relapse prevention strategies was also poor; indeed, he did not believe the superficial strategies, based purely on distractive off-ward activities he had developed prior to engagement in C-Co, would fail him. He was proved wrong during a period of ward isolation when he was unable to access his usual routine and found himself isolated, acutely paranoid, and depressed. Finally, he had repeatedly refused, for the duration of his inpatient stay, to share with his MDT information regarding the extent of his psychosis experiences at the time of his index offence and the extent of his current symptom profile. In therapy he would say, 'I want to forget it, I don't want to talk about it, it was a long time ago.'

In contrast, a considerable amount changed over the course of C-Co. During therapy he collaboratively negotiated and developed safe parameters for sharing powerful cathartic experiences, including the expression of anger, fear, happiness, sadness, and distress. These parameters also allowed him to express his interpersonal sensitivity without fear of punitive actions or harsh judgements. He developed trust and began to meaningfully engage with both the therapeutic process and his MDT. James supported his C-Co practitioner in recommending to James's MDT that James be referred to the Anger Management Group after C-Co, where he subsequently meaningfully and beneficially engaged. He also engaged in a devising a thorough relapse prevention, lapse management and wellness strategy maintenance plan.

As regarded the risks associated with his index offence, during therapy James was able to put together a two-page text to share with his MDT to help him more confidently convey his symptom experiences at the time of his index offence. The text proved an incredibly powerful and cathartic experience for James as did the sharing of it with his MDT. It documented and reflected his mental health experiences on the day of his index offence, and the tragic actions he perpetrated on others as a result of following A's instructions. When James first shared the text with his C-Co practitioner, time and compassion were needed to support James to reconcile and come to terms with his new perception that he had killed people he very much loved because of his fear of A and because of his paranoid beliefs that these people did not love him and were trying to harm him.

Despite inclusion of the text in his case report and James's offer of consent to share the text within this thesis, whist thanking James for his permission, the researcher felt it necessary to further explore this with him. The researcher and James co-agreed that this was a deeply personal account which included details which could compromise James's anonymity and was not essential to include – a brief co-agreed description of things that were important to James would suffice. The researcher also further explored this with his university mentors with the conclusion that it was right not to include the text for ethical reasons. James's ability to share his text with his MDT led to his subsequent productive engagement following C-Co in index offence work with his named psychologist and referral and then transfer to conditions of lesser security.

4.4.8.6 Relapse Prevention.

James collaboratively developed a relapse prevention pack with a set of exercises to complete with his named nurse or key worker. Exercises were designed to be completed weekly or monthly.

During the follow-up phase, the practitioner met with James and his named nurse, first monthly and then every three months for six months to support the completion of the exercises. Sections of the pack included:

Section 1: Information and Contents: This section contained information about the pack, its contents and how to use it.
Section 2: All About Me. This was James's description of himself including his likes and dislikes, strengths and achievements.
Section 3: My Recovery Journey. This section contained a timeline charting James's recovery.
Section 4: Wellness Strategy Checklist. This section contained a list of the exercises and activities he could complete on a regular basis which James felt helped to sustain his recovery and prevent relapse.
Section 5: Lapse and relapse profiles: This section contained lapse and relapse signatures.
Section 6: Lapse and relapse management plans. This section contained a list of actions and interventions that could be followed to promote recovery were James to experience a lapse or relapse.
Section 7: Resources. This section contained resources developed over the course of therapy such as James's BMX presentation alongside exercise sheets and self-rating measures.
Section 8: Positive Data Log: This section contained a log of positive events that happened in James's life which he added to weekly and reflected on monthly.
Section 9: CORE-OM (Evans et al., 2000; Core Information Management Systems Group, 2007). This section contained spare CORE-OM sheets and graphs that could be used to compare against James CORE-OM relapse and lapse scores and help determine whether he might be lapsing or relapsing.

4.4.8.7 Group Consolidation.

After the follow up period James also attended the CBTp consolidation group. He produced three games squares representing his experiences of C-Co, two of which were included in Slater and Painter (2016) and the third provided below (Table 7). Whilst the game square in Table 7 depicts a positive impact of C-Co, as does one of the game squares included in Slater and Painter (2016), a weight being lifted, the third game square produced by James (a judge with a gavel) representing his initial experience of the chief complaint orientation stage of C-Co, indicates that James

experienced uncertainty, nervousness, dread, dismissiveness, and anger during this stage of C-Co (Table 1, Slater & Painter, 2016, p. 7, Appendix 3).

Table 7: One of the Game Squares Produced by James as Part of the CBTp Consolidation Group.

	Taking Flight: As the interventions started to have effect, I began to feel freed from some of my problems. It felt like having wings. I felt I could achieve things I couldn't before. It gave me a better quality of life than I'd had for years. I could manage.

4.4.9 Discussion.

In response to Research Question 3: *'What impact does C-Co have on patients?',* the aim of the single case analysis was to offer a rich, in-depth description and illustration of C-Co praxis and to describe the impact of this. The impact of chief-complaint orientation, the impact on psychosis symptoms and risk, the impact of relapse prevention, and the utility of the adopted method are discussed in turn and comparisons made with the existing literature. The results suggest that C-Co had a positive impact on engagement, psychosis experiences and risk, as well as transient negative effects. Whilst all the individual HS CBTp literature used the method of single case analysis or case series, the thesis research offers considerably more praxis depth than any previous research. It also better illustrates the level of adaptation needed to engage a typically non-adherent HS patient, providing an original contribution and a praxis template for others to consider, thereby contributing to both academic and practical knowledge.

Chief-complaint orientation and engagement are crucial components of C-Co designed to address the high level of non-adherence in HS contexts. Few of the other individual HS CBTp studies reference the importance of such adaptation and fail to offer the degree of depth and praxis

application the research single case analysis offers. The specific impact of chief-complaint orientation on James was that he engaged meaningfully in psychotherapy for the first time. The single case analysis illustrates how working together on the non-symptom based chief complaint of others seeing him as a bag of symptoms, in combination with short 10-minute sessions, led to James's engagement.

This orientation provided the adaptation needed to engage James, to skill set him to address his complaint using CBT techniques, and to importantly demonstrate proof of value in CBT as a means of achieving helpful change. This circumvented engagement barriers caused by poor insight, health dissonance and non-adherence which precluded all previous attempts to engage James. CBT techniques like survey work, normalisation, psychoeducation via connecting with inspirational others, guided discovery, behavioural experiments, and cognitive reattribution, using thought challenge records, were successfully used to address James's chief complaint. This supports conclusions drawn by Ewers et al. (2000) and Garrett and Lerman (2007) that the initial augmentation of HS CBTp, with a chief-complaint orientated intervention and ethos of co-investigation, productively facilitates the engagement of typically non-adherent HS patients and offers a gateway to the subsequent deployment of more established, symptom specific, nomothetic CBTp approaches. The thesis case analysis therefore demonstrates that chief complaint orientation is a crucial component of HS CBTp.

The thesis case analysis also demonstrates that adapting HS CBTp to include an initial chief-complaint orientated stage facilitated the subsequent formulation of James's psychosis experiences and risk (Fig. 4 and Fig. 5) as well as the use of more established symptom specific CBTp interventions for hallucinations, depression, persecutory delusions, anxiety, poor self-esteem, high interpersonal sensitivity, and continuing risk. This supports the critical importance of adaptation in HS CBTp approaches and of co-production identified by Slater and Townend (2016). It also supports the fundamental role of risk within HS CBTp formulation (Bentall & Haddock 2000). This demonstrates that C-Co can facilitate the formulation of psychosis experiences and associated risks. A greater depth of detail is provided in the thesis case analysis about the subject's experiences of auditory command hallucinations than the existing literature (Bentall & Haddock, 2000; Benn, 2002; Cawthorne, 2003). A greater depth of detail is also provided about the techniques used to reduce associated distress and lack of empowerment. A description of James's hallucinations, frequency, intensity, level of distress and impact, as well as his coping strategies, is provided. Data is provided about each CBT technique used including positive reinforcement, voice diaries, voice

challenge records, mindfulness, and voice dialogue. The positive impact was considerable and is conveyed in the stark contrast between the drawings made by James of his primary voice pre and post intervention (Fig. 6 and Fig. 8). Positive impact is also conveyed by a game square James developed for 'Taking Steps' (Table 1, Slater & Painter, 2016, p.7, Appendix 3). It depicts a large weight with an arrow pointing upwards underneath it. The linked description states, *"Someone was there to help me fight back at the voices. I manage my voices now. They don't manage me. I've learnt they can't tell me what to do. I've learnt they can't make me do things,"* (Table 1, Slater & Painter, 2016, p. 7, Appendix 3). As James's index offence had involved acting on command hallucinations to kill others, this impact also reduced risk and later facilitated engagement in index offence work. This demonstrates that C-Co had a positive impact on hallucinations and associated risks.

The impact of HS CBTp to target delusions (paranoid and grandiose) is the predominant symptom researched within the individual HS CBTp literature (Slater & Townend, 2016). The thesis case analysis therefore adds to this literature but again offers a far greater depth of detail. The negative and paranoid perceptions James held are listed and his maladaptive coping via avoidance and impression management highlighted. Established interventions like further assessment and mapping via the use of the Maastricht Paranoia Questionnaire (Escher et al., 2004), the use of thought diaries, weighing up the evidence, and behavioural experiments are detailed before a description of impact is offered. The positive gains made by James align with those reported within the case study literature adding emphasis to the evidence that established nomothetic CBTp approaches for delusional beliefs and interpersonal sensitivity can have efficacy in a HS context. This demonstrates that C-Co had a positive impact on delusions.

By demonstrating that CBTp can have a positive impact on depression and low self-esteem in psychosis, the thesis case analysis importantly adds to what is known. Only one other case analysis reports specifically targeting these symptoms as part of HS CBTp (Slater, 2011). This is a concerning statistic given the prevalence of negative psychosis symptoms. This bias is also evident within the wider CBTp literature (Morrison et al., 2018). Examples of the negative self-evaluative beliefs held by James are provided, alongside his maladaptive coping via isolation and resignation. Details are given about the established CBT approaches including pie chart work, reattribution and guided discovery, and positive data logging that were used with good effect resulting in a more positive self-image and the emergence of positive self-evaluative beliefs. This demonstrates that C-Co had a positive impact on the negative symptoms of psychosis.

One of the 'Taking Steps' games squares developed by James involved a stylised self-portrait next to a large question mark with the description, *"When I was asked to do CBTp I was very unsure, and I had a lot of questions I wanted to ask. I was also asked a lot of questions. I felt very nervous and full of dread. I thought I wasn't understood. I didn't think anyone could understand. It made me angry that someone was trying to help,"* (Table 1, Slater & Painter, 2016, p.7, Appendix 3). This demonstrates that C-Co had a negative transient impact on mood. Similar transient iatrogenic effects on mood and esteem are reported within the case study literature and include reactive transient low mood resulting from the change process, transient adverse cognitive, emotional, and behavioural effects during the resource acquisition phase of therapy, and transient feelings of worthlessness during the initial stages of therapy (Bentall & Haddock, 2000; Benn, 2002; Garrett & Lerman, 2007; Slater, 2011). The thesis case analysis therefore supports and adds to what is known about the transient negative impact of HS CBTp on patients.

The thesis case analysis demonstrates that C-Co reduced the impact of index offence related psychotic experiences resulting in James's engagement in index offence work and a reduction in forensic restrictions. A similar effect is reported in the literature with adherent patients but less so with non-adherent HS patients (Ewers et al., 2000; Benn, 2002; Rogers and Curran, 2004; Garrett & Lerman, 2007; Slater, 2011). In the independent inquiry which resulted from his index offence, James's non-adherence was deemed integral to his killing of others. Prior to his offences, James had attempted to seek support from services but had felt alienated during this process, a level of alienation and non-adherence he continued to exhibit in HS care. The thesis case analysis therefore importantly adds to the HS CBTp literature as it evidences that chief compliant adaptation leads to significant risk reduction with non-adherent patients.

None of the case studies reported by Slater and Townend (2016) provide details about relapse prevention plans or approaches to consolidating gains, both integral components of effective CBTp (Avashthi et al., 2020). By detailing the development of a relapse prevention plan with James and the consolidation of his therapy gains as part of 'Taking Steps', the thesis case analysis makes an original contribution to what is known about HS CBTp. However, the case analysis does not explore or evidence the role this may have had in maintaining James's gains and only offers details that it happened. It is difficult to therefore draw inferences about the effect of this with the regard to impact. Further reporting and research about the impact of relapse prevention as part of HS CBTp is warranted.

The aim of this component of the organisational case analysis was to provide a single case analysis of the application and impact of C-Co with a typical, treatment resistant, non-adherent, HS patient. This has been provided and illustrates a typical HS patient progressing through the stages of C-Co described in Fig. 2; chief complaint orientation, symptom-based CBTp, relapse prevention, and consolidation.

The aim of this component was also to provide a response to Research Question 3: *What impact does C-Co have on patients?* The results of the single case analysis demonstrate that C-Co had a positive impact on:

- Adherence via chief complaint orientation
- Voice hearing
- Depression and low self-esteem
- Wider engagement
- Interpersonal sensitivity
- Paranoia
- Risk

The results also indicate that C-Co had transient negative impacts on James during the chief complaint orientation stage of C-Co, from the change process and from the re-attribution of some of his beliefs, particularly those associated with voice hearing and his index offence. The results of this research component therefore indicate that C-Co had a positive patient impact and a transient negative impact.

4.4.10 Limitations

The adopted method and results support the assertion that single case analysis is an apposite method of investigating the impact of HS CBTp (Benn, 2002; Slater & Townend, 2016). However, comparative analyses of single case studies or case series remains problematic as is evident when comparing the thesis case analysis with Slater (2011). Both share the same subject of C-Co, both were conducted in the same hospital using the same mode of delivery, and both are single case analyses, but the adopted techniques differ as do elements of study purpose. Variations in modality

adaptations, context, delivery, and mode of application limit effective triangulation of single case analyses outcomes (Yin, 2018). However, co-occurring themes can be hermeneutically identified (Slater & Townend, 2016). Whilst the thesis case analysis outcomes therefore support and further add to the positive and transient negative impacts of C-Co reported by Slater (2011), to facilitate a case series of specific C-Co impact the case analysis approach adopted in the thesis or that adopted by Slater (2011) would need to be replicated with different subjects. To date only two studies, Benn (2002) and Garett and Lerman (2007) have effectively used descriptive case series (n=2 and n=8 respectively) to describe HS CBTp impact.

Whilst the thesis single case analysis offers considerably more praxis depth than any previous case study research of individual HS CBTp impact, and better illustrates the level of adaptation needed to engage typically non-adherent HS patients experiencing psychosis, it remains limited in scope and wider generalisability. Comparative analyses of single case studies or case series remains problematic as is evident within the HS individual CBTp literature (Slater & Townend, 2016). Variations in modality adaptations, context, delivery, and mode of application preclude the effective and meaningful triangulation envisaged and hoped for by researchers like Benn (2002). The evidence is also limited to a single case (n=1) and is therefore not generalisable.

4.4.11 Recommendations.

Standardisation of single case analysis techniques across HS contexts or further case series to determine HS CBTp impact is therefore recommended as is the adoption of chief-compliant adaptations in CBTp targeted at non-adherent (typical) patients in HS contexts.

4.4.12 Section Summary.

In this section of the Component Outcomes chapter, single case analysis was adopted to describe and illustrate C-Co application and praxis. Based on the patient's routine case report, the analysis is commensurate with previous HS CBTp research approaches and adopts a method which is considered most suited to the subject and context. In the context of the organisational case analysis, the single case analysis provided a rich description of C-Co praxis and subsequent impact, synthesising patient and practitioner perspectives, with noted global effects on psychosis experiences and risk. Whilst other case analyses of HS CBTp have been conducted, none offer the same depth of detail about impact or of praxis. As such this component offers unique and original

insights into both C-Co praxis and impact as well as HS CBTp praxis. The next research component analyses participant experiences of C-Co.

4.5 Component 4: Participant Experiences of C-Co.

4.5.1 Introduction.

This section of the Component Outcomes chapter was initially drafted in 2015. As with other sections of this thesis, this draft chapter formed the basis of a subsequent peer-reviewed publication (Slater & Painter, 2016). Mr Painter's contribution to the publication is detailed at the start of this thesis within the statement of attribution. A full copy of Slater and Painter (2016) is provided with permission from the publishers in the appendices (Appendix 3). The aim of this research component and the published work was to explore, describe, illustrate, and better understand participant experiences of C-Co. It aimed to provide a response to Research Question 3: *What impact does C-Co have on patients?* and Research Question 4: *What impact does C-Co have on practitioners?* A summary of Slater and Painter (2016) is provided, following by a critical appraisal and a summary of the component results in respect of the research questions. The summary of Slater and Painter (2016) includes a review of pertinent literature published since Slater and Painter (2016) and considerable additional game square and movement card data that was not published as part of Slater and Painter (2016).

4.5.2 A Summary of Slater and Painter (2016) and Scrutiny of Additional Data not Included in Slater and Painter (2016).

4.5.2.1 A Review of the Literature.

A review of the literature by Slater and Painter (2016), which adopted a similar approach to Slater and Townend (2016), but incorporated forensic and non-forensic studies, yielded 11 results with potential relevance (Table 8). These studies highlighted that routine evaluation of patient and practitioner experiences was integral to improving and maintaining CBTp impact and quality and as a means of resolving barriers and enhancing effectiveness. The review also indicated that research remained limited, and that there were no such studies conducted in HS contexts. The most common form of investigation was the use of interviews to derive data for transcription and subsequent thematic analysis. Slater and Painter (2016) stated that this approach was likely to disadvantage HS

patients (Laithwaite & Gumley, 2007) and that alternative more innovative methods were needed in HS contexts.

A reapplication of the literature search strategy identified two further studies with potential relevance published since Slater and Painter (2016) (Ferrito & Moore, 2017; Cawthorne, 2019). Cawthorne (2019) focused on practitioner experiences of delivering an adapted individual HS CBTp approach (CBTp(f)). As Cawthorne (2019) excluded patient experiences it was felt her study had greater relevance to Research Component 5: Practitioner Perspectives of Delivering C-Co. As Ferrito and Moore (2017) focussed on practitioner experiences of delivering generic CBT to patients with anti-social personality disorder, the study was excluded from the organisational case analysis as it did not meet the inclusion criteria of using HS CBTp with non-adherent, treatment resistant psychotic patients (see Chapter 2).

Table 8: Participant Evaluation Literature (© Slater).	
Berry C. & Hayward M. (2011).	A systematic review and synthesis of the literature pertaining to service user perspectives of CBT for psychosis.
Davis, L. W., Ringer, J. M., Strasburger, A. M. & Lysaker, P. H. (2008).	Participant evaluation of a CBT program for enhancing work function in schizophrenia.
Dunn, H., Morrison, A. P. & Bentall, R. P. (2002).	Patients' experiences of homework tasks in cognitive behavioural therapy for psychosis: a qualitative analysis.
Kilbride, M., Byrne, R., Price, J., Wood, L., Barratt, S., Welford, M. & Morrison, A. P. (2013).	Exploring Service Users' Perceptions of Cognitive Behavioural Therapy for Psychosis: A User Led Study.
Laithwaite, H. & Gumley, A. (2007).	Sense of self, adaptation and recovery in patients with psychosis in a forensic NHS setting.
McGowan, J. F., Lavender, T. & Garety, P. A. (2005).	Factors in outcome of cognitive-behavioural therapy for psychosis: users' and clinicians' views.
Messari, S. & Hallam, R. (2003).	CBT for Psychosis: a qualitative analysis of client experiences.
Morberg Pain, C., Chadwick, P. & Abba, N. (2008).	Clients' experience of case formulation in cognitive behaviour therapy for psychosis.
Pitt, L., Kilbride, M., Nothard, S., Welford, M. & Morrison, A. P. (2007).	Researching recovery from psychosis: a user-led project.
Waller, H., Garety, P., Jolley, S., Fornells-	Training Frontline Mental Health Staff to Deliver "Low Intensity" Psychological Therapy for Psychosis: A Qualitative Analysis of

Ambrojo, M., Kuipers, E., Onwumere, J., Woodall, A. & Craig, T. (2013).	Therapist and Service User Views on the Therapy and its Future Implementation
Wood, L., Price, J., Morrision, A. & Haddock, G. (2013).	Exploring service users' perceptions of recovery from psychosis: A Q-methodological approach.

4.5.2.2 Aims.

Slater and Painter identified two aims to their research, the first to use collaborative group game design to research experiences of individual C-Co, and the second to evaluate the efficacy and impact of the novel method that was used.

4.5.2.3 Method.

The research component adopted a critical realist methodology using PAR as a method. This incorporated elements of grounded theory and thematic analysis and was deployed via an innovative use of collaborative group game design. Feminist PAR (FPAR) is widely used internationally to support, inform, and develop activist policy (FPAR Academy, 2025). It is used to advance the rights of marginalised groups via the development of collaborative relationships to empower and amplify the voice of those groups and foster their agency (Htun & Weldon, 2012). In this instance PAR facilitated the development of a collaborative relationship between the researcher and the participants and between the participants themselves, facilitating new and important insights into the experiences of C-Co patients and practitioners and in a broader sense their experience of HS psychotherapy. Aligned to the researcher's methodology, the publication of this research facilitated the wider dissemination of those experiences and voices.

4.5.2.4 Sampling.

Participants were purposively sampled by the researcher from consenting C-Co practitioners who had completed C-Co with at least one patient who agreed to be involved in the CBTp consolidation group, and patients who had completed C-Co or were in follow up and who agreed to attend the CBTp Consolidation Group. Importantly patient participants had all been considered non-adherent and treatment resistant prior to engaging in C-Co.

4.5.2.5 Data Collection.

A supplied format approach of collaborative game design using a monopoly board type platform incorporating a ten-stage game design sequence was used (Schell, 2008; Whitton and Moseley, 2012). Collaborative, participant session facilitation was adopted, guided by the researcher and Mr. Painter, who were in turn supervised by a senior art therapist and guided by members of the Association of Learning Technologies Games and Learning Special Interest Group (GL-SIG). The following data formats were generated by Slater and Painter (2016): game squares, game play, the game's name, and participant feedback.

4.5.2.6 Data Analysis.

The data lent itself to thematic and descriptive analysis, visual representation, and dynamic participant validation.

4.5.2.7 Ethical Considerations.

Slater and Painter (2016) reported in the published article that their study had been categorised as service evaluation involving standard clinical practice (HRA, 2014) and that commensurate guidance, support and permissions were sought and gained. Whilst this sufficed for the published article, it is important to expand on ethical considerations further as part of the thesis. Whilst the research intent to further understand and develop psychotherapy interventions for non-adherent HS patients with experience of psychosis may be considered beneficent, it was also important to reduce any potential risks to participants and demonstrate non-maleficence. In the context of the research all patient participants can be considered vulnerable, especially so given the conditions of detention and inherent power imbalance between healthcare staff and patients, keyholders and non-keyholders and dynamic informed consent about how data might be used. Actions that mediated vulnerability were therefore necessary to respect patient autonomy and ensure ethical principles were adhered to. These actions included gaining informed consent from patients and their responsible clinicians, the anonymisation of data, and the right to withdraw, as well as the research process itself.

One of the reasons PAR is widely endorsed by feminist researchers is because of its integral respect for subject autonomy via the active inclusion and empowerment of vulnerable, marginalised individuals in the research process (Htun & Weldon, 2012). The PAR research process specifically

empowers participants to determine the course and result of the research with inclusion throughout. Whilst a supplied game format was adopted, patient participants had control of how that was subsequently deployed, its result, what the result might be called, and importantly how it might be used and disseminated. Their decisions in the context of the research, and therefore their autonomy, were respected throughout the research process. Supporting this level of autonomy during an active research process involved constant inclusive decisions at both a micro (in-session) and macro level, with the group facilitators finely balancing the aim to focus on game production within a supplied format without this in anyway leading patient decisions on what game might subsequently emerge. An important example of how the concepts of justice and autonomy were integrated into and central to the research was the collaborative decision of how 'Taking Steps' might be used after the completion of the Consolidation Group and the dynamic process of consent this necessitated. This is also reflected in the agreement not to destroy 'Taking Steps' after an agreed period but rather enable its continued use as an aid to socialise other patients and potential practitioners about C-Co and what their CBTp journey might include.

The same process of ensuring autonomy and justice was also extended to practitioner participants. Although practitioner consent to engage in the consolidation group was explicit within their conditions of service, the same process of consent applied to patient participants was also applied to practitioner participants and any practitioner board squares that became part of 'Taking Steps' were subject to the same process of anonymisation as patient squares, thereby further respecting autonomy. Practitioner autonomy was further respected due to the PAR method that was deployed necessitating their involvement and control (with patient participants) of many of the research steps and decisions.

Respect for autonomy also extended to the members of the public who subsequently provided feedback after playing 'Taking Steps' – the game which subsequently evolved from the research component. The idea for members of the public to play 'Taking Steps' emerged as part of the PAR process. This was subsequently incorporated into the thesis dissemination process and necessitated an additional process of consent to respect patient and practitioner autonomy. The idea to offer an opportunity to players to feedback their experience, which also emerged from the PAR process, also necessitated additional considerations regarding ethics. Player autonomy was subsequently respected via a statement on the feedback cards and verbal reinforcement of this and? of how feedback would be shared with members of the consolidation group and that any feedback provided

should be provided anonymously. Informed consent was subsequently implied via the provision of player feedback.

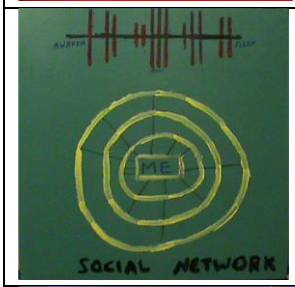
Facilitator supervision and reflection, and guidance from the Association of Learning Technologies Games and Learning Special Interest Group, were important determinants in facilitating and ensuring respect for patient autonomy during the research process.

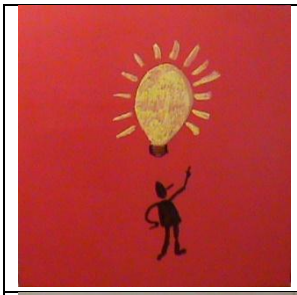
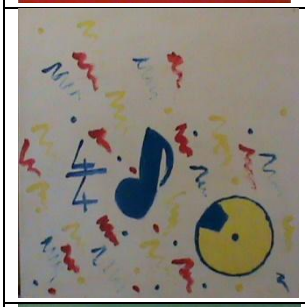
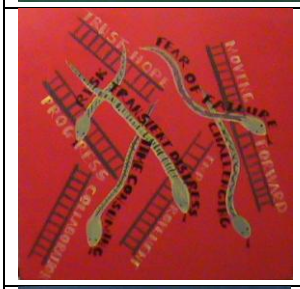
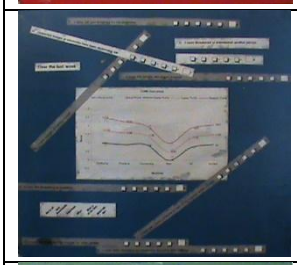
4.5.2.8 Results.

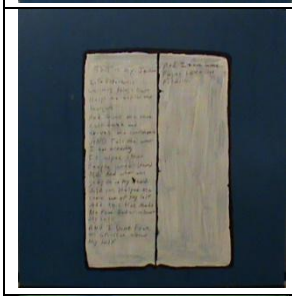
Participants developed 24 game square illustrations with matching descriptions. These were painted onto MDF boards and sequenced into a life-size monopoly type game (Fig. 1, Slater and Painter, 2016, p. 6, Appendix 3). A photograph of delegates at conference playing 'Taking Steps' is provided within the dissemination section of the Component Outcomes chapter (Fig. 10). The game squares depicted referral and discharge (1 square), 'bridging' between therapy stages (2), assessment (5), intervention (11), and relapse prevention (5) experiences. Only five of these game squares were included in Slater and Painter for illustrative purposes (Table 1, Slater & Painter, 2016, p. 7, Appendix 3). Illustrations and explanations of games squares not included within Slater and Painter (2016) are provided in Table 9 in the sequence they appear in the game. This additional data provides a considerably greater insight into 'Taking Steps' and participant experiences than could be conveyed in the published article. The data suggests that patient participants experienced transient negative effects during the first stage of C-Co, but positive effects thereafter. The data suggests that practitioners experienced a mix of both positive and negative experiences of C-Co over the course of delivery.

Table 9: 'Taking Steps' game squares - which include those developed by both patients and practitioners (© Slater).

	The Unknown: this board represents practitioners' reflections on processes involved in the initial assessment stage in CBTp. Practitioners need to complete a thorough assessment while managing: their feelings regarding venturing into the unknown when presented with a patient they do not know; their hopes for therapy; their anxieties regarding their own skills and the need to establish a good therapeutic relationship to build the rest of the work on.

	Introductions: starting CBTp was like a meeting of two people who don't know each other. You give it your best shot, but it doesn't always go well. You might get along better with a different therapist. Luckily, the one I finished up with suited me best.
	Being Watched: When I started CBTp it was like the big brother eye watching. Everything was watched and judged. It put me on edge.
	Judge and Jury: When I started CBTp it was frightening. I didn't want to open up to a relative stranger. I thought they would judge me on my past, on the things I've done. I thought it'd be about punishing me.
	Social Networking: The most important therapy intervention for me was social networking. I don't feel as lonely. I didn't think I had anyone around me. I didn't think anyone cared or had the time. The more I began to see, the more I saw there were others, there were people around me, more than I thought, people who were there for me and spent time with me.
	Taking Flight: As the interventions started to have effect, I began to feel freed from some of my problems. It felt like having wings. I felt I could achieve things I couldn't before. It gave me a better quality of life than I'd had for years. I could manage.
	The toolbox: This board represents CBTp practitioners' aims in treatment of helping patients to develop a toolbox of skills both to get the most out of CBT and to be able to use after they have been discharged from the programme.

	Light Bulb Moments: Working through therapy was like having lots of light bulbs go off in my head. I got an understanding of what it was like for therapy to work. I became aware of myself. I became aware of people around me. I started to credit myself for the good characteristics I have rather than always dwelling on the bad and thinking everyone else thought bad of me.
	Learning to Relax: Part of my CBTp included a programme of relaxation using music and imagery. It was a highlight of my therapy because it was so easy and beneficial. It calmed my nerves which allowed me to be more open and to work on my experiences.
	Saying Hello: In CBTp you take a look in the mirror and see yourself for what you are. Acceptance helped me to keep going in the face of adversity.
	Snakes and Ladders: This board represents practitioners' reflections on their experience of delivering CBTp interventions. At times, when specific interventions seem to have had a good effect, it can feel like real progress is being achieved. At other times, perhaps due to: interventions going less well; the practitioner's inexperience or fluctuations in the patient's motivation, it can feel like much of the progress is undone, a bit like sliding down a snake in a game of snakes and ladders.
	Self-monitoring: This was a 'CORE' part of therapy. Completing the assessments like the CORE always helped get to the root of any problems or issues I have and helped monitor these in a completely fun and painless way.
	Digging for Victory: CBTp was like digging my way to success. We dug into my experiences to understand them and make a difference.

	Instruction Videos: Working with CBTp helped me to learn different strategies to cope and helped with confidence. It helped me to recover from a lonely place in time. I feel I've got a set of things to guide me in life and to help me recover, that I'm at the start of something hopeful.
	Relapse Prevention: Patients develop a relapse prevention and wellness strategy maintenance pack with their practitioner during the last stage of therapy in order to consolidate and maintain the gains that have been made.
	Goal! I've been through a number of courses and therapy programmes. I felt I did well in CBTp. It doesn't change everything. What it did change was like scoring the deciding goal.
	New Horizons: I don't know what the future might bring but I do know I have a relapse prevention plan and that that plan will help me get to where I need to be.
	Finding my voice: In CBTp I was encouraged to write down the things that were in my head, things I didn't feel I could just tell people. It made me feel relieved to share my problems and the ways I'd tried to cope with life as a child and an adult. I don't bottle it up now. I use my journal to tell people about what's going on in my head. There's space to write a future.
	Having filled the toolbox: This board represents practitioners' reflections on the final stages of treatment. There can be a sense of satisfaction arising from seeing patients progress through the end of the therapy process and leave better able to manage, monitor and maintain their mental health.

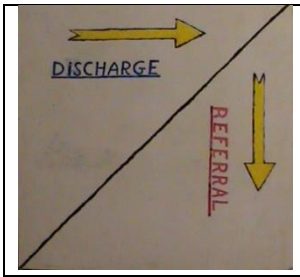
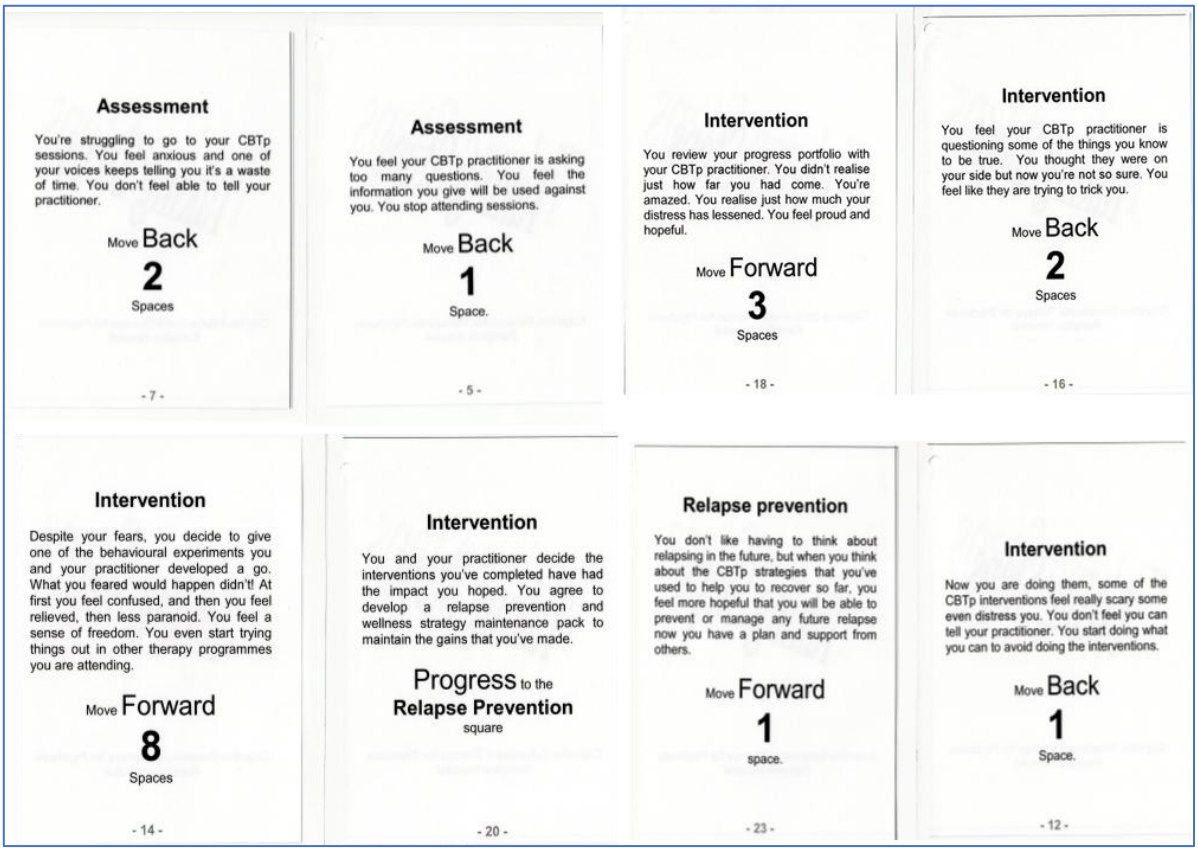
	Well done! You have made really good progress through the CBTp work you have done. You've proved to yourself and your MDT that you can use what you have learnt. You feel ready for discharge and are pleased at being offered follow up sessions to help you maintain and boost the gains you have made.

Fig.9: Examples of Movement Cards (© Slater).



Movement cards were developed by participants to guide player movement around the game squares. Additional movement cards not included in Slater and Painter (Fig. 1, 2016, p. 8, Appendix 3) are provided in Fig. 9. This additional data provides a considerably greater insight into how participants felt they 'moved' through therapy than was conveyed in the published article. Game play was non-linear. Backward movement was linked to transient negative patient experiences of C-Co like intervention linked distress, increased symptom experiences, and avoidance. Forward movement was linked to positive patient intervention effects, working together, trust, positive risk taking, sharing, listening, and qualities patients felt aided therapy transitions like collaborative evaluation about readiness, co-agreement, taking a chance, and validation of progress. These cards

suggested C-Co had both a positive impact on patient participants and a transient negative impact. The game name 'Taking Steps' was chosen by participants because the game represented the therapy steps participants had taken and the need for players to physically take steps to progress through participants' experiences of C-Co.

Table 10: An Overview of Core Categories and Subcategories (adapted from Fig 3. Slater & Painter, 2016, p. 10, Appendix 3).

Core Category	Subcategory
COLLABORARTION	Understanding Others
	Similarity
	Confidence and Openness
	Decreased Isolation
	Self-Compassion
	Insight
GAME DESIGN	Enjoyment
	Empowerment
	Consolidation
HOPE	Helping Others
	Optimism
CONSTRUCTIVE CRITICISM	

A data-driven mode of constant-comparative, emergent analysis (Glaser & Strauss, 1967; Glaser, 1992; Boyatzis, 1998; Charmaz, 2006) was used to code participant data derived from feedback cards about the collaborative group game design method. Four core categories, each with relevant sub-categories, emerged from the 40 identified codes. Slater and Painter used a tree diagram to illustrate core and sub-categories (Fig. 3, Slater & Painter, 2016, p. 10, Appendix 3) and a tag cloud to illustrate weighting (Fig. 4, Slater & Painter, 2016, p. 11, Appendix 3). Examples of coded participant responses linked to the core and sub-categories were provided within the text (Slater & Painter, 2016, pp. 9-12, Appendix 3). Table 10 (adapted from Slater & Painter, 2016) provides a similar overview. Of the core categories '*collaboration*' was the most heavily weighted and of the subcategory's '*enjoyment*' the most heavily weighted. Examples of informant responses organised according to category and subcategory were then provided.

4.5.3 Discussion.

The aim of this research component was to provide a response to Research Questions 3 and 4: '*What impact does C-Co have on patients?'* and *'What impact does C-Co have on practitioners?'* respectively. PAR in the form of collaborative group game design was used to evaluate patient and practitioner experiences of C-Co (Slater & Painter, 2016). Additional data to that published in Slater and Painter (2016) was provided. This discussion is organised around the stages of the 'Taking Steps' game – referral, assessment, intervention, and relapse prevention. A critique of the method is provided via discussion of the thematic analysis. The results demonstrate that C-Co had a positive impact on patients but also transient iatrogenic effects, and a positive and negative impact on practitioners. The results support and add to the existing literature about what is known about participant experiences of CBTp. The adopted method offers an original contribution to the literature. The research is also unique in that it is the only study, published or fugitive, to analyse HS patient experiences of CBTp. An interpretation of the findings is offered, and recommendations made. Research limitations are explored within the critical appraisal of Slater and Painter, 2016, offered in section 4.5.4. and recommendations offered in section 4.5.5.

Stage-linked experiences and transitions were evident in the sequencing of the game squares, starting with referral, then assessment, intervention and finally relapse prevention. The sense portrayed by the game squares and movement cards that referral was not always co-agreed and more representative of service hegemony, accords with similar observations in other studies (Benn, 2002). Patients chose to label the phase after referral as 'Assessment'. Although the term does not explicitly reference the adapted chief complaint orientated stage of C-Co, data from the 'Assessment' game squares, game square descriptions and movement cards suggests that practitioners and patients incorporated their experiences of chief-complaint orientation into this phase.

During the 'Assessment' phase considerable iatrogenic effects are illustrated within the game square data. Anxiety, nervousness, dread, anger, poor understanding, a sense of being watched and judged, and maladaptive misconceptions were evident. The game square depicting a judge banging down his gavel is particularly powerful alongside the description that patient believed that C-Co was about punishing him. James, the subject of the single case analysis (section 4.4) produced this square. It applied to initial experiences during chief-compliant orientation when short, 10-minute sessions were all he was able to tolerate. Iatrogenic effects on practitioners are also noted during this phase. The first game square in Table 9 represents practitioner experiences of chief-complaint orientation. It illustrates their anxieties about engaging a new patient, about whether they are good

enough, and about their hopes for therapy. The sharing of this and other practitioner squares with patients during stage six of the study process (Application, (6), Slater & Painter, 2016, p. 4, Appendix 3) had a quite profound, normalising effect. C-Co patients became aware of the anxieties and vulnerabilities C-Co practitioners also experienced at the start of therapy.

'Assessment' movement cards also describe iatrogenic effects, but also convey a sense of forward movement and positive impact. Backward movement was linked to experiences like patient's feeling information may be used against them and symptoms such as voices telling patients not to trust their practitioner. Forward movement was linked to patients testing out whether disclosures were used against them, and to openness, collaboration, relationship building, and trust. Collaboration was a particularly strong theme throughout the literature and this research component. It was the most weighted core category within the research thematic analysis. Similar findings are reported within the literature during the engagement phase of CBTp (Messari & Hallam, 2003; Waller et al., 2013) as are the key roles of hope, trust, and empowerment in resolving initial iatrogenic effects (McGowan et al., 2005; Pitt et al., 2007; Morberg Pain et al., 2008).

During the 'Intervention' phase, positive and negative impacts were also evident. Patient game squares suggest an entirely positive impact using direct descriptions of the impact of CBTp techniques, and metaphors to make positive comparisons. The positive impact of techniques like social networking, relaxation, self-monitoring, acceptance, thought challenge and reattribution, and curiosity to delve deeper and understand more are illustrated. Metaphors like 'Digging for Victory' are used to show how distressing psychosis experiences were explored and overcome, how C-Co had been like engaging in an instructional video about strategies to combat psychosis, how C-Co resulted in a patient looking at himself in the mirror and seeing himself in a positive way for the first time, how C-Co was like a series of helpful 'light-bulb' moments, and how the positive impact of C-Co interventions 'felt like having wings'. Effects like those highlighted are reported by Laithwaite and Gumley (2007).

The practitioner 'Intervention' squares also used metaphor to convey C-Co impact, using a toolbox to illustrate the range of skills that are co-developed during C-Co and have a positive impact on psychosis, and a snakes and ladders board to convey their own experiences of delivering C-Co interventions. The metaphor of a snakes and ladders game was used by C-Co practitioners to convey both the negative emotional impact on them when interventions are going less well (sliding down a snake) and positive emotional impact when interventions go well (standing atop a ladder).

The illustration has phrases attached to each ladder conveying positive impact (‘moving forward’, ‘trust and hope’, ‘collaboration’, ‘improvement’), and snake (‘fear of failure’, ‘challenging’, ‘risk’, ‘time consuming’, transient distress’), conveying negative impact. Cawthorne (2019) also reported a mixed impact, albeit predominantly negative, on practitioners from delivering CBTp(f), another context-specific, adapted HS approach for individual CBTp.

‘Intervention’ movement cards similarly demonstrated a mixture of positive and negative impact. Forward movement and positive impact were associated with collaborative exploration and analysis of problems and progress, of a patient co-developing an intervention plan with their practitioner and giving this a go together, of practitioners and patients keeping a shared portfolio of gains which was linked to increased patient pride, hopefulness and sense of accomplishment, and for patients giving techniques like behavioural experiments, especially those linked to paranoia or voice omnipotence, a go despite their fears. Backward motion and negative impact were associated with patients not feeling their practitioner ‘was on their side’ and instead trying to trick them as part of a wider system of control, and the fear that interventions could cause, which patients felt unable to voice to their practitioners. Messari and Hallam (2003) found similar negative impacts where patients reported feeling controlled, missed and that the wider system needs were perceived by practitioners as more important than theirs.

In contrast to the other phases ‘Relapse Prevention’ game squares and movement cards indicate an entirely positive impact. The impact of the relapse prevention phase of CBTp is not addressed within the existing HS literature. This data is therefore unique. A Formula One car is used in one patient game square as a metaphor to portray the positive impact of iteratively testing and refining relapse prevention strategies, giving that patient a sense that he could now build a future. Other metaphors portrayed within patient game squares liken C-Co relapse prevention to scoring the deciding goal in a football match, to having a roadmap to support future recovery and stability, to being like a journal that now has pages in which to write a future, conveying a positive impact from relapse prevention work. Direct description includes a sense of accomplishment, of increased social inclusion as a protective factor, and of recognition that C-Co may not change everything but provides confidence in having a future and longer-term recovery.

The practitioner relapse prevention game square also portrays a positive impact on practitioners. This depicts a person with their hands in the air holding their now full toolbox. Words like anxiety, hope, relief, and achievement are added to the square alongside a thought bubble declaring ‘What

next!'. This conveys a caring stance from practitioners which includes caring about the future of patients, of wishing patients the best, of relief that their patients have successfully completed therapy, and a belief that the 'Relapse Prevention' phase of C-Co creates confidence for the future. Within the game square description, partitioners reflect their own sense of accomplishment and satisfaction at seeing patients progress to this stage of C-Co and feel that they have helped patients better manage, monitor, and maintain their psychosis experiences and recovery because of this.

All 'Relapse Prevention, movement cards facilitate forward movement and subsequent progression to discharge from the CBTp service. Interestingly the movement cards describe how reviewing progress to develop a relapse prevention plan can be upsetting but that this is offset by an increased sense of accomplishment and a realisation of just how far they have progressed. Proof of value is also portrayed as an important factor with practice of the strategies within the relapse prevention plan leading to increased confidence and hope, and to forward movement.

The thematic analysis reported in Slater and Painter (2016) provides a unique contribution to what is known about methods of impact analysis in HS contexts. Collaboration, hope, of being able to understand and be more open with others, the development of self-compassion, and increases in insight are evident. This demonstrates that PAR using group game design is an effective, viable qualitative method for generating data about the impact of CBTp on both patient and practitioner participants and that there are considerable and extremely important secondary gains to adopting such an approach. The approach deviates considerably from the norm and usual method of interviewing CBTp participants and then using thematic analysis of transcripts to determine impact. This deviation affords participants multiple means of expression, thereby surmounting common difficulties within the target population linked to verbal literacy; difficulties that are not addressed by any other study. Via playing 'Taking Steps', the PAR approach also offers non-participants a deeper, experiential means of appreciating therapy experiences (please see Fig. 11, section 4.8.3.2, for an example of non-participants experiencing 'Taking Steps').

The aim of this component of the organisational case analysis was to evaluate participant experiences of C-Co (patient and practitioner) using a novel PAR method of collaborative group game design. It also aimed to evaluate this method of research. Considerable additional data to that offered by Slater and Painter (2016) was provided. These additional game square illustrations and movement cards in conjunction with Slater and Painter (2016), suggest both positive and transient negative experiences of C-Co for patients and both positive and negative experiences of C-Co for

practitioners. The core and subcategories, and codes from the thematic analysis suggest a largely positive impact resulting from the research method with the benefits of collaboration being the most weighted.

The aim of this component was also to provide responses to Research Question 3: *What impact does C-Co have on patients?* and Research Question 4: *What impact does C-Co have on practitioners?* The component results demonstrate that C-Co had a positive and transient negative impact on patients and a positive and negative impact on practitioners.

4.5.4 Limitations and a Critical Appraisal of Slater and Painter (2016)

The novel method adopted by Slater and Painter (2016), whilst innovative, may be difficult to replicate. It substantially deviates from the method norms deployed in other CBTp participant studies. Whilst original in contribution to what methods might be adopted to scrutinise participant experiences, the unique format of the data and subsequent analysis makes comparison difficult and any inferences about generalisation problematic. Whilst Slater and Painter (2016) document the steps taken in applying their PAR method, it would be interesting to establish whether others adopt a similar approach. To date the researcher is not aware of any such replication. Yet Slater and Painter (2016) do not claim that inferences about HS CBTp participant experiences can be made, only that inferences regarding C-Co at that time can be made. The adopted critical realist methodology is both advantageous and disadvantageous. Whilst it offers rich qualitative insights into the experiences of C-Co participants, it fails to offer any definitive, quantifiable data about the impact of C-Co or HS CBTp more generally.

4.5.5 Recommendations.

Recommendations for further research that analyse patient experiences and the impact of HS CBTp, using innovative methods like PAR that also include practitioner experiences and do not disadvantage patients, are made. The potential for secondary gains from the research process should also be considered.

4.5.6 Section Summary.

This component of the organisational case analysis explored and investigated the impact of C-Co from a practitioner and patient perspective using a novel research approach. In their evaluation Slater and Painter (2016) highlighted that the results indicated several important findings that both supported but added to existing forensic and non-forensic CBTp research findings, whilst also offering an entirely unique and original contribution to what is known from a participant perspective about the impact of HS CBTp and specifically C-Co. The work constitutes a unique and seminal contribution to the literature as there are no other published or fugitive studies that evaluate the experiences of typical HS patients. The component evaluation of using an entirely original PAR approach involving group game design adds to what is known about the creative research methods that might be successfully deployed in HS contexts to explore HS CBTp participant experiences, particularly approaches that do not inherently disadvantage those involved. The next section of the Component Outcomes chapter explores practitioner perspectives of delivering C-Co.

4.6 Component 5: Practitioner Perspectives of Delivering C-Co.

4.6.1 Introduction.

Praxis adaptation by skilled practitioners is necessary particularly in complex environments such as conditions of HS (Bentall & Haddock, 2000). Praxis complexities are further compounded by a lack of resources to employ commensurate numbers of accredited therapists (Garety et al., 2000). This precludes CBTp provision according to need (Kuipers, 2011). The pressure to explore more practicable means of provision, like the use of non-accredited practitioners, is therefore considerable, but not without controversy (Waller et al., 2013). C-Co was designed to be delivered by non-accredited nurse practitioners. Understanding practitioner experiences is therefore integral to further service development. This research component aims to provide a response to Research Question 4: *What impact does C-Co have on practitioners?*

4.6.2 Aim.

To explore non-accredited practitioner experiences of delivering C-Co.

4.6.3 Method.

This research component adopts a critical realist methodology and aims to describe the experiences of non-accredited C-Co practitioners. Despite criticisms that critical realism remains a largely male dominated and androcentric methodology it has gained increasing traction as a feminist approach to research. The position that neither the empirical causality of real-world events nor the subjective experience of these offer sufficient understanding when viewed in isolation accords with the critical-emancipatory stance central to feminist theory. Feminist critical realism embraces both the impact of a subordinating real world on the individual, but importantly also the impact that subordinated individuals may have on the real world as a catalyst and agent for change. The belief in this symbiosis is integral to feminist activism. In the context of this component, C-Co practitioners could be considered subordinated individuals as they were delivering a psychotherapeutic intervention in a professional context dominated by pharmacology and the medical-model of disease.

4.6.4 Sampling.

A convenience sample of practitioners delivering C-Co was approached to see if they might consent to have their supervision sessions recorded, anonymised, and transcribed as part of this research component. In total seven practitioners were approached with six consenting to take part - three females and three males. Experience of nursing ranged from 3-25 years and all practitioners had worked in the HS context for at least three years. All were non-accredited and had not received any formal CBT or CBTp training other than that offered by the HS CBTp service delivering C-Co.

4.6.5 Data Collection.

Formal semi-structured one-to-one interviews with the researcher as interviewer were conducted and recorded with a convenience sample of C-Co practitioners. Interviews were conducted in the CBTp Service Office within the hospital's psychology department. Recordings were transcribed and cross-validated with individual practitioners. The data set comprised of these recordings.

4.6.5.1 The use of formal semi-structured interviews with the researcher as interviewer.

Interviews collect primary data of a more detailed nature that might not otherwise be possible through other research methods. They are considered a 'mainstay' of qualitative research (Savin—Baden and Howell Major, 2013). They can facilitate a deeper understanding of participant

experiences and perspectives (those of C-Co practitioners) in relation to a specific phenomenon – in this instance C-Co. Data from interviews is most usually transcribed, coded and analysed into themes. In the context of this, component themes are used to evaluate C-Co impact on practitioners and ultimately inform further service development. Interviews involved asking individuals (C-Co practitioners), who have knowledge about or exposure to a particular phenomenon (C-Co delivery), questions about their experience of that phenomenon.

Interviews can be structured, unstructured, or semi-structured; group or on-to-one; formal or informal. Structured interviews, using a set order of closed-ended questions, can be used in exploratory and explanatory research. Whilst structured interviews facilitate the parsimonious identification of trends, they risk self-verification and limit depth of response. Conversely, unstructured interviews, based solely on the interviewee's responses and the curiosity of the interviewer, are more difficult to comparatively analyse, can be time-consuming, and risk significant irrelevant data. Semi-structured interviews, based on a prescribed set of questions with non-scripted, in-action, secondary questions based on interviewer curiosity offer the advantages of both structured and unstructured interviews whilst also limiting some of the disadvantages.

This interview format can be both exploratory and explanatory, in this instance facilitating the exploration of C-Co practitioner experiences of delivering C-Co through a harmonised question list, whilst also engendering sufficient flexibility, via secondary questioning, to uncover individual interviewee explanations of those experiences. The authenticity of this explanatory function was further enhanced by the adoption of a one-to-one, rather than focus group, interview format. Whilst focus groups can support consensus building and may result in a more manageable data set, one-to-one interviews are more likely to expose and enhance the authenticity and meaning of both conflicting and homogenic data (Savin-Baden & Howell Major, 2013). In-situ, informal interviewing was rejected over formal interviewing as in-situ interviews may have compromised comparable data and theme identification and were more likely to be compromised by interviewer memory biases. In-situ interviewing would also have been inappropriate and may have yielded only limited data regarding the component aim and research question.

The interviewer, questions asked, and method of analysis are also integral to the subsequent authenticity of the data and the trustworthiness of themes, and any claims made, or inferences drawn. In this instance the researcher was the interviewer. This could be considered contentious, and a potential confound, given the conflict of interest of the researcher's duality of role as both

interviewer and service manager. This was explored with the researcher's supervisor at that time, Dr Townend, and a cost-benefit analysis conducted. Factors considered included: power-dynamic, social context, interviewer-participant relationship, the rhetoric of interviewing, researcher bias, reactivity, participant autonomy and component beneficence. These factors are of particular importance given the feminist methodology adopted by the research. It could be argued that the potential power imbalance between the researcher and the practitioners based on service role, might have led to reactivity, a process by which interviewees moderated their responses to appear in a positive light or to limit potential negative consequences. This may have served to exacerbate the power-imbalance already inherent in research interviews (Holloway & Galvin, 2017). Access to authentic responses that reflected practitioners' true beliefs and emotions may therefore have been compromised as might participant autonomy. The social context of the researcher as a more senior professional within the hospital hierarchy may have further compounded reactivity.

Whilst the researcher as interviewer may have supported researcher knowledge and skills development within the context of the thesis, it was important to consider whether this risked an iatrogenic impact on participants, compromising component beneficence. The interviewer-participant relationship and strategies like cross-validation to increase authenticity were therefore critical determinants. The researcher's relationship with practitioners was based on his role as the service manager and supervisor, the shared norm of nursing, and inter-personal dynamics based on individual characteristics and person identity. Such variables can be both advantageous and problematic (Holloway & Galvin, 2017). Advantages included the existing collegial relationships between the researcher and practitioners, a shared culture of service values, beliefs and aims, and existing trust founded within the supervisee/supervisor relationship. Problems included potential over-involvement and unjustified assumptions. Strategies that therefore enhanced participant autonomy, data authenticity and analysis validity were important to mediate confounds and ensure beneficence. These included cross-validation of both transcripts and themes with participants and the engagement of a research assistant to independently identify themes in parallel with the researcher. These considerations are further explored within the Ethical Consideration section below (4.6.7).

4.6.5.2 Question Development

Semi-structured supervision sessions, conducted by the practice lead, were routinely used to illicit practitioner experiences of delivering C-Co. Co-agreed themes from these sessions, derived by a

rudimentary in-action process of thematic analysis by the service lead and practitioner, were routinely used to inform supervision discussions, practitioner training and service development. During these sessions, practitioners were given the opportunity to respond to a set of questions linked to their practice experiences. Supplementary questions were used where appropriate to further explore responses. The component aim was to use this routine process more formally to research C-Co impact on practitioners. The questions used within the semi-structured research interviews are given below and evolved from the researcher's reflections on the questions most asked during routine supervision. Secondary questions based on interviewer curiosity were also asked and responses summarised and clarified as part of the interview process. The researcher adopted the stance of 'naive interviewer' when asking questions to overcome assumptions that may have emerged from shared cultural values and beliefs (Holloway & Galvin, 2017).

Interview primary questions:

- What are your reflections on being a C-Co Practitioner?
- How has your experience of being a C-Co practitioner changed from when you first started?
- What are the difficulties of being a C-Co practitioner?
- What stresses have you experienced during your time as a C-Co practitioner?
- Is there anything you would change about being a C-Co practitioner?
- What things have you done as a C-Co practitioner that you feel really pleased about?
- What advice would you give to a new C-Co practitioner just starting out?

4.6.6 Data Analysis.

The anonymised supervision session transcripts were subject to thematic analysis and dynamic participant validation (Boyatzis, 1998; Bryman, 2012). The transcripts were first analysed by the practice lead (thesis researcher) and a department researcher, independent of each other. An iterative process of comparison and convergence then took place between the department researcher and lead to identify an agreed set of themes. These themes were then subject to a further verification process via dynamic participant validation with practitioners (Strauss & Corbin, 1998).

Despite being one of the most adopted approaches to qualitative data analysis, the process of thematic analysis remains poorly defined and lacks any consensus regarding both terms and

procedure (Bryman, 2012). There is no 'one' agreed approach and multiple procedures and systems have emerged, which are often context dependent. It is therefore likely that the process a researcher adopts may in some ways be eclectic and influenced by several modes of analysis (Bryman, 2012). This is true of this research component. Whilst it relies heavily on the stages of analysis suggested by Boyatzis (1998) and practical example provided by Charmaz (2006), it also draws on the constant comparative method and process of cross-validation referenced by Strauss and Corbin (1998) and the examples and core components suggested by Bryman (2012). Interestingly, none of these sources didactically or explicitly identify the cognitive and emotional processes by which researchers identify themes. They instead pose questions and offer frameworks which may support the researcher to 'discover' such themes based on their conscious and unconscious schemas and their individual relationship to the research. They also suggest processes of independent validation, cross-validation, or dynamic participant validation to enhance authenticity and trustworthiness and add a further dimension of co-construction. Whilst software systems have been developed to support these discoveries, Bryman (2012) suggests there is a potential for these to constrain true analysis. Sources do however agree on the need for transparency of process. A schematic of the process of analysis in this component is provided below in Table 11 to aid transparency.

Table 11: A Schematic of Component Method and Analysis.

Sampling	Convenience sample of practitioners delivering C-Co
Data collection	• Formal, semi-structured, one-to-one interviews with the researcher as interviewer • Primary questions emerged from the researcher's reflections on the questions most asked in routine supervision • Validation of anonymised transcripts by individual participants
Analysis	1. Organising: organising the data into a format that could be analysed. This involved double spacing and making single sided prints of transcripts. 2. Familiarisation: immersion and saturation via reading and re-reading the data 3. Coding: beginning to cut extracts from the transcripts (codes) and organise these into sub-categories (discrete piles of codes with 'post-it-note' sub-category identifiers) 4. Refining: using a process of constant comparison to refine which codes were in each sub-category and refining sub-category identifiers, beginning to group the sub-categories into core-categories and naming these. 5. Independent validation: iterative process of comparison and convergence between the researcher and independent department researcher having both completed stages 2 to 4 independent of each other. 6. Cross-validation: verification of core-categories, sub-categories and codes via dynamic participant validation in which participants were presented with the outcome of step 5 of the analysis.
Writing up	Writing up the component within the thesis

Collaborations	Collaborative development of a C-Co supervision and training model based on component outcomes (see section 4.8.3.4)

4.6.7 Ethical Considerations.

Via consultation with the NRES process (HRA, 2014) and Trust research department, the research was categorised as a form of service evaluation involving anonymised C-Co practitioner views captured from a routine process. A formal review by the hospital Research and Ethics Governance group, Trust Governance and Research Lead and University Ethics Committee supported this categorisation. Guidance, support, and permissions commensurate to this categorisation were sought and gained.

Although the research component did not generate practitioner data in addition to that already produced as part of routine clinical care, it did apply a more robust method of capture and analysis via recorded interviews, transcription, and thematic analysis. Convenience sampling was used, and existing C-Co practitioners approached to see if they might consent to their data being used for the purposes of the research in the manner described. Subsequent recordings of practitioner supervision sessions for the purposes of the research with the researcher as practice lead, were destroyed once anonymised transcriptions had been produced and had been subject to practitioner validation. Practitioners had the right to withdraw their data up until the analysis commenced and it was agreed that transcriptions would be kept on a secure password protected server. Careful consideration was also given to only include examples of extracts in the thesis that would not risk inadvertently compromising anonymity.

Despite these actions one might argue that practitioner autonomy may have been impeded by the duality of the researcher as both interviewer and practice lead. Whilst peer research may offer the possibility of greater equality between researcher and subject this may not be the case if the researcher is in a position of professional authority such as a practice lead (Holloway & Galvin, 2017). The inherent power imbalance may compromise the resulting data and act as a confounding variable by placing indeterminable and subtle pressures on the interviewee to moderate their behaviours and censor any ‘true’ response that they feel may be harmful professionally. Although one practitioner did not consent to their data being included in the research, one cannot assume that other practitioners felt similarly empowered. Nor can one exclude the possibility that this practitioner may have consented had the interviewer been independent of the CBTp Service. The

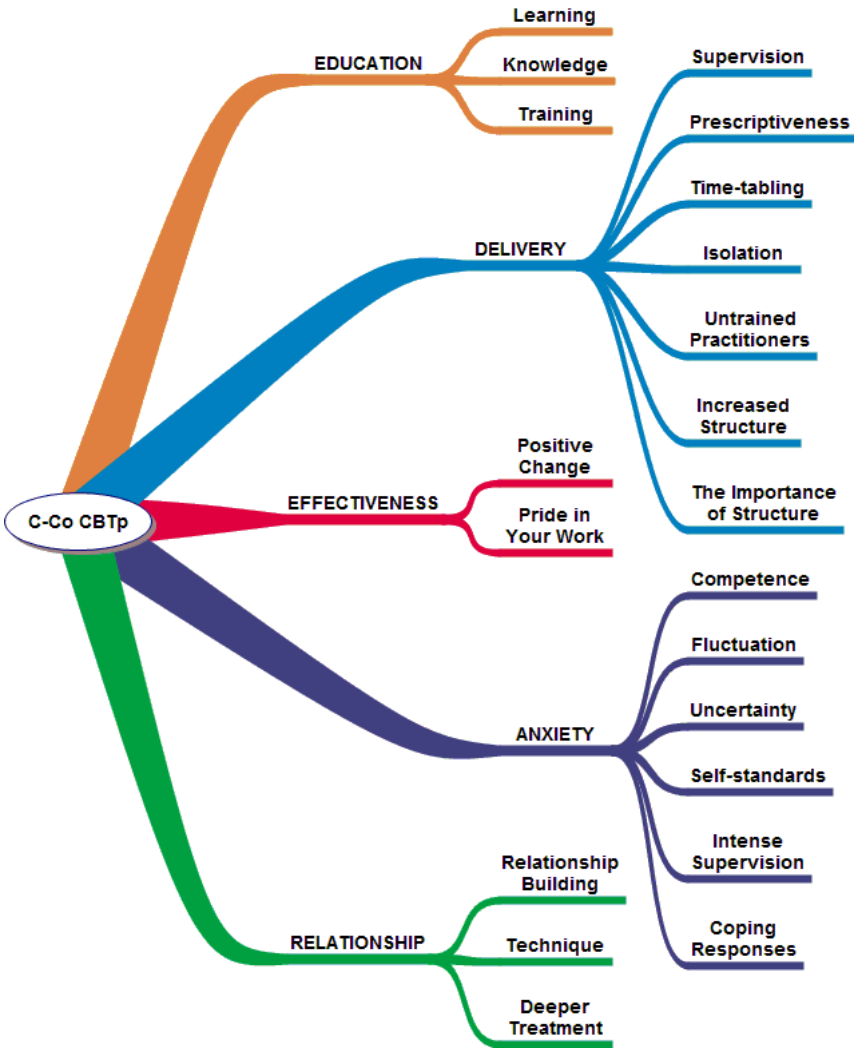
exclusion of this practitioner's data, whilst respecting their autonomy, may therefore also have potentially skewed any resultant analysis and compromised the concept of justice via the exclusion of a possible critical voice.

However, one might also argue that the researcher as practice lead may have enhanced autonomy, justice and beneficence and represented an acceptable non-maleficent risk. Unlike with an independent researcher, trusting relationships may have already been developed between practitioners and the service lead, in which practitioners felt empowered to offer 'true' opinions. Practitioners may have already been socialised to sharing constructive criticisms with the practice lead to support the CBTp service and C-Co to develop. Proof of value may also have already been established with participants aware that their constructive criticisms lead to actions that helped to improve their practitioner experience. The subsequent collaborative development of a practitioner training and supervision model based on the component themes may have subsequently added to this proof of value and better aligned the research with the ethical concept of justice (please see the dissemination component). Cross-validation of themes with an independent researcher and practitioner subjects may have further respected practitioner autonomy and reduced risks of data being unrepresentative or skewed.

4.6.8 Results.

Five core categories, each with relevant sub-categories comprising a total of 67 codes, emerged from the practitioner interviews. Core categories and sub-categories are illustrated in Fig. 10. A description of each core category with pertinent examples coded to each interviewee is provided.

Fig. 10: A Tree Diagram of Identified Themes from Practitioner Feedback (© Slater).



4.6.8.1 Education (Ed).

These themes suggested that practitioner knowledge and confidence increased over time. Practitioners learnt most from group training and supervision days where they were able to compare and share praxis experiences and gain reassurance. However, practitioners also held a sense of an ongoing knowledge deficit which they felt might only be addressed via access to accredited training.

Ed1: Learning:

"It was great meeting up with other practitioners. On training days and [group] *supervision I learnt from listening to them and sharing difficulties."* (Int.6).
"I learnt a lot about CBT in quite a deep way rather than just a few techniques. I learnt about how those techniques actually work in practice and that those simple techniques tap into a lot of different things" (Int. 4).

"There are lots of things I have learnt in the CBTp programme that I have been able to use in the rest of my work as well" (Int. 2).

"Practitioner days [group training and supervision], *I thought they could have been more frequent because when we did eventually get all together, they were cracking days and very beneficial."* (Int. 5).

Ed2. Knowledge:

"As I became more proficient and more knowledgeable about what I was doing, it became a lot easier to put in place." (Int. 1).

"I guess the downside is that your CBT knowledge still feels limited, that limits your confidence, I had difficulty sometimes being responsive to the change in the situation in the room." (Int. 4).

Ed3. Training:

"I would have felt more comfortable if I'd had access to do some accredited training. I wonder whether someone that was accredited in the first place might have been able to do it better, be more effective." (Int. 6).

4.6.8.2 Delivery (D).

Practitioners stressed the importance of supervision and structure but also struggled with over-prescriptiveness. Timetabling proved difficult and practitioners sometimes felt detached from CBT peers and the wider MDT. The non-accredited practitioner model was queried regarding efficiency and sustainability.

D1. Supervision:

"On my one CBT day [a week] *it felt like I was getting a lot of supervision and some training which helped…"* (Int. 4).

D2. Prescriptiveness and D7. The Importance of Structure:
"It's good to have structure, but it also felt prescriptive." (Int. 1).

D3. Timetabling:

"When you are only doing two long days on the ward….at some point you have got to fit in an extra-long day every couple of weeks to fit in that extra time, which when you have a young family ends up being a lot when you could be at home" (Int. 3).

D4. Isolation:

"[On your practitioner day] y*ou feel a little bit isolated; it generally feels quite distant and hard to feel part of the rest of the team."* (Int. 6).

D5. Untrained Practitioners:

"I felt that the accredited lead would get more done if they went out there and saw every patient themselves rather than supervise practitioners to do it, they could probably do it in half the time, if not less." (Int. 2).

"…the amount of time it takes them [patients] *to get it and the amount of time it takes to deliver it seems to be a long process."* (Int. 3).

"I did wonder at the end of it how efficient the process was, having untrained CBT practitioners delivering the CBT." (Int. 4).

"I think it would be useful to be accredited, or at least to have as much training as possible. In an ideal world you'd have 6 or 7 accredited therapists delivering C-Co." (Int. 1).

"Getting accredited would be a good thing and you could put it on your CV, you need to have something to show for all the hard work." (Int.2).

D6. Increased Structure:

"It's [C-Co delivery] *quite organised, structured now…there is more of a definite plan."* (Int. 1).

4.6.8.3 Effectiveness (E).

Practitioners saw the therapeutic benefits to patients and benefits to their own professional development of delivering C-Co.

E1. Positive Change:

"It [C-Co] *seems to do what it means to do; the patients seem to get more out of it."* (Int. 3).

"I'm a big C-Co fan, I've seen what it can do. The patients I saw, I saw change, just having confidence in somebody, the confidence to say things." (Int. 1).

"One guy I worked with was able to talk about his experiences in a lot more depth than he had ever done in the past. I was able to understand the kind of complex experiences they [patients] *have…how very simple looking solutions developed together can meet their needs."* (Int. 4).

"There are lots of things I've learnt in the CBTp programme that I've been able to use in the rest of my work, I've learnt a lot about myself as well which I found really useful." (Int. 5).

"The work is, I think, phenomenal actually in terms of its scope compared to the impact other therapies have." (Int. 6).

"The relapse prevention work is, I think phenomenal in terms of its scope compared to some relapse prevention work that I have been taught…" (Int. 4).

"I will be able to take a lot of the stuff I've learnt into the future." (Int. 1).

"It's [being a C-Co practitioner] *been a very positive experience."* (Int. 2).

E2. Pride in Your Work:

"I suspect if you asked a governing body…they would turn round and say an unqualified [non-accredited] *practitioner in CBTp should be going nowhere near a patient but look at what we've managed to achieve."* (Int. 2).

4.6.8.4 Anxiety (A).

Practitioners sometimes experienced frustration and uncertainty and their sense of competency fluctuated. Self-limiting beliefs, secondment pressures, the complexity of the context and patient population and the resultant reliance on high levels of supervision and support, increased anxiety.

A1. Competence:

"It almost felt like it had to be therapy-by-proxy, it made me question my own skills and judgement and made me feel deskilled, I suppose, and unknowledgeable." (Int. 6).

"I am going out there, these are real patients, real difficulties, real paranoia, real individual anxieties. On the ward [as a nurse] *I'm confident I can deal with all these issues, well I know I can, but as far as CBTp is concerned I'm completely out of my comfort zone sometimes."* (Int. 4).

"I felt I relied quite heavily on the service lead, maybe some of its confidence, but I felt I needed a lot of input to give the best to the patients." (Int. 1).

A2. Fluctuation:

"I have continual ups and downs delivering C-Co" (Int. 3).

A3. Uncertainty:

"One of the dilemmas this department [C-Co] *faces is if you* [supervisor/practice lead] *go off sick, practitioners would be left in limbo because we are umbilically bound to you for our knowledge"* (Int. 2).

"What worries me about this service [C-Co] *is what happens if you* [supervisor/practice lead] *break your leg? What use am I to anybody frankly because I do not know enough to go out there and do proper CBTp"* (Int. 6).

A4. Self-Standards:

"I feel a little bit kind of incompetent, a little bit like I don't really know enough, just kind of go in with a very small toolbox of stuff which isn't enough." (Int. 4).

A5: Intense Supervision:

"Supervision [individual] *could feel quite intense, and maybe, at times, it felt like it was a bit over the top and I felt like I was put on the spot a lot."* (Int. 4).

A6: Coping Responses:

"Because we ended up learning bits as we went along to fulfil the needs of the next session or the next few sessions it was hard quite hard to link those things together, I got anxious...I guess the main way of coping was to rely on you [the lead]*…it helped talking to other practitioners."* (Int. 1)

4.6.8.6 Relationship (R).

Practitioners recognised the benefits of the therapeutic relationships they were able to build by adopting a C-Co approach to CBTp.

R1. Relationship Building:

"I really started to appreciate the relationship building aspect of it [C-Co]*."* (Int.4).
R2. Technique:

"Before I was very, very technique focussed, but I began to see the limits of that and the importance of the relationship." (Int.2).

R3. Deeper Treatment

"I think it [C-Co] *gives you the flexibility at the start to get to know the individual on a much deeper level because you've got to develop trust: (a) you are learning more about them and (b) they learn more about themselves."* (Int. 1).

"You get to know the individual on a deeper level because you've got to develop that relationship more on a one-to-one basis and develop trust and, hopefully get a lot more from that person than what you might do if you were just passing on the ward or just working in a normal ward environment." (Int. 5).

4.6.9 Discussion.

The aim of this component of research was to analyse the impact of C-Co on practitioners providing a response to Research Question 4: '*What impact does C-Co have on participants?'* This was achieved via a thematic analysis of the content of routinely held C-Co practitioner supervision sessions. The results indicate that C-Co has a positive and negative impacts on practitioners. This section of the thesis discusses the results of the thematic analysis and a comparison of results in the context of the available HS CBTp literature. Limitations and suggestions for further service development and research are then provided following the discussion section. C-Co is delivered by non-accredited practitioners, comprised of clinical ward-based nurses, seconded a day a week to the HS CBTp service. They have a maximum caseload of three patients, receive initial modality training, quarterly training and group supervision and an hours one-to-one weekly supervision with an accredited CBT therapist (section: 1.2.3.3). Section 4.3 demonstrates that C-Co practitioners achieve CBT modality fidelity and praxis competence.

Results demonstrate that C-Co practitioners' sense of knowledge and confidence increased over time and that group supervision and training days were key to this process. Results also demonstrate that the skills and knowledge gained from delivering C-Co benefited practitioners in their ward-based nursing roles. However, there was also an ongoing sense of a knowledge deficit which practitioners felt might only be filled via a recognised accreditation process such as that provided by the BABCP. Practitioners felt that accreditation might offer something more tangible than their current practice to put on their CV. Emphasis was also placed on the importance of individual

supervision and the structure offered via C-Co protocols, although these could also feel too intense and prescriptive.

Whilst practitioners reported C-Co having a high level of practice efficacy especially regarding relationship development with non-adherent patients, they also reported that efficacy was dependent on individual supervision scaffolding their practice. This form of 'therapy-by-proxy' could result in practitioners feeling less competent and vulnerable given their perceived reliance on individual supervision to guide and steer their practice. Concerns were raised about the subsequent impact on efficacy if the supervisor were absent. Concerns were also raised by practitioners about the utility and sustainability of the non-accredited model of practice adopted by C-Co. Whilst knowledge and confidence increased, so too did anxiety, critical self-standards and a sense of uncertainty which contributed to *'ups and downs'* in practitioners' sense of fulfilment. It was also evident that the service model of practitioners seconded one day a week on different days led to a sense of isolation which increased the amount of anxiety practitioners experienced. A relationship between sense of knowledge, competence and the level of anxiety experienced by practitioners was identified. Modifiers which increased sense of knowledge and competency were linked to decreases in practice anxiety.

The utility of protocols to guide non-accredited practitioners in delivering low intensity CBTp is well established as is the importance of group supervision and training (Turkington et al., 2006; Duffy et al. 2013; Hayward et al. 2018). Yet the limitations of protocols regarding complex individual case work, especially within forensic contexts, are also evident (Bental & Haddock, 2000). The results suggest C-Co practitioners found protocols and structure useful but also too prescriptive and too inflexible to adapt to praxis requirements. Practitioners also reported that the level of supervision needed to scaffold and help them adapt their practice was too intense. According to James et al. (2001) a competent accredited therapist should be able to adapt flexibly to the moment to moment needs of the patient within the therapeutic interaction. Not all C-Co practitioners felt able to do this and felt dependent on raising session needs, outside of therapy, within their supervision to respond to these needs within the next therapy session. There was a sense amongst some C-Co practitioners that this process slowed therapy and extended intervention periods.

Whilst C-Co practitioners were able to recognise that they achieved positive outcomes particularly regarding relationship building and specific interventions such as relapse prevention, there was also a sense that an accredited practitioner might achieve the same results more efficaciously. There was

not a sense amongst C-Co practitioners though that they achieved fewer positive outcomes than those that might be achieved by an accredited psychotherapist. Most practitioners felt a sense of pride in their accomplishments, particularly given patient complexity. They also felt being a C-Co practitioner had a beneficial impact on their nursing practice. This ability to recognise patient improvements and value practice is integral to support ongoing implementation of CBTp approaches (Waller et al., 2013).

Whilst it was felt by C-Co practitioners that outcomes may take longer to achieve than via C-Co delivered by an accredited therapist the literature does not necessarily support this. Guidance relating to the provision of CBTp via accredited psychotherapists points to a range of between 2 and 154 sessions dependent on whether a specific symptom or a holistic approach to psychosis is adopted (NICE, 2009). C-Co was designed as a holistic rather than single symptom approach for use with complex non-adherent high secure forensic patients. The number of sessions might therefore be expected to fall towards the higher end of the range and therefore seem longer for practitioners when compared to single symptom interventions or those conducted with well-engaged community patients. Interestingly the anxieties reported by the C-Co practitioners are also not dissimilar to those experienced by trainee CBT therapists and indeed some accredited psychotherapists (Duryee et al., 1996; Harrhoff, 2006; Bronson et al. 2008). However, unlike previous studies, C-Co practitioner anxieties and sense of knowledge and competence seemed independent of gender (James et al., 2001). Published models of how competence and knowledge may improve also differ, with few of these models being specifically focused on the reduction of anxiety as a means of increasing practitioner perceptions of competence and knowledge. However, unaddressed anxiety related schemas are perceived as barriers to effective CBT practice (Harhoff, 2006).

A comparative analysis of convergence and divergence between the results of component 4 and Slater and Painter (2016), which also detail the impact of C-Co on practitioners, and the results of this component are provided as part of the Component 8: Summative Synthestis and Convergent Validity offered in Chapter 5. Besides the researchers own works, there is only one other study within the literature for comparative analysis that specifically reports on practitioner experiences of delivering an adapted context-specific HS CBTp approach - Cawthorne (2019). Whilst this research component therefore adds to the limited HS CBTp literature, it also provides an original contribution as the chief complaint orientation of C-Co crucially differs to the purely nomothetic symptom-based CBTp(f) approach evaluated by Cawthorne (2019). Cawthorne (2019) used a

Delphi study to explore consensus amongst nurse and psychology practitioners delivering CBTp(f) as to why approach efficacy seemed limited, why uptake was poor, and why annual referrals had reduced to zero. Whilst Cawthorne (2019) claimed that CBTp(f) was *'fit for purpose'* (Cawthorne, 2019, p. 60) this is unsubstantiated in relation to the positivist standards of literature and evidence scrutiny adopted by Cawthorne (2019). The claim emerged from an earlier study conducted by Cawthorne of limited validity which failed to achieve significance (Cawthorne, 2003, see Chp. 2). No explicit data was provided in Cawthorne (2019) about whether practitioners were accredited. Whilst the generic CBTp theories underpinning CBTp(f) are comprehensively explored by Cawthorne, only limited details of any adaptations are provided. This is further exacerbated by a failure to provide an in-depth analysis of protocol praxis. Despite these limitations, Cawthorne (2019) remains an admirable and important undertaking and the only study, besides this thesis component, to explore the views of practitioners delivering adapted individual HS CBTp.

As reported by Cawthorne (2019), practitioners uniformly found the CBTp(f) protocol (a document of more than 10,000 pages) overly complex and not straight forward to utilise, reporting it to be cumbersome. This contrasts with the positive structure C-Co practitioners felt was offered via C-Co protocols. However, a sense by practitioners that C-Co protocols might be too prescriptive and intense accords with Cawthorne' s results (Cawthorne, 2019). Respondents in Cawthorne (2019) also reached a consensus about their perceived knowledge and praxis expertise in relation to protocol application. Respondents felt that they lacked knowledge in relation to the protocol despite specific training and ongoing supervision. Anxieties about practitioners' sense of knowledge and praxis expertise are also apparent within the results of this research component. Although alongside these anxieties, C-Co practitioners voiced a high level of practice efficacy with non-adherent patients and a strong sense of accomplishment, they also felt dependent on the accredited supervisor to scaffold practice.

Whilst respondents in Cawthorne (2019) valued supervision, this was criticised as often involving general CBT models and as not being sufficiently CBTp(f) specific. Cawthorne (2019) also reported that supervision uptake was poor. This contrasts with some of the positive impacts reported regarding C-Co supervision. C-Co practitioners found supervision and training helped increase their knowledge and confidence and had broader benefits within their primary roles. However, research component data also indicates iatrogenic effects linked to anxiety and an awareness of knowledge deficits exposed by supervision. It was felt these might only resolve via a formal process of study and accreditation.

Respondents in Cawthorne (2019) identified that praxis deviations from the CBTp(f) protocol were necessary to engage patients but disagreed over the degree of variation or what level of deviation might be deemed acceptable. Respondents also felt that a tiered approach to treatment, including the availability of low intensity interventions for psychosis, may be more beneficial than CBTp(f). Interestingly this perception is not supported in the results of this research component. C-Co practitioners did not report the need to deviate from the protocol and perceived C-Co as having a high level of efficacy. This contrast may be due to the differences between C-Co and CBTp(f), specifically the lack of any chief compliant orientation within CBTp(f) or any adapted engagement approach to surmount typical non-adherence. This may also account for the poor CBTp(f) efficacy, uptake and referral rate reported by Cawthorne (2019).

The aim of this component of the organisational case analysis was to research the experiences of non-accredited C-Co nurse practitioners delivering C-Co. This was done using recordings of routine semi-structured supervision sessions with C-Co practitioners that were transcribed and made subject to thematic analysis and dynamic participant validation. The resultant 67 codes and core and sub-categories and the relationships between these indicate that the impact is complex and multifaceted. In the context of the organisational case analysis the aim of this component was to also provide a response to Research Question 4: *What impact does C-Co have on practitioners?* The results of this component demonstrate that C-Co had a positive and negative impact on non-accredited C-Co nurse practitioners.

4.6.10 Limitations.

As with Cawthorne (2019), this research component has several limitations. Practitioner interviews were conducted solely by the researcher as service lead. The questions to facilitate interviews and collect data were also set by the researcher and may therefore also have skewed outcomes. Whilst the use of an independent researcher limited bias in theme development, ultimately these themes may have emerged from a skewed data set. Although the analysis was aided by a researcher independent of the C-Co team and included a process of participant validation, the inherent power imbalance between the interviewer and interviewees may have skewed data regarding interviewer bias and practitioners not wanting to disclose their true opinions to the researcher. One of the practitioners approached declined involvement in the study which may have also biased results via the exclusion of potential critical opinions. On reflection, notes were not made relating to researcher observations of interviewees during interviews. Nor were more extensive notes made of the process

of comparison and convergence engaged in with the independent department researcher during analysis. These limitations detract from both validity and trustworthiness and are a point of learning for the researcher. Whilst the researcher concurs with Bryman (2012) that computer systems that support analysis may also potentially compromise 'discovery', of note is that the independent department researcher used Microsoft Excel to complete and organise analysis stages 2-4 whereas the researcher used paper, scissors and post-it-notes. Whilst the researcher preferred the use of a physical, tactile medium to analyse the data, he noted that the use of Excel may offer a more parsimonious means of storing and subsequently writing up results.

4.6.11 Recommendations.

The inclusion of standardised measures which quantified changes in practitioner competence, knowledge and related anxiety may have offered a more robust analysis. Although the use of an independent interviewer may have helped to reduce error, a Delphi study to iteratively facilitate the emergence of practitioner opinion and items of consensus, like the approach deployed by Cawthorne (2019), may have offered a more rigorous and accepted method of reducing potential data bias and also therefore analysis errors. Ongoing study is therefore required as is a wider analysis that includes the views of practitioners delivering adapted CBTp approaches in other HS contexts to those of Cawthorne (2019) and this research. A model of HS CBTp supervision and training which offers a system to enhance positive modifiers and resolve negatives modifiers in relation to practitioner experiences may have value. The thesis dissemination results (C7) describe the collaborative development of such a model devised using the outcomes of this research component (please see section 4.8.3.4).

4.6.12 Section Summary.

In this section of the Component Outcomes chapter, anonymised transcripts from the recordings of routine semi-structured supervision sessions with C-Co practitioners were subject to thematic analysis and dynamic participant validation. Five core categories of themes emerged from the analysis, each with relevant sub-categories comprising a total of 67 codes. Outcomes add a significant amount of original data to the extremely limited literature and suggest a complex and multifaceted, positive, and negative impact on practitioners. The synthesis of the component results within an organisational case analysis in also unique and original. Other than component 4 and the researcher's peer-reviewed publication (Slater & Painter, 2016) work, a reapplication of the

exploratory search strategy used by Slater and Townend (2016) highlighted only one study (Cawthorne, 2019) which specifically reported on practitioner experiences of delivering individual adapted CBTp in HS contexts. The results from the research component were discussed in relation to this study. An analysis of component convergence and divergence with the results of the component with those of component 4 and Slater and Painter (2016) is provided in Chapter 5. The next section of the Component Outcomes chapter offers the results of a quasi-experimental, exploratory statistical analysis of C-Co pre and post, subjective and objective, outcome measure data.

4.7 Component 6: An Exploratory Analysis of Pre and Post C-Co Outcome Measure Data.

4.7.1 Introduction.

The need for research into the application and development of psychological approaches is acute in high secure care provision (Steel, 2008; Slater & Townend 2016) and is supported by poor levels of treatment generalisation between other settings and HS care (Mason, 1999; Shah et al., 2009). The high incidence of patient non-adherence and treatment resistant psychosis, and links between this and index offence severity (Laithwaite et al., 2007), similarly underpin the chronic need for effective HS psychological approaches (Bartlett, 1993; Shah et al., 2009).

4.7.2 Method.

One of the available sources of C-Co impact routinely gathered and lens through which impact might be viewed, was pre and post outcome subjective and objective measure data. This research component therefore adopted an exploratory, positivist, quasi-experimental method within the framework of the feminist methodology to evaluate the impact of C-Co on patients by offering a comparison of the available pre and post intervention subjective and objective outcome measure data. It also aimed to provide response to Research Question 3: *What impact does C-Co have on patients?*

Whilst previous group HS CBTp research has subjected pre and post outcome measure data to statistical analysis to determine impact - most notably Williams, Ferrito, and Tapp, 2014 - this research component is the first individual HS CBTp study to adopt a positivist method of statistical analysis of repeat outcome measures to determine significance, effect size, and power of impact.

Whilst it therefore represents a unique and original contribution to the individual HS CBTp literature, it is also ambitious and not without considerable limitation. The exploratory nature of this component as part of a challenge to the established norms (Benn, 2002) about what research methodologies and methods may be used to research the efficacy of individual HS CBTp, must be emphasised. Randomisation, power, and normal distribution of results have previously proved problematic in individual HS CBTp research and may continue to do so, compromising generalisability. It is important to emphasise how the use of positivist methods within a feminist methodological framework differ from the adoption of a positive methodology per se. Whilst empirical feminists argue that positivist methods and terms have importance as a means of challenging the dominant discourse by adopting the same scientific language, they reject the objectivity and value neutrality assumed by the deployment of such methods within a positivist methodology, arguing that this serves only to perpetuate socially constructed dominance and bias. The theory underpinning this thesis, its construction via the researcher's experiences and presuppositions, as explored in earlier chapters and laid bare in Component 1, does not pretend to be value-neutral. The adoption of positivist methods within this thesis component therefore sits within that paradox of both objectivity and bias.

A positivist quasi-experimental method was therefore adopted for this research component. A within subjects, repeated measures design was used to statistically compare pre and post C-Co data using two observer based objective measures (rated by ward staff) and two subjective measures (rated by C-Co patient participants).

4.7.3 Component Hypotheses.

1. The component research hypothesis predicts that a positive statistical difference will be achieved between pre and post C-Co outcome measure scores for male non-adherent, treatment resistant HS patients who have completed C-Co.

2. The null hypothesis predicts that there will be no difference or that any difference will be entirely due to chance or error.

4.7.4 Sampling.

Patients were purposively sampled from the group of patients who had been referred for C-Co during the research period (n=51). Purposive sampling was used as the research was retrospective and pragmatic based on routine data gathered by the HS CBTp service. Cases were retrospectively selected from patients who offered the best 'fit' (n=11) regarding typical characteristics of the population particularly non-adherence and treatment resistance (Taylor, 1998), who had completed C-Co, who had not been in receipt of any other additional interventions since commencing C-Co, who had engaged in completing outcome measures, and whose named nurses had completed and returned objective outcome measures.

Of the 51 patients referred to the CBTp service during the period under scrutiny (2008-2015), 34 had completed therapy, 13 were currently engaged in therapy, 2 remained on a waiting list, one had died whilst detained, and one had been discharged to conditions of lesser security. Of the 34 patients who had completed C-Co, 25 had been considered non-adherent, experienced distressing residual symptoms despite primary treatment with antipsychotic medications, and had not been in receipt of any additional interventions whilst in receipt of C-Co. Of the 25 patients identified, 11 had engaged in the completion of subjective pre and post outcome measures and their named nurses had completed and returned commensurate pre and post objective outcome measures. Of the remaining 14 patients, they had either chosen not to engage in completing outcome measures, had not had objective measure outcomes submitted by their named nurses, had not provided consent for inclusion, or had incomplete data sets. There was also insufficient post follow-up data to include this within the analysis. The nursing milieux and provision of antipsychotic medications (without changes) remained constants prior to and during C-Co and there were no additional interventions whilst patients were in receipt of C-Co.

It is important to emphasis within the context of the thesis, research setting, and number of available subjects, randomisation was not possible. A control with which to compare the sample to those receiving treatment as usual, such as a waiting list control, was also not used which may limit generalisability. The sample size was also insufficient to achieve *a priori* power. These potentially confounding factors are explored below.

4.7.5 Data Collection.

Four measures, two objective and two subjective) were used to collect pre and post outcome data. The objective measures used were the Life Skills Profile LSP-39R (Rosen A., Hadzi-Pavlovc D.,

Parker G. & Trauer T., 2006) and the Nurses' Observation Scale for Inpatient Evaluation NOSIE-30 (Honigfeld G., Gillis R.D. & Klett C.J., 1965, 1966, Lyall D., Hawley C. & Scott K., 2004). The subjective measures used were the Brief Symptom Inventory BSI (Derogatis, L. R. & Melisaratos N., 1983; Derogatis, 1993) and the Positive and Negative Affect Schedule PANAS (Watson, D., Clark, L. A. and Tellegen, A., 1988). All measures were deemed to have sufficient reliability and validity for the purposes of the research. Whilst all the measures had been used within previous psychosis and forensic research, not all had been validated for use with high secure hospital patients (Lyall, Hawley & Scott, 2004).

Given the high level of non-adherence within the target population, to reduce possible masking effects and better respect patient autonomy and decision making regarding how their data might be used, routine collection of subjective baseline psychometric data is only initiated after completion of the chief complaint stage of C-Co and is based on patient choice. Patients who engage with baseline measures are subsequently approached to repeat these measures post therapy and post follow-up (please see section 1.2.3.4 for an overview of the assessment and evaluation process used in C-Co and section 4.4 for a praxis example) and their verbal consent for the use of their anonymised outcome measure data for service evaluation purposes reappraised. Routine objective measures are sent out to named nurses to complete and return to the CBTp service where they are collected by the practitioner assigned to deliver C-Co to the patient. Baseline and post therapy subjective measures are rated by patients with their C-Co practitioner and completed via a structured interview process. Post follow-up measures were sent to named nurses to complete with patients and return to the CBTp service. For this research, data was collected from the outcome measures completed as part of routine C-Co provision.

4.7.6 Data Analysis.

SPSS v22 (IBM, 2013) and G*Power v3.1.9.3 (Faul et al., 2007; Heinrich Heine Universität, 2015) were used to analyse the available data. The data was first tested for normality using a Shapiro-Wilk test and then for significance. A one tailed paired samples T-test was used to determine significance with parametric data and a one tailed related samples Wilcoxon Signed Rank Test was used to determine significance with non-parametric data. Effect size was subsequently calculated using Cohen's d and an exploratory *post-hoc* calculation of power was completed for each item. The data and analysis were then independently verified by a researcher from the National Institute of Mental Health's Evaluation Team. It must be emphasised *a priori* power was not achieved based on the

sample size and the research lacked randomisation or a comparative control. The underlying statistical assumptions linked to levels of subsequent generalisability were therefore not met. These factors are reflected on later in the discussion and limitations sections of the component.

4.7.7 Ethical Considerations.

The research site had approval for research and evaluation purposes to use anonymised data generated as part of routine clinical care including the retrospective use of anonymised outcome measure data. As only data gathered as part of routine care was included within the analysis, the research was categorised as service evaluation. Commensurate permissions were sought and gained from the Trust's Research Management and Governance Committee, from the hospital research, audit, and evaluation committee, and from the University of Derby Health and Social Care Research Ethics Committee.

Although the research site had approval to use anonymised data generated as part of routine clinical care for research and evaluation purposes, thereby facilitating the inclusion of anonymised pre and post outcome measure data in this component as part of service evaluation, further exploration and challenge is required of the underlying assumptions such approval entails. The concepts of vulnerability, informed consent, capacity, and right to withdraw, and therefore patient autonomy require scrutiny. To meet ethical requirements the site approval relies heavily on anonymisation of data, assumptions of capacity or implied consent on the patient's behalf via Responsible Clinician and MDT referral, and consistent and uniform awareness amongst patient's about how their outcome measure data might be used during and beyond their detainment in HS conditions. There is an expectation that clinicians who subject patients to outcome assessments verbally inform those patients of how their anonymised data might be used and record the patient's response in their running healthcare record. A trawl of available records linked to projects that the researcher was aware had benefitted from this site-side approval identified multiple examples where this expectation had indeed been adhered to. However, the entries lacked discrete identifiers which would have made them more straight forward to find and therefore audit and lacked consistency of content, particularly regarding the withdrawal of consent. The researcher was not able to identify any formal compliance audits, nor any detailed guidance on how to complete these entries, or the critical elements they should contain. This included guidance about how data from patients who completed measures but did not consent to the inclusion of that data in service evaluation or

research would have their data excluded from such studies. These concerns were formally raised with the then chair of the Hospital Clinical Audit and Service Evaluation Committee.

Within the approval there may also be a potential assumption of capacity when consent is being verbally sought, which the researcher challenges. The researcher was unable to source any guidance on how issues regarding capacity should be appropriately managed as part of the site approval. The Mental Capacity Act (GB, 2005) stipulates that capacity must be assumed unless there is reasonable cause for doubt. The researcher would argue that HS patient vulnerability, and severity and complexity of presentation, particularly pre-treatment, are likely to offer sufficient grounds to doubt and subsequently assess and record capacity to ensure autonomy has been sufficiently respected. Whilst implicit provision of consent on behalf of patients is incorporated into the MDT and RC referral process for psychological therapies and may therefore potentially circumvent issues of patient capacity regarding research uses of anonymised outcome data, this process does not seem to conform with the best interest process stipulated within the MCA. The researcher was also unable to source guidance about how the right to withdraw might also be respected as part of a blanket approval.

Despite site approval, additional actions were therefore taken by the researcher to ensure respect for patient autonomy as part of the component. Whilst helping to reduce potential masking effects and mediate initial non-adherence, the completion of pre-treatment outcome measures only after completion of the chief complaint stage of C-Co also better supported patient autonomy as it offered a more informed process of consent via the experiential exposure to C-Co, as well as a tested and supportive practitioner relationship with which consent might be better explored. Patient absolute choice was also respected and documented in a manner that could inform subsequent sampling. Indeed, of the 25 patients who met the non-adherence inclusion criteria, 14 had chosen not to engage in completing outcome measures, not provided direct consent or did not have complete datasets. One limitation of C6 is that the researcher failed to record what proportion of the 14 patients were excluded purely because of a lack of patient consent or how many of the patients who chose not to complete outcome measures did so based on not wishing their data to be used as part of research or service evaluation.

4.7.8 Results.

Tables 12, 13 and 14 offer a summary of the measures, their domains, the significance achieved, the effect size and power. Table 12 summarises the effect sizes of domains which achieved significance and power. During the thesis *viva voce* and subsequent recommended amendments, the examiners highlighted that Tables 12 and 13 may benefit from the inclusion of additional data like standard deviations and means. The initial rationale for the inclusion of certain descriptive statistics in preference to others was to simplify the dataset and add focus. As the researcher no longer worked with the HS context in which the research took place or in the same NHS Trust, it proved difficult to access the required data as the researcher's access request is not part of an immediate care provision requirement or a current safeguarding concern (GB, 2018).

Table 12: Observer Based Measures (© Slater).

Measure	Test	Domain	Significance	Effect Size (*d*)	Power (0.80)
LSP-39R	Wilcoxon	Self-care	$p < 0.01$ (0.003)	0.719	(0.716)
		Nonturbulence	Not significant	-	-
		Social contact	$p < 0.01$ (0.004)	0.477	-
		Communication	$p < 0.01$ (0.004)	0.413	-
		Responsibility	$p < 0.05$ (0.021)	0.376	-
NOSIE-30	t-test	Social interest	Not significant	-	-
		Activity retardation	Not significant	-	-
	Wilcoxon	Social competence	$p < 0.01$ (0.010)	0.868	0.849
		Neatness	Not significant	-	-
		Irritability	$p < 0.05$ (0.025)	0.691	(0.688)
		Manifest psychosis	$p < 0.05$ (0.031)	0.668	(0.661)
		Depression	$p < 0.05$ (0.017)	0.792	(0.788)

Table 13: Measures Rated Through Patient Subjective Report (© Slater).

Measure	Test	Domain	Significance	Effect Size (*d*)	Power (0.80)
PANAS	Wilcoxon	Positive Affect	Not significant	-	-
	t-test	Negative Affect	$p < 0.05$ (0.013)	0.701	(0.698)
BSI	Wilcoxon	Hostility	$p < 0.05$ (0.038)	0.613	(0.621)
		Phobic anxiety	$p < 0.01$ (0.009)	0.740	(0.718)
		Depression	$p < 0.01$ (0.004)	1.196	0.974
		Positive symptom distress	$p < 0.05$ (0.021)	0.889	0.847
	t-test	Somatisation	$p < 0.01$ (0.005)	0.961	0.906
		Obsessive compulsive	$p < 0.01$ (0.005)	0.968	0.910
		Interpersonal sensitivity	$p < 0.05$ (0 .016)	0.750	(0.748)
		Anxiety	$p < 0.01$ (0.002)	1.134	0.968
		Paranoid ideation	$p < 0.01$ (0.006)	0.923	0.885
		Psychoticism	$p < 0.001$ (0.0005)	1.380	0.995
		Global severity index	$p < 0.01$ (0.001)	1.236	0.984
		BSI symptom total	Not significant	-	-

Table 14: Outcomes Which Attained Both Significance and Power (© Slater).

Observer reported effects	**Patient subjective reported effects**
social competence *d* = 0.868	positive symptom distress *d* = 0.889 paranoid ideation *d* = 0.923 psychoticism *d* = 1.380 global severity index *d* = 1.236 Depression *d* = 1.196 Somatisation *d* = 0.961 obsessive compulsiveness *d* = 0.968 anxiety *d* = 1.134

4.7.9 Discussion.

The aim of this facet of research was to quantify the impact of C-Co on patients via an exploratory quasi experimental method using statistical analysis of subjective and objective pre and post outcome measure data providing a response to Research Question 3 *'What impact does C-Co have on patients?'* Commensurate hypotheses were offered. High levels of significance, impact and *post hoc* power were achieved demonstrating that C-Co has a positive impact on the HS patient sample involved in the research. No other individual HS CBTp research has previously attempted such an approach based on context-based limitations like small sample size. Whilst this research is therefore original and makes a significant contribution to professional knowledge and practice about HS CBTp and C-Co impact, it must also be considered exploratory and the results applicable to the subject sample only.

Each measure domain was analysed for significance. Of the 26 domains analysed, six failed to achieve significance ($p<0.05$). The null hypothesis cannot be rejected for these domains. For the remaining 20 domains one could argue that the null hypothesis can be rejected as significance was achieved. However, the quasi-experimental nature of the adopted method suggests this is not a generalisable result and applicable only to the research sample. Effect sizes and *post hoc* power were calculated for domains that achieved significance. Impact based on effect size was small (3 domains), medium (8 domains), and large (9 domains). Interestingly nine of the significant domains achieved significant post hoc power. Although the assumptions on which generalisability are based were not met, this is an interesting result as it challenges the existing perception that quantitative experimental methods and a purely positive methodology cannot be applied in individual HS CBTp research due to context-based barriers. The fact that post-hoc power was achievable in some instances suggests that, were effect sizes maintained in later research, a smaller randomised sample (19-24 subjects) may achieve a priori power and therefore support generalisability. Despite these limitations, these results suggest that C-Co achieved a considerable positive affect on psychosis experiences amongst non-adherent HS patients subject to the research.

For several items in the observer-based measures (non-turbulence, social interest, activity retardation and neatness) sufficient significance was not achieved to reject the null hypothesis. For all other items sufficient significance was achieved to reject the null hypothesis, albeit the requirements for generalisability were not met. This suggests that there were significant observed positive differences in patient self-care, social contact, communication, responsibility, social competence, irritability, manifest psychosis and depression between pre and post therapy data for

the research sample. Effect sizes for these items were promising ranging from 0.376 (a small effect) to 0.868 (a large effect). However, for self-care, social contact, communication, responsibility, irritability, manifest psychosis, and depression one could argue that insufficient power was achieved to fully exclude type II error. These outcomes may therefore only have significance for the research sample. Observed changes in social competence achieved a large effect size and power and may therefore be an area for further study using a more robust experimental design and randomisation of sample.

For two of the items in the subjective patient reported measures (positive affect and BSI symptom total), the null hypothesis could not be rejected. All other items achieved significance. This indicates that over the course of C-Co there were significant self-reported positive differences in negative affect, hostility, phobic anxiety, depression, positive symptom distress, somatization, obsessive compulsiveness, interpersonal sensitivity, anxiety, paranoid ideation, psychoticism, and global severity for the research sample. Effect sizes for these items are extremely promising, the lowest of which was a medium effect size for hostility (0.613), with nearly all other items achieving a large effect size. For depression, anxiety, psychoticism, and global severity the effect size was greater than 1. For negative affect, hostility, phobic anxiety, and interpersonal sensitivity one could again argue that insufficient power was achieved to fully exclude type II error. Self-reported changes in depression, positive symptom distress, somatisation, obsessive compulsiveness, anxiety, paranoid ideation, psychoticism, and global severity index are therefore the most defensible outcomes and may therefore be an area for further study using a more robust experimental design and randomisation of sample.

The above results were unexpected. Due to the small sample size and exploratory, quasi-experimental nature of the component, the researcher thought it unlikely that a considerable proportion of domain outcomes would achieve significance, or that any domains would achieve a high effect size, or indeed *post hoc* power. The researcher expected that the results from this research study would most likely confirm suggestions within the individual HS CBTp literature that single case analyses or case series are the most practicable and possibly only means of assessing the impact of HS CBTp. Whilst experimental designs have been adopted in group studies (Williams et al., 2014), possible similar assumptions by other individual HS CBTp researchers may explain why experimental, quantitative statistical analysis of individual HS CBTp impact has not been previously attempted using repeat measures. The researcher originally believed that cross-site studies to facilitate a greater sample size would be needed to achieve significance, impact, and

power. These results therefore have considerable importance. Not only do they indicate C-Co efficacy and a considerable positive impact on the research sample, but the results also demonstrate that quantitative research methods using statistical analysis can have merit as part of analysing individual HS CBTp impact. This therefore contrasts with earlier assumptions about the research approaches possible in HS contexts regarding HS CBTp impact.

The results support the directions provided within healthcare guidance (NICE, 2009; NICE, 2014) that CBTp can be an effective adjunct to pharmacological treatments. Given the sample inclusion criteria of this research, the component result statistically proves that C-Co was an effective and extremely important adjunct to treatment with antipsychotic medications for the non-adherent, treatment resistant, psychotic HS patient research sample. However, the results also prove that C-Co has a very different impact on HS patient experiences of psychosis to that of medication. The efficacy of pharmacological treatments for psychosis is determined by the level of symptom amelioration achieved. In this research the number of psychosis symptoms experienced by the sample group did not significantly change (or ameliorate) over the course of C-Co (please see BSI symptom total, Table 13). Yet the impact on the patients of these symptoms did, considerably.

This is an important distinction for two reasons. Firstly, it suggests that the efficacy of individual HS CBTp may be better determined by changes in the impact on a patient of a particular psychosis symptom, not on whether that symptom fully ameliorates, and secondly, that there is a danger of failing to fully appreciate the impact of individual HS CBTp if symptom amelioration remains the only determinant of efficacy. This directly and controversially challenges the dominant discourse within psychiatry that symptom amelioration is the gold standard of efficacy and challenges the dominant medical conceptualisation of psychosis as a disease that can only be effectively 'treated' with medication. Whilst early non-forensic CBTp research used symptom amelioration to determine efficacy, a more sophisticated understanding that moved away from such determinants emerged. Changes in the relationship a psychotic patient has with their symptoms and changes in the levels of associated distress became more representative determinants of CBTp efficacy (Birchwood & Trower, 2006). This research is the first to statistically evidence the potential need for a similar perspective in HS contexts. This finding also supports the wider definition of psychosis adopted by the organisational case analysis (section 1.1.5). The results of this research component are therefore extremely promising, not least because they allow the quantitative dominant discourse within HS psychiatry to be challenged using its own ontological and epistemological perspective.

The results summarised in Tables 13 and 14 indicate that for the majority of subjective and objective measure domains significance was achieved for the research sample and the null hypothesis could be rejected. For a minority of domains significance was not achieved. Of those domains that achieved significance effect sizes were small to large and a positive impact on the research sample demonstrated. Nine domain outcomes also achieved *post hoc* power (Table 13). As the underlying assumptions of the statistical analysis were not met, most notably due to a lack of sampling randomisation, the results cannot be generalised and are applicable to the sample only, regardless of power. However, the power calculation suggests that, were effect sizes maintained, a comparatively small sample might achieve a priori power in future studies were subjects randomised.

In the context of the organisational case analysis the aim of this component was to provide a response to Research Question 3: *What impact does C-Co have on patients?* The results of the components demonstrate that C-Co had a positive impact on the patients who were part of the research sample.

4.7.10 Limitations.

As an exploratory use of a positivist quasi-experimental method to determine individual HS CBTp impact, this thesis component highlights several important limitations. The failure to randomise the sample may have introduced a selection bias, compromised statistical validity, and compromised the control of confounding variables. The absence of a control group, failure of the sample to achieve *a priori* power, and lack of uniform parametric data further compounds these potential biases. The assumption of causality to C-Co in the absence of medication changes, absence of other interventions, and of the uniformity of nursing care, might also be challenged. For example, James the subject of the single case analysis, had been exposed ‘unsuccessfully’ to several previous psychotherapies. Might this attrition have contributed to his more meaningful engagement with C-Co? Did patient’s who had been repeatedly exposed to other psychotherapies subsequently engage better with C-Co as a result? These potential confounds and others were not factored into the analysis. The results of the statistical analysis may therefore by compromised and the assumptions underlying gold standard quantitative research not met. The results cannot therefore be generalised and are applicable only to the sample subjected to analysis.

However, as an exercise in exploring the possible methods by which individual HS CBTp might be evaluated, it has value. If perceived as a qualitative study that adopts a quasi-experimental positivist method, it has value in demonstrating the impact of C-Co on a target group of purposively sampled HS patients, and in demonstrating that positivist methods should not be rejected out-of-hand when researching individual HS CBTp impact, as is suggested with the literature (Slater & Townend, 2016). Were similar effect sizes maintained in a more rigorous study, the *post hoc* power that was achieved for some items in this component also suggests that a relatively small sample might be used in similar research increasing the potential for future samples to be appropriately randomised and the assumptions underlying the methods of statistical analysis met.

However, there are several limitations. Longitudinal data was too inconsistent for inclusion. It was therefore not possible to statistically establish if gains were maintained over a longer period. Whilst all the measures were routinely used within forensic contexts, further testing is needed to fully validate use in HS conditions. The Positive and Negative Syndrome Scale (PANSS) (Kay et al., 1987) was considered as an alternative measure. It is validated for forensic use, provides subjective and objective data and is considered the industry standard for assessing the presence of psychosis. However, its application is more complex, requires greater resources, takes considerably more time, and is predominantly used to determine treatment efficacy via symptom amelioration. Although the data and analysis were independently verified, the lack of a control group, of sample randomisation, of blinding, and of independent data gathering, may lead to criticism regarding generalisation.

4.7.11 Recommendations.

Further quantitative experimental statistical analyses of individual HS CBTp outcome measure data are recommended regarding the impact of both C-Co and other individual HS CBTp approaches. Alongside randomisation, a waiting-list control to further strengthen causal attribution should also be considered in future research. Were effect sizes maintained in future research, only a small increase in sample size (19-24 subjects – calculated using G*Power) may be needed to achieve *a priori* power regarding further study.

4.7.12 Section Summary.

In this exploratory research component an exploratory, quasi-experimental positivist, within subjects, repeated measures design was adopted within a feminist methodological framework to

provide a statistical analyse of pre and post objective and subjective outcome measure data. Eleven patients were sampled through purposive inclusion criteria. Outcomes indicate that C-Co had a positive impact on patients who were part of the sample in several important domains. This research component represents an original contribution to the individual HS CBTp literature as it helps to further explore and challenge previously established norms about what research methods can and cannot be used to evaluate individual HS CBTp. In the next section of the Component Outcomes chapter the research dissemination strategy and impact are analysed and discussed.

4.8: Component 7: Dissemination Strategy and Results.

4.8.1 Introduction.

As part of his doctoral studies, the researcher was encouraged to adopt an active approach to dissemination. This resulted in several published works, national and international conference presentations and workshops, awards, and collaborations. This research component aimed to provide a description of the organisational case analysis dissemination strategy and the results to date of strategy application. This research component was also designed to provide a response to Research Question 5: *What impact has C-Co had via the dissemination of results?*

4.8.2 Dissemination Strategy.

4.8.2.1 Method.

The University of Derby Guidelines for Your Doctor of Health and Social Care Thesis (Townend et al., 2014) stipulate that over the course of their research students will be encouraged to develop: "*skills in the dissemination of professional and service development through publication and/or conference presentations."* (p.3). The guidelines stipulate that dissemination should be a core consideration of the thesis. Fine (2016) reminds us that the important, almost existential question of 'to whom are we accountable' (p.362) should guide our reflection on how best to disseminate new knowledge.

Whilst focused on C-Co impact, the researcher is mindful the organisational case analysis results sit within the contexts of both national and international HS CBTp provision, and of psychiatric care more generally. There is an obligation to develop a commensurate dissemination strategy. This

combination of specific and wider dissemination aligns with the National Institute for Health and Care Research (NIHR) (2019), definition of dissemination as *'getting the findings of your research to the people who can make use of them, to maximise the benefit of the research without delay.'* According to Professor Chris Whitty, Chief Scientific Advisor for the Department of Health, as cited by the NIHR (2019), '*Research is of no use unless it gets to the people who need to use it.'* Considerations when disseminating research should include objectives, audience, format, timeline, resources, strategy and means of evaluating impact (NIHR, 2019). Findings should be disseminated as widely as possible (Savin-Baden & Major, 2013) and multiple formats adopted to maximise benefit (Holloway & Galvin, 2017).

Some researchers in the field of HS CBTp stipulate that only positivist, peer reviewed modes of dissemination have value (Cawthorne, 2019). The researcher rejects this notion. Within the organisational case analysis, the researcher has evidenced the prejudicial stance that narrow, single paradigmatic forms of understanding promote and sustain, often to the detriment of marginalised groups like HS patients to whom the researcher feels ultimately responsible (Fine, 2016). Throughout the thesis the researcher has been sensitive to hermeneutic considerations and has embraced multi-modal, innovative approaches to knowledge creation and exploration. The adopted dissemination strategy is no different and it embraces the same feminist methodological perspective as the research. It was multi-modal in format and targeted towards multiple audiences nationally and internationally. Its primary aim has been to maximise the potential flux and therefore impact in what is considered known across a variety of paradigms about the provision of C-Co and HS CBTp, thereby stimulating and embracing opportunities for further democratic dialogue, practice innovation, and research (Longino, 1993).

4.8.2.2 Data Collection.

Over the course of his studies, the researcher collated a list of his publications, conference presentations, interactive workshops, awards, and collaborations. These form the basis of the results. Alongside the collated list the researcher made note of circulation figures, article access, journal impact factor, number of presentation and workshop attendees, feedback, prominence of awards, and collaboration impact.

4.8.2.3 Data Analysis.

There is no one recognised method or process for determining dissemination impact or rigorous research identifying how dissemination impact may be enhanced (Chapman et al., 2021; NIHR, 2019). Impact frameworks that offer paradigmatic flexibility, that embrace both quantitative and qualitative modes of evaluating impact, that focus on producing flux within what is known, and advance praxis are generally deemed to have most impact (NIHR, 2019). Aligned to the researcher's feminist methodological position and national guidance, a multi-method analysis employing descriptive statistics, qualitative feedback, and quantitative metrics is adopted to analyse the dissemination data.

4.8.2.4 Ethical Considerations.

There is an ethical imperative to disseminate research (McCarthy & O'Sullivan, 2008). This need can be considered beneficent and just, providing participant autonomy is respected and ensured (Hek & Moule, 2006). Importantly, the failure to disseminate research that demonstrates iatrogenic or adverse impact from health interventions constitutes a breach of ethical requirements with regard to all four ethical principles (Hek & Moule, 2006). Although the research site had approval to use anonymised data generated as part of routine clinical care for evaluation and research purposes, including the dissemination of outcomes, the dissemination of anonymised outcome data was integral to the ethics submissions and approvals gained by this research as was the importance of ensuring all impacts were faithfully and transparently portrayed. Interestingly, 'Taking Steps', the result of Component 4, facilitated tangible feedback that could be shared with the CBTp Consolidation Group members who had developed the game. This required not only the sharing of anonymised results but also the anonymisation of feedback from 'players' so that this could be ethically shared with group members. It also required that those providing feedback, were aware that this may be shared with the group members who had created 'Taking Steps' (please see the feedback card in Appendix 6).

4.8.3 Dissemination Results.

4.8.3.1 Publications.

- Slater, J. (2014). CBT for Psychosis in a High Security Environment. *CBT Today*, 42(3), p. 9. The readership of *CBT Today* in which Slater 2014 was published, whilst not peer reviewed, has an electronic and paper circulation of more than 17,000.

- Slater, J. & Painter, G. (2016). Taking Steps: Using collaborative group game design to consolidate and evaluate experiences of individual chief complaint-orientated cognitive behavioural therapy for psychosis (C-Co CBTp) in conditions of high security. *The Cognitive Behaviour Therapist*, 9(19), pp. 1-16.
  The impact metrics for Slater and Painter (2016) published online (CUP, 2023b) indicate that the full text of the article has been requested and accessed 337 times and the abstract 541 times and that it has been cited in three other articles (Pipkin et al., 2021, Fitzgerald & Ratcliffe, 2019, McLeod et al., 2022).

- Slater, J. & Townend, M. (2016). Cognitive Behaviour Therapy for Psychosis in High Secure Services: An Exploratory Hermeneutic Review of the International Literature, *Behavioural and Cognitive Psychotherapy*, 44(6), pp. 652-67.
  The readership metrics for Slater and Townend (2016) (CUP, 2023c) indicate that the full text of the article has been requested and accessed 503 times and the abstract 1151 times, and cited in one other article (Davies et al., 2019). The journal impact factor is 2.4 (Academic Accelerator 2023) and ranked 96 of 292 similar publications.

- Slater, J. (2020). On being assessed…An autoethnographic exploration of being assessed by psychiatric services: A service user and nurse perspective. *Journal of Mental Health Nursing,* 40(4), pp. 13-18.
  The researcher chose to specifically target nursing journals for publication. This was influenced by the researcher's core profession of nursing. Journal choice was limited to journals that had facility to fully reproduce both the text and importantly some of the illustrations contained within 'On Being Assessed'. The article was accepted by a journal with this facility but to which the researcher also had an existing affiliation as a member of its editorial board and as a peer reviewer. The article was therefore blind peer-reviewed by academic colleagues known to other editorial board member colleagues but not the researcher, rather than reviewers who were known to the researcher and were potentially aware of both his doctoral studies and his previous healthcare experiences. The version of 'On Being Assessed' the article contains is abridged in that, whilst the text is largely complete, it contains fewer illustrations. Direct impact metrics were not available for Slater 2020, although the publication is reported to have an impact factor of 5.6 (although it was not clear how this was derived or against what other publications) and more than 2000 paper and electronic subscribers.

4.8.3.2 Conference Presentations and Interactive Workshops.

- XIV Annual Meeting of the International Association of Forensic Mental Health Services, Toronto 2014.
    - Cognitive Behaviour Therapy for Psychosis (CBTp) in Conditions of High Security – A United Kingdom Overview *(Symposium).*

  This symposium was attended by an international audience of 33 people and overran due to the number of questions.

- 43rd BABCP Annual Conference and Workshops, University of Warwick 2015.
    - Cognitive Behavioural Therapy for Psychosis in Conditions of High Security – An Overview of Provision within the UK *(Symposium involving providers from 4 of the UK's HS hospitals organised by the researcher).*

  This symposium was attended by 11 people, questions were limited.

- National Institute for Health and Care Excellence Annual Conference 2016, Nottingham.
    - C-Co CBTp: Innovating to Evaluate *(Poster and interactive Experience of 'Taking Steps').*

  Consent from the 'Taking Steps' creators was gained to enable other people to experience 'Taking Steps' through playing 'Taking Steps' (Appendix 5). The NICE conference workshop resulted in 'Taking Steps' being experienced by 47 people including other healthcare professional and the significant others of people who had experienced psychosis (Fig. 11), all of whom were offered the opportunity to provide anonymous feedback via feedback cards. Their feedback is provided in Appendix 6 and an example feedback card provided. Feedback was subsequently shared with members of the CBTp Service Consolidation Group who had crated 'Taking Steps'.

- 20th International Society for Psychological and Social Approaches to Psychosis International Congress (2017), Liverpool.
    - Working for Change *(collaborative symposium).*
    - Chief Complaint Orientated Cognitive Behavioural Therapy for Psychosis in Conditions of High Security: An Organisational Case Study Proposal *(symposium).*

Please see 4.8.3.5 Collaborations for further details of 'Working for Change'. This symposium was well attended and the latter less so; however, the researcher did not directly count the number of attendees at either symposium.

- 4th Horatio Festival of Psychiatric Nursing "Working in Partnership", Malta 2017.
    - Chief Complaint Orientated Cognitive Behavioural Therapy for Psychosis (C-Co) in Conditions of High Security (HS): An Organisational Case Analysis *(Symposium.)*
    - Taking Steps: Using collaborative group game design to evaluate participant experiences of psychotherapy in conditions of high security *(Poster).*
    - On being assessed…An auto-ethnographic exploration of a recovery journey from psychotic patient to award winning nurse psychotherapist *(Paper).*

  Both symposium and paper were presented in the same room which had a capacity of approximately 50 delegates. The room was approximately a third full for the symposium and full of people and people standing for the paper. Poster presentations were presented on screens at different places on the conference walkways and rotated. Whilst the conference had over 500 delegates, it is not possible to stipulate how many may have been exposed to the poster.

- Cognitive Behavioural Psychotherapy – Master's Programme, University of Derby 2017.
    - CBT for Psychosis *(Workshop).*

  This was attended by students from one cohort on the CBT MSc at the University of Derby. There were 12 attendees. The workshop offered an overview of C-Co and referred to some of the results within the thesis. Feedback was not elicited.

- East Midlands Recovery and Outcomes Group Annual Meeting 2017.
    - On being assessed…An auto-ethnographic exploration of a recovery journey from psychotic patient to award winning nurse psychotherapist *(Paper).*

  This was presented to delegates at the annual group meeting. The audience was comprised of service users, carers, and healthcare professionals. Feedback was not elicited.

Fig. 11: Delegates at the National Institute for Health and Care Excellence Annual Conference 2016 in Nottingham experiencing ‘Taking Steps’ (reproduced with permission from © Nottinghamshire Healthcare NHS Foundation Trust).

4.8.3.3 Awards.

- Koestler Trust, Awards for the Arts, Platinum Award: The Koestler Trust provides a nationally recognised award scheme which promotes the arts in prisons and secure hospitals as a means of rehabilitation. In 2015, ‘Taking Steps’ (component 4 of the organisational case analysis) was chosen out of more than 8,000 projects in the UK to receive a Platinum Award, the Koestler Trust’s highest accolade. The awards were published nationally, and winners’ art exhibited at the Hayward Gallery in the Southbank Centre in London. The Centre hosts 4.4 million visitors each year (Appendix 7). Feedback from the Koester Trust was subsequently shared with members of the CBTp Service Consolidation Group who had crated ‘Taking Steps’ and the Koestler Trust also provided each group with an anonymised embossed certificate like the one provided in Appendix 7 in recognition of their achievement.

- Health Service OSCARS (Outstanding Service Contribution and Recognition Scheme): Awarded Innovator of the Year 2016, presented for innovation in psychotherapy within forensics contexts, specifically C-Co. The researcher was put forward for the award by colleagues involved in the delivery of C-Co and his award published in his Trust's newsletter (Appendix 7).

- National Service User Awards (NSUA) 2018, winner of the Service Users' Award, the only award voted for entirely by service users. The NSUAs are an annual celebration of service user led and collaborative projects both in private and NHS mental health contexts throughout the UK. The awards recognise the achievements of working together to innovate and develop better more effective services. Unbeknownst to the researcher, patients from the C-Co Consolidation Group and from another project the researcher initiated, the first HS service-user led Hearing Voices Group (HS-HVG), nominated the researcher, C-CO and HS-HVG for the award (Appendix 7).

4.8.3.4 Collaborations.

- The United Kingdom High Secure Hospitals CBT for Psychosis Collaboration Group (2013-2017). Group membership included therapy service managers and CBTp psychotherapy deliverers from Ashworth, Broadmoor, Carstairs and Rampton Hospitals. The group was set up and initially chaired by the researcher to facilitate the sharing of published and fugitive CBTp evaluation projects from its member hospitals. This was integral to the research literature review strategy and subsequent outcome. The collaboration also resulted in the dissemination and further development of the CBTp algorithm offered by Slater and Townend 2016 combining the most effective CBTp interventions developed across the UK HS hospital sites.

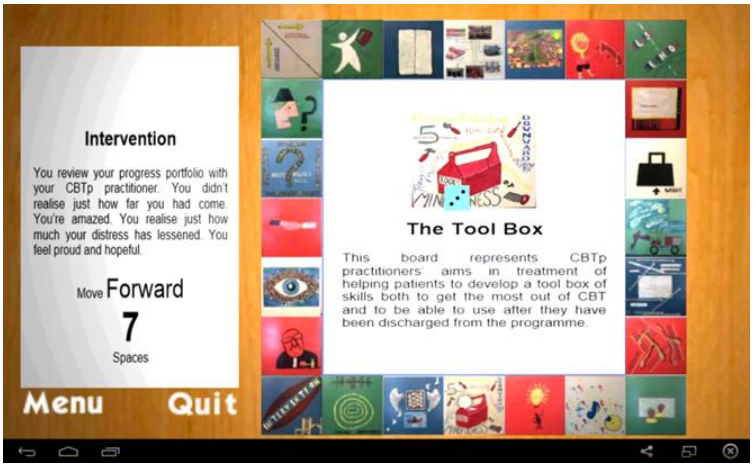
- Academic peer review (2013, 2015): Chaired by Dr Nicola Whitton, a Senior Research Fellow at Manchester Metropolitan University, the Association of Learning Technologies Games and Learning Special Interest Group (GL-SIG) is a national group comprised of leading academics from universities across the UK. The group is experienced in and supports the design, use and evaluation of games in practice, as well as the academic study of games and player communities and their potential contributions to learning. As participatory action research involving group game design was unprecedented within healthcare contexts, the researcher sought out advice

from the group. Group members kindly shared some of their publications, the information, and ideas from which helped shape the process used to develop Taking Steps. Following the completion of Taking Steps 10 members of the GL-SIG were invited to play the game and offer academic peer review (please see Appendix 6 for the GL-SIG comments).

- CBT for psychosis course development by Stanford University USA (2016): The researcher was contacted by Clinical Assistant Prof. Kate Hardy Clin.Psych.D from the Department of Psychiatry and Behavioural Sciences at Stanford University School of Medicine to assist in the development of the Department's CBTp pilot course. Prior to contact Prof. Hardy had read the student's publication in the Journal of Behavioural and Cognitive Psychotherapy (Slater & Townend, 2016). The student provided further consultation and support to Prof. Hardy and her students during the development and subsequent implementation phase of the pilot course. The course was subsequently commissioned to run state-wide.

- App Development (2016): Following presentation at conference the student was approached by Dr Samad Ahmadi, Director of De Montfort University School of Computer Science and Informatics. Dr Ahmadi suggested a collaboration to develop an app which could offer potential users an insight into what engaging in psychotherapy and C-Co might be like. It was felt this would have application for both health professionals and patients. The app which was subsequently developed (Fig. 12) used components of the research and was available for download on Android between 2016 and 2017. During this period there were 103 downloads (one of which was the researchers).

Fig. 12: Screenshots from the Android App of Taking Steps (reproduced with kind permission from De Montford University ©)

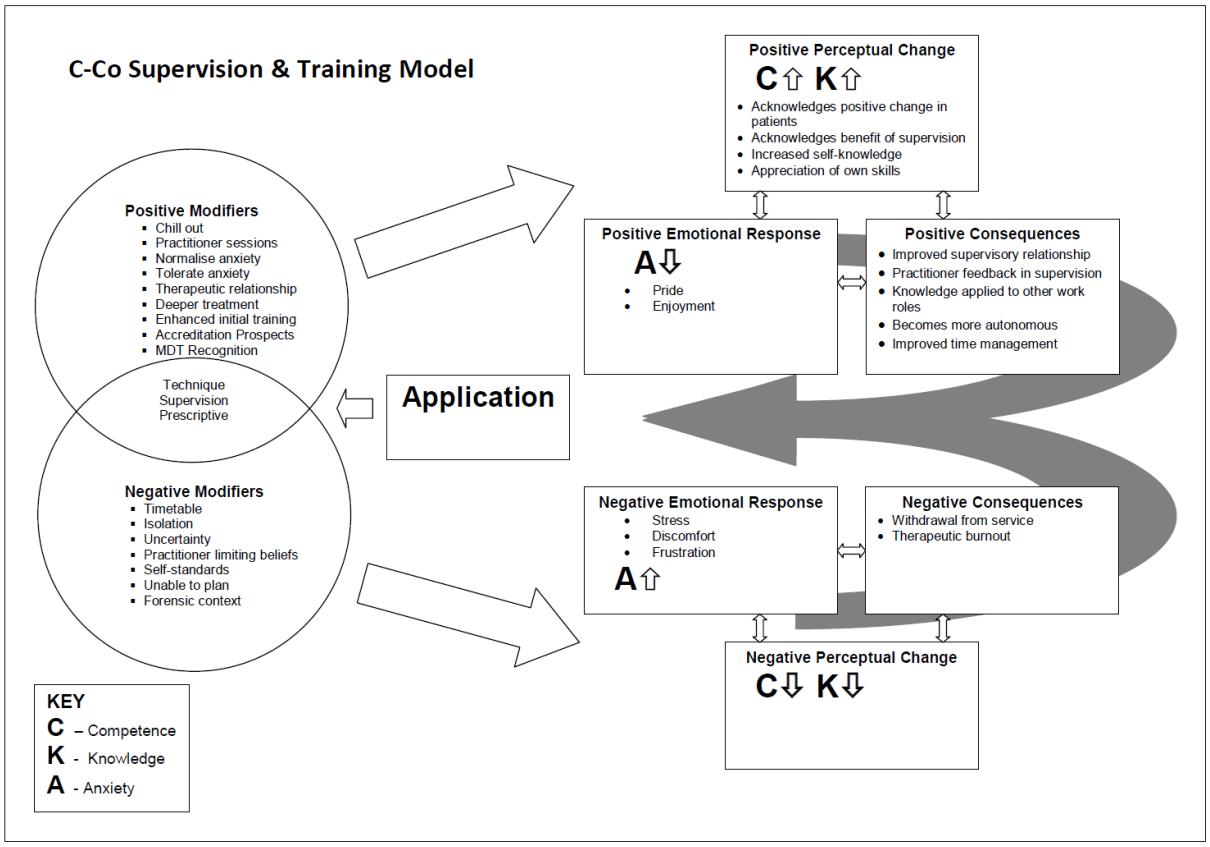


- Collaboration with members of A Disorder for Everyone (AD4E) and the 'Drop the Disorder' Facebook group, including Nicky Hayward, Prof. John Read, Dr. Gary Sidley, Teri Tivey, and Jo Watson. The collaboration was to deliver a symposium at the 20th International Society for Psychological and Social Approaches to Psychosis International Congress (2017) - Making Real Change Happen. The symposium was entitled 'Working for Change - What are the major obstacles preventing a shift towards a more psycho-social approach to people with distressing psychotic experiences?' The symposium evolved over several months of correspondence between the presenters. The aim was to develop an interactive symposium that encouraged delegates to share their own thoughts about the major obstacles to change within services for people experiencing psychosis. It included a discussion about health dissonance as defined and experienced by the researcher and emphasised the importance of service co-development.

- Collaborative development of a C-Co supervision and training model: Working as a group with the service lead, the C-Co practitioners identified from their supervision, participant research component outcomes, and further reflection on practice, three core elements which they felt

impacted upon their ability to deliver C-Co and the sense of fulfilment they gained. These were their sense of competence, their perception of how knowledgeable they felt, and their levels of anxiety. It was felt and hypothesised that modifiers which negatively affected competence and knowledge increased anxiety and led to poorer practice application and sense of fulfilment. In contrast it was felt and hypothesised that modifiers which positively affected competence and knowledge decreased anxiety and led to better practice application and sense of fulfilment. An iterative process of encirclement subsequently occurred whereby practitioners attempted to illustrate diagrammatically their hypotheses, refining this until the conceptualisation provided in Fig. 13 was arrived at. The resultant conceptualisation illustrates positive and negative modifiers, as well as modifiers that can be both positive and negative. It illustrates how these can impact upon competence, knowledge and practice and subsequently influence C-Co application. The model was subsequently adopted by the HS CBTp service to guide C-Co practitioner supervision and training with the aim of enhancing positive modifiers and limiting the impact of negative modifiers.

Fig. 13: Co-developed C-Co Supervision and Training Model (© Slater).



- Collaborative development of a book chapter: During his work and association with the East Midlands Recovery and Outcomes Group and National Service User Group (please see conference presentations and awards above) the researcher was approached by Nathan Filer, author of The Shock of the Fall (Filer, 2013), a poignant fictional account of a young boy's journey to understand his psychosis and navigate often unhelpful health services. Mr. Filer wished to collaborate with the researcher on a chapter for a book about schizophrenia and psychosis. Mr. Filer wished to centre each chapter around personal experiences of a different symptom of psychosis alongside different interpretations of the experience and a critical review of linked literature. The chapter refers to the CBTp work the researcher has undertaken and linked work on voice hearing within the HS context. It involved Mr. Filer visiting the HS hospital in which the researcher worked, meeting voice hearers who attended the hospital HS-HVG, many of whom had engaged in C-Co, and interviewing the researcher about his own experiences of psychosis. Permissions were sought from the patients involved and the Trust for Mr. Filer to publish the results which were co-developed via an iterative process involving patients, the researcher, and the Trust. At the Trust's and HS hospital's request the synonym 'Jasper' was used instead of the researcher's name and no reference was made to the name of the HS hospital. The book, in both its formats, is estimated to have sold over half a million copies - including digital and audio formats (Faber, 2023) and is recommended as essential reading for mental health professionals and GPs (Basket, 2020). The reference for the work is provided below.

  Filer, N. (2019b). Chp. 11 The Keyholder, the Non-Keyholders and the Voices (pp.208-226) in *The Heartland: Finding and Losing Schizophrenia***.** Faber & Faber Ltd: London. Also published as: Filer, N. (2019c). *This Book Will Change Your Mind about Mental Health***,** Faber & Faber Ltd: London.

4.8.4 Discussion.

The aim of this section is to discuss and critique the impact of C-Co through the dissemination of component research results. This provides a response to Research Question 5: *What impact has C-Co had via the dissemination of results?* An active approach to dissemination during and beyond the period of study was encouraged as part of the DPrac. Within the context of the organisational case analysis this research component facilitates the inclusion of wider C-Co impact within the summative secondary analysis. The results indicate that considerable dissemination of thesis results

has occurred encompassing a variety of media. In keeping with thesis methodological perspective, a multi-modal dissemination strategy was adopted in the hope that this may create the greatest flux within what is known from the perspective of multiple epistemologies and ontologies about the impact of C-Co and HS CBTp. Quantitative and qualitative determinants of impact indicate that the creation of flux, the strategy aim, has been achieved through publication, conference presentation, awards, and collaborations. Whilst his impact could be considered largely positive, it was not possible to determine practice impact. Dissemination strategy limitations are discussed and recommendations for further dissemination made following the discussion.

In a recent comparative review and metanalysis of the impact of quantitative, qualitative, and mixed modality research dissemination strategies in healthcare, there was limited evidence of praxis impact (positive or negative) regarding any of the approaches. There was also little consensus within the literature about the mechanisms that may subsequently enhance impact (Chapman et al., 2021). In the absence of further research, impact frameworks that offer paradigmatic flexibility, that embrace both quantitative and qualitative modes of evaluating impact, that focus on producing flux within what is known, and advance praxis, are most aligned with the researcher's methodological perspective and are also advocated in healthcare by the NIHR (NIHR, 2019). Quantitative and qualitative determinants of impact are therefore considered regarding the creation of flux and praxis impact.

There is no one system of empirical analysis that quantifies research dissemination impact in its widest sense. Existing systems of quantitative measurement, often paradigmatically biased, are usually limited to published works in the form of publication impact and circulation, number of citations, how often an abstract has been accessed and how often a published work has been downloaded. This approach to measuring impact is often criticised as reinforcing positivist, publisher, and political hegemony (NSUN, 2018) yet remains the dominant and most valued mode of measurement. Dissemination via publication was therefore a justifiable component of the research dissemination strategy as a means of creating flux within more dominant forms of healthcare discourse and therefore possible praxis change. Other forms of quantifying impact may include the number of people who attend a conference presentation, the number of times an app is downloaded, the number of awards that are received, and the number of resultant collaborations.

Four articles (Appendix 3) and one book chapter relating to the research results and C-Co were accepted for publication. The metrics for these publications vary in their level of specificity. Whilst

it was possible to establish a full set of metrics for Slater and Townend (2016) and Slater and Painter (2016), it was only possible to offer circulation figures for others. Slater and Townend (2016) and Slater and Painter (2016) therefore had the most quantifiable impact from a positivist perspective. The impact of the other publications can only be inferred through level of circulation but would suggest that the impact of Filer, (2019a) (a circulation of more than 0.5 million) had the greatest impact, followed by Slater 2014 (a circulation of 17,000) and then Slater, 2020 (a circulation of 2,000). Similarly, the impact of the Taking Steps App can be quantified - it was downloaded 103 times, one of which was by the researcher. The number of delegates attending the researcher's workshops and conference presentations can also be quantified (11 to 50+, although the data is incomplete as the researcher did not always count the number of attendees). So too can the number of awards (3) and the number of resultant collaborations (7) that have arisen because of this component of the organisational case analysis. These metrics and descriptive statistics convey that there was a quantifiable impact from the dissemination of research component results.

There is an implicit assumption when quantifying dissemination impact that big is better, that a higher impact factor, higher citations, more attendees, more downloads, and more awards equates to greater flux and greater practice impact (Chapman, et al., 2021). Yet this is difficult to substantiate without systematically qualifying the direct impact on people exposed to the research via dissemination and the subsequent impact on their practice. Qualitative feedback and evidence of impact was elicited from people who played 'Taking Steps' and from the awards the researcher's C-Co work received. Delegates at the NICE Annual Conference in 2016 and members of the GL-SIG were given the opportunity to feedback their experiences of Taking Steps via anonymised feedback cards. This feedback is collated in Appendix 6 and offers direct evidence of impact.

A total of 41 feedback cards were completed (10 by the GL-SIG, and 31 by NICE delegates). GL-SIG feedback validates Taking Steps as an innovative, thought provoking means of conveying what it might be like to experience CBTp. Comments were made such as: *'Fantastic, colourful insight that really makes you think,' '...unlike anything I've done before...,' 'Really enjoyed the format and the way it combined real accounts from patients,' 'I enjoyed reading into the pictures and found the true patients or practitioners words a reward in themselves.'* Constructive criticisms and ideas on how to improve 'Taking Steps' were also offered such as: *'...you could use android to protype a game system,' 'I'm not sure I would want to "gamify" the game as it is because it could make light of a serious process,' 'From a theoretical perspective, this is interesting as it is technically not a game, more a playful intervention.*' These reflections on the playing 'Taking Step' demonstrate the

generation of flux both regarding GL-SIG members knowledge of CBTp, the use of PAR group game design within healthcare and wider settings, and the utility of using games to disseminate people's experiences of psychotherapies such as C-Co.

Themes from the feedback from NICE delegates included: recognising the games utility in helping carers, family and mental health professionals better understand C-Co and the challenges patients experience; the impact of the artwork and game on them; the effort and care that had been taken in developing the game; the hope the game conveyed; recognising that progress in CBTp was non-linear; and being emotionally moved by the game. One particular response conveys these impacts: *"I really enjoyed the activity. The pictures and stories were extremely helpful and made me more aware of patient difficulties. It made me more aware of the obstacles patients' face when doing therapy (ambivalence, being able to manage their feelings, being open and testing their beliefs). It also made me aware of the obstacles the CBT programme therapists deal with (patients wanting different therapists, containing patients' fears, etc). One of the stories I read on the cards was very empowering."* These reflections demonstrate the generation of flux regarding delegates knowledge of CBTp impact and therapy process, their knowledge of how patient and practitioner experiences might best be conveyed, and their knowledge of their own practice. The qualitative feedback provided by GL-SIG members and NICE delegates demonstrates considerable positive impact and importantly the creation of flux within what is known.

The awards the researcher received for his work on C-Co and for research components also convey the impact of dissemination. The awards convey the impact of the research on service users, healthcare professionals, and the wider public. The Service-User Award is probably one of the most rewarding accolades the researcher has received in his career as it is to service users and patients that the researcher feels most responsible (Fine, 2016). Voted for by service users nationally, it demonstrated an impact on service users beyond patients that were directly involved in C-Co. It demonstrates that they saw merit and value in C-Co. The receipt of a healthcare OSCAR similarly demonstrates that healthcare professionals also saw merit, innovation, and value in C-Co.

In their feedback (Appendix 7), the Koestler Awards judges stated: *"'A Journey' is a fantastic idea both in terms of the collaborative production and development of the game and towards being a useful and innovative tool. The scale and beautiful visuals of the game we found to be hugely successful and that the game will continue to be used was a major factor in 'Taking Steps' being awarded the Platinum Award. Congratulations! Amazing Work."* This too conveys a positive

impact from result dissemination. In combination, the awards demonstrate that flux in what was known about C-Co and in what was known about HS CBTp was created. However, neither the qualitative data from the awards or that elicited from people who played 'Taking Steps' helps to determine praxis impact. It is not known from any of the dissemination approaches deployed whether these resulted in tangible changes to healthcare practices.

The quantitative and qualitative data generated in response to research dissemination proves that the aim of creating flux in what is known about HS CBTp has been achieved and exceeded but fails to determine the impact on healthcare praxis.

The application of the research feminist dissemination strategy resulted in several published works, national and international conference presentations and workshops, awards, and collaborations. Quantitative publication metrics and descriptive statics of conference and workshop attendees and number of app downloads was provided. Qualitative data in the form of feedback from workshop attendees and members of the GL-SIG was highlighted. These results indicate that result dissemination has created flux as intended, however it is not possible to determine what praxis impact this may have had. In response to Research Question 5: *What impact has C-Co had via the dissemination of results?* the component results therefore demonstrate that flux has been created in what was known about C-Co and HS CBTp, however praxis impact is much harder to discern.

4.8.5 Limitations.

There are no recognised methods for determining the impact of multi-modal research dissemination strategies. Whilst inferences regarding flux may be made, praxis impact is difficult if not impossible to discern. There is no one standardised or recognised approach to quantifying publication impact. How robust and more widely applicable the analysis and strategy used in this component are, is therefore difficult to assert. Despite undoubtedly creating flux, as was intended, the impact of this on practitioners, practice, and patients, is difficult, if not impossible to gauge beyond anecdotal inferences. This poses an ethical conundrum. There is broad agreement that there is a moral, legal ethical, and professional obligation to disseminate health evaluation and research data (Savin-Baden & Howell Major, 2013; Townend et al., 2014; NIHR, 2019). However, if praxis impact cannot be robustly verified, and systems for such verification remain underdeveloped, one must question whether the ethical obligation to disseminate outcomes can really be realised.

4.8.6 Recommendations.

The results suggest that qualitative systems of feedback and the data that is subsequently generated are integral to being able to determine impact and substantiate any assumptions made relating to quantitative data. Offering further opportunities for people to play 'Taking Steps' and eliciting feedback are warranted to further analyse C-Co impact. A more rigorous thematic analysis of 'Taking Steps' feedback would also support further claims made regarding impact. The researcher is unaware of any publisher of healthcare literature that systematically asks people who have read a published work or abstract or who have cited an article what direct impact it has had on them and importantly on their practice. A pilot study may help to establish benefits and viability. The incorporation of qualitative feedback systems at conference for delegates to feedback impact are also recommended.

4.8.7 Section summary.

In this section of the Component Outcomes chapter the thesis dissemination strategy and the results of applying this have been described. The thesis has adopted a multi-modal and innovative dissemination strategy aligned to the thesis feminist methodology with the aim of creating flux in what is known from a variety of paradigm perspectives about the delivery and impact of C-Co and CBTp in HS contexts. The results have included peer reviewed publications, conference presentations, awards, and meaningful collaborations.

4.9 Chapter Summary.

In the previous chapter the researcher described and illustrated his methodological perspective, chosen method of research, and ethical considerations. In this chapter, the results from applying that method regarding C1-C7 were offered and discussed, aligned to the research aim and research questions. Each research component was explored in a separate section. Each section contained further details on the techniques used and ethical considerations specific to that component of the organisational case analysis. Component specific limitations and recommendations were also given. Section format was guided by the editorial criteria offered by relevant peer reviewed publications to aid dissemination and the initial drafts of two of the sections (4.2 and 4.5) became the basis for subsequent publications (Slater & Painter, 2016; Slater, 2020).

An autobiographic account of the researcher's first time being assessed by psychiatric services was first provided to aid transparency regarding researcher motivation, potential bias, C-Co

development, research genesis, and research justification. A descriptive single case analysis of C-Co application and praxis was then provided before a re-analysis of Slater's (2011) work on C-Co modality fidelity, which remains the only fidelity data of this nature to have been reported in relation to CBTp in HS contexts nationally and internationally. Participant experiences of C-Co were then explored via the application of an innovative investigation method of collaborative game development as part of participatory action research. This resulted in the 'Taking Steps' life-size game. Practitioner perspectives of delivering C-Co based on the thematic analysis of practitioner supervision transcripts were then provided. The next section of the component outcomes chapter focused on the data from pre and post outcome measures offering a quasi-experimental statistical analysis of this. Thesis dissemination strategy and results were then described and discussed. Of note is that each research component offers a unique and original contribution to what is professionally known about CBTp impact and practice in HS contexts and specifically about C-Co impact.

The next chapter of the thesis provides a summative synthesis of research component outcomes (C1-7) via triangulation (C8) to determine the level of convergent validity achieved from which summative claims and propositional conflations are then made and discussed. Limitations and recommendations for component 8 are then offered.

CHAPTER 5: SUMMATIVE CLAIMS AND PROPOSITIONAL CONFLATIONS.

Component 8: Summative Synthesis and Convergent Validity.

5.1 Introduction.

The summative synthesis of research component outcomes via triangulation is central to the organisational case analysis and the adopted feminist research methodology as this process facilities a greater objectivity regarding the subject of research (Longino, 1995; Yin, 2018). Triangulation facilitates the exploration of convergent validity through an examination of complementarity or dissonance when multiple methods and data sources are deployed to research the impact of a given subject, in this instance C-Co. The approach is founded on the underlying assumption that component result convergence enhances result validity and facilitates summative claims. Within a feminist methodological framework, dissonant results also have value. When dissonance is constructively explored within a democratic dialogue, objective new insights and areas for further research and inquiry emerge.

Despite considerable reference to the use of triangulation within the research literature, very little has been published regarding praxis application and procedure. The triangulation of the component results in this research was informed by the seminal works of Denzin (1978) and Fielding and Fielding (1986) and the praxis protocol offered by Farmer et al. (2006). Both the ‘what’ and the ‘how’ of triangulation are important to consider (Farmer et al., 2006). Using the framework offered by Farmer et al. (2006), the ‘what’ of the triangulation are the research component outcomes and the subject the research questions relating to C-Co impact. All four of Denzin’s (1978) types of triangulation - methodological, data, theoretical and investigator - are analysed within the research triangulation protocol. Depending on outcome this may strengthen or weaken convergent validity and any summative claims. The ‘how’ of the triangulation approach is largely procedural in that steps within the triangulation protocol and the progression through them must be transparently documented, affording potential replication (Farmer et al., 2016).

In this research component the triangulation protocol used by the organisational case analysis is described. The protocol is then applied and Denzin’s (1978) four types of triangulation used to analyse complementarity and dissonance between research components and component results. The level of convergent validity the organisational case analysis achieves, in relation to the research

questions, is then determined and discussed and limitations and recommendations offered. A response to Research Question 6: *What level of convergent validity was achieved by the organisational case analysis?* is provided.

5.2 Triangulation Protocol.

A four-stage triangulation protocol was adopted, influenced by the works of Denzin (1978), Fielding and Fielding (1986), Yin (2003), Famer et al. (2006), and Yin (2018). This involved the following steps:

1. Sorting (Table 15).
2. Methodological, data, theoretical, and investigator triangulation.
3. Triangulation of research component results.
4. Determination of the level of convergent validity achieved by the organisational case analysis.

The purpose of sorting was to collate pertinent information from the individual research components to aid triangulation. The purpose of Step 2 was to use Denzin's (1978) four triangulation types to triangulate component methodologies, source data, methods, resultant data, sample, purpose, theories, and investigators for convergence. Step 3 triangulated research results for convergence. Step 4 then offered a determination of the level of convergent validity the organisational case analysis achieves based on the outcomes from Steps 2 and 3.

5.3 Triangulation Protocol Application.

5.3.1 Sorting.

The sorting of pertinent data from the individual research components is provided in Table 15 to support triangulation.

Table 15: C-Co Organisational Case Analysis Research Components and Outcomes – Pertinent Data for Triangulation (© Slater).					
Sample.	**Autoethnography:** materials were purposively sampled from the researcher's possessions and reflexive research journal to convey researcher transparency. **Modality Fidelity and Praxis Competency:** random selection – 3 C-Co session records were randomly selected for independent CTS-R rater assessment from 56 recordings. **Patients:** purposive sample - only patients who had been considered non-adherent prior to engaging in C-Co, who continued to experience distressing residual symptoms despite the prescription of antipsychotic medications, and who had not been in receipt of any other psychotherapies during the provision of C-Co were included in the research. Patient and Responsible Clinician consent were sought. **Practitioners:** purposive - C-Co practitioners who had completed C-Co with a patient (C4), convenience - C-Co practitioners receiving supervision who consented (C5). **Dissemination:** convenience sample based on number of examples of research dissemination and people who provided workshop and peer review feedback responses.				
Data.	Except for the autoethnography research component, all praxis data was routinely gathered as part of C-Co provision.				
Research Component.	**Praxis Data.**	**Method.**	**Resultant Data.**	**Linked Research Questions.**	**Interpretation.**
C1: Autoethnography: Description and Inferences as Part of Reflexive Practice.	The researcher's reflexive research journal, linked photographs, and drawings.	Reflexive practice autoethnography (n=1).	Autoethnography.	R1: What impact has the researcher had on the research?	The researcher offers transparency regarding how his own experiences of psychosis may have influenced the research.
C2: C-Co Modality Fidelity and Praxis Competency.	Recordings of practitioner and patient C-Co sessions.	Statistical analysis of inter-rater reliability, description of aggregate score range and aggregate mean (n=3 of 56 C-Co sessions recordings).	Descriptive statistics.	R2: Does C-Co achieve modality fidelity and praxis competence?	Causation of impact may be attributed to CBT.
C3: A Descriptive Single Case Analysis of C-Co Application.	C-Co case report involving patient data.	Single case analysis (n=1).	Descriptive data of C-Co praxis.	R3: What impact does C-Co have on patients?	C-Co had a positive impact on the patient subject regarding risk and psychosis. C-Co had a negative impact on the patient subject in the form of transient iatrogenic effects.
C4: Participant Experiences of C-Co.	CBTp consolidation group outcomes involving patients and practitioners.	PAR using collaborative group game design and thematic analysis (n=15 – 10 patients 5 practitioners).	Game squares, movement cards, (themes in relation to method utility).	R3: What impact does C-Co have on patients? R4: What impact does C-Co have on practitioners?	C-Co had a positive impact on patients regarding risk and psychosis. C-Co had a negative impact on the patients in the form of transient iatrogenic effects. C-Co had a positive and negative impact on practitioners.
C5: Practitioner Perspectives of Delivering C-Co.	Transcriptions from practitioner supervision sessions.	Thematic analysis of transcribed interviews (n=6).	Themes.	R4: What impact does C-Co have on practitioners?	C-Co had a positive and negative impact on practitioners.
C6: An Exploratory Analysis of Pre and Post C-Co Outcome Measure Data.	Pre and post subjective and objective patient outcome measure data.	Statistical analysis of repeat measure outcomes, within subjects' design (n=16).	Significance, effect size, power.	R3: What impact does C-Co have on patients?	C-Co had a positive impact on patients regarding risk and psychosis.
C7: Dissemination Strategy and Results.	Publication metrics, presentation attendance, app downloads, presentation feedback.	Quantitative and qualitative determinants of impact (n=22 examples of research dissemination, n=31+10 workshop and peer review feedback responses).	Publication & attendance metrics, number of collaborations and awards, descriptive workshop feedback.	R5: What impact has C-Co had via the dissemination of results?	C-Co has had both positive and negative impact on others via dissemination, impact on practice has been harder to discern.

5.3.2 Methodological, Data, Theoretical, and Investigator Triangulation.

The organisational case analysis has involved multiple components, with multiple methodological perspectives, multiple data sources, multiple methods, and multiple resultant data formats (Table 1, Table 15). Framed within a feminist methodological perspective, the high level of dissonance between individual research component methodologies, methods and resultant data formats was deliberate and is fundamental to organisational case analysis. The research was designed to analysis C-Co from multiple perspectives, using multi-methods, thereby increasing summative objectivity. There was therefore a low level of complementarity between component methodologies, methods, and resultant data formats.

All the data for all the research components was also sourced from the same sample population of patients and practitioners. Although not by design or an *a priori* research consideration, a similar set of practitioners and patients provided most of the source data for all the research components. The subject of the single case analysis was part of the patient sample for the PAR research of participant experiences. Eight of the ten patients who provided the source data for the PAR research comprised eight of the eleven patients for whom complete data sets were available for the analysis of pre and post outcome measures. All the practitioners who provided source data for the PAR research provided source data for the thematic analysis of practitioner perspectives. Some of the practitioners and patients from the same sample set used in the other research components were also the subjects of the session recordings used to quantify fidelity. There was therefore a high level of complementarity between research component's sample and data source.

This has an extremely important implication in that it affords propositional conflation regarding convergence (Ripley, 2018). This makes any dissonance that is identified more interesting but also harder to interpret. Propositional conflation aids in the development of summative claims and additional research questions for further study. This is explored further in the discussion section of this chapter (5.4). Several of the research components shared an identical purpose via the research questions posed. Table 15 provides details of this in the column of 'Linked Research Questions'. This indicates that the single case analysis, pre and post outcome measures research, and PAR all had the purpose of researching C-Co impact on patients. It indicates that the thematic analysis of practitioner perspectives, modality fidelity, and PAR all had the purpose of researching C-Co impact on practitioners. All components had the shared purpose of researching C-Co impact. For each research component there is also a shared specific purpose with two other components

researching either the impact of C-Co on patients or the impact on practitioners. There was therefore a high level of purpose complementarity between research components. Complementarity of research component outcomes that share the same purpose can enhance convergent validity.

When research components share a common purpose and data source, pluralism of methodology, method and resultant data format further strengthens convergent validity when there is complimentary between interpretations of component results (Denzin, 1978; Fielding & Fielding, 1986). However, dissonant interpretations are much harder to decipher as a result and risk weakening any summative claims made by the researcher. The low complementarity between research component methodologies, methods, and resultant data may therefore strengthen convergent validity if there is complementarity of component results but weaken validity if there is dissonance.

Interestingly, Famer et al.'s (2006) use of different source data for each research component meant that to avoid this contention they used the same method for each research component and for triangulating outcomes. They also deployed a system for weighting the different codes their analysis produced. The feminist methodology adopted by the researcher asserts that the weighting of research component outcomes is counter-productive in the context of the organisational case analysis as each component or facet is weighted equally regarding value. Emphasis was instead placed on the number or 'weight' of research components and level of result complementarity. The researcher asserts that convergent validity may be directly proportional to the number of research components with complementary results and thereby enhanced, or indeed weakened, by the number of research components within an organisational case analysis.

All research components shared the same theories of psychosis, treatment, and efficacy assessment, thereby achieving a high level of complementarity. A broader, trauma-based, inclusive theory of psychosis was adopted in all components. The theory that C-Co would lead to more efficacious treatment of psychosis by surmounting levels of non-adherence and treatment resistance typical amongst HS patients, was also adopted by all components. The theory that efficacy was more usefully assessed from multiple perspectives rather than solely by symptom amelioration was also uniform across components. The level of theoretical complementarity was therefore high with no dissonance.

The research theories of psychosis, treatment, and determination of efficacy are dissonant to the medical theories dominant within HS contexts. A summative synthesis of component impact with a high level of convergent validity would add considerable weight to any claim that the theories adopted by the organisational case analysis may have greater utility regarding treatment efficacy than dominant medical theories.

There are elements of investigator triangulation and intersubjectivity throughout the research components (Table 15 – method column). Both independent scrutiny (by you as the reader and by an independent researcher) and dynamic participant validation (by patients and practitioners who participated in the research) were used. However, as this work is part of a doctoral qualification, a fully intersubjective approach was not adopted. The triangulation of component results has therefore not involved an independent researcher to potentially challenge the researcher's analysis. The researcher's interpretation of outcomes may also include an element of 'intuitive' analysis resulting from the researcher's own biases and his depth of relationship with the subject and context of the research. This was explored in depth within the sections relating to Component 1: *Autoethnography: Description and Inferences as Part of Reflexive Practice.* However, the transparency and depth of process detail offered within this research component may instead empower any reader or additional 'investigator' to reach their own determination of complementarity or dissonance (Farmer et al., 2006).

Table 16: Complimentary and Dissonance of Result Interpretation between Research Components (© Slater).

Research component.	**Positive impact on patients.**	**Negative impact on patients.**	**Positive impact on practitioners.**	**Negative impact on practitioners.**
C3: A Descriptive Single Case Analysis of C-Co Application.	✓	✓ Transient.	Not researched.	Not researched.
C4: Participant Experiences of C-Co.	✓	✓ Transient	✓	✓
C5: Practitioner Perspectives of Delivering C-Co.	Not researched.	Not researched.	✓	✓
C6: Pre and Post C-Co Outcome Measure Data.	✓	Not researched.	Not researched.	Not researched.
Totals.	**3 of 3**	**2 of 2**	**2 of 2**	**2 of 2**

5.3.3 Triangulation of Research Component Results.

Table 16 illustrates the level of complementarity and dissonance between research component results. The totals demonstrate complete complementarity of results with no dissonance between all components that researched impact on patients and impact on practitioners.

5.3.4 Level of Convergent Validity Achieved by the Organisational Case Analysis.

This research component aimed to provide a summative synthesis of research component outcomes via triangulation to determine the level of convergent validity the organisational case analysis achieved. A triangulation protocol developed by the researcher was used to achieve a response to Research Question 6: *What level of convergent validity was achieved by the organisational case analysis?* The high level of complementarity in relation to data source, component sample, purpose, and theory, the low level of complementarity regarding component methodologies, methods and resultant data, the parity of weighting between components, the high number of research components, and the comprehensive level of complementarity achieved through component result triangulation, indicates that the organisational case analysis achieves a high level of convergent validity.

5.4 Discussion.

The aim of this component of the organisational case analysis was to provide a summative synthesis of the previous research components to determine the level of convergent validity the organisational case analysis achieved, thereby providing a response to research question 6: *What level of convergent validity was achieved by the organisational case analysis?* This was facilitated via the use of a four-stage triangulation protocol, developed by the researcher, based on Famer et al. (2006), and influenced by the seminal works of Denzin (1978), Fielding and Fielding (1986) and Yin (2003; 2018). The result demonstrated that the organisational case analysis achieved a high level of convergent validity between the results of its component parts. Not only does this enhance the results of individual research components via additional verification, but it also validates any claims made about the summative impact of C-Co based on that convergence and facilitates propositional conflation between components. As a result, a response to research question 7: *What was the summative impact of C-Co?* can now be provided.

5.4.1 Summative Claims.

As illustrated in Table 15, the synthesis of component outcomes via triangulation substantiates with a high level of validity the following summative claims in relation to the organisational case analysis research questions and C-Co impact on patients and practitioners:

- C-Co has a positive impact on psychosis and risk in non-adherent HS patients with treatment resistant psychosis (R3).
- C-Co has a transient negative impact on psychosis and risk in non-adherent HS patients with treatment resistant psychosis (R3).
- C-Co has a positive impact on non-accredited nurse practitioners delivering C-Co (R4).
- C-Co has a negative impact on non-accredited nurse practitioners delivering C-Co (R4).

5.4.2 Propositional Conflation.

The high level of convergent validity also facilitates propositional conflation between the research components, thereby substantiating the following additional claims:

- C-Co nurse practitioners, who are non-accredited and achieve modality competence, are impacted positively and negatively by C-Co.
- A context specific adapted HS CBTp approach that achieves CBT modality fidelity and is delivered by non-accredited practitioners has a positive and transient negative impact on psychosis and risk with non-adherent HS patients.
- A context specific HS CBTp approach that is adapted using chief-complaint orientation to address high levels of patient non-adherence typical in HS contexts, has a positive and transient negative impact on psychosis and risk in HS patients whose psychosis is deemed to be treatment resistant.
- An innovative range of paradigmatically pluralist methods can be successfully used in HS contexts to research the impact of context specific adapted individual CBTp on non-adherent HS patients whose psychosis is deemed treatment resistant.

5.4.3 Implications.

The summative claims and positional conflation substantiated by the high convergent validity achieved by the organisational case analysis have important implications and represent an original contribution to what is known about individual HS CBTp. They represent a direct challenge to the positivist medical theories of psychosis, treatment, and efficacy dominant in HS psychiatry. They directly challenge existing theories of what research methods and methodologies can be successfully deployed in HS contexts to evaluate individual CBTp and directly challenge the hegemony of accreditation within CBTp application. They further substantiate the theory that chief-complaint orientation in adapted individual HS CBTp is necessary to successfully mediate the impact of non-adherence, thereby challenging other forms of adaptation. These implications are discussed further below.

5.4.3.1 Challenging Dominant Medical Theories of Psychosis, Treatment, and Efficacy in HS Contexts.

On the strength of the results of the organisational case analysis the researcher wholly rejects the dominance of the medical understanding and determinants of efficacy within HS contexts regarding the conceptualisation and treatment of psychosis and risk. On this basis the researcher also rejects the dominance in HS contexts of the terms ‘non-adherence’ and ‘treatment-resistance’. The researcher asserts that these terms are misleading, inaccurate, reduce optimism and promote and sustain a damaging medical hegemony when used generically. The researcher is not stipulating that the medical conceptualisation and pharmacological treatment of psychosis are without merit nor that the terms non-adherence and treatment-resistance may not be accurate from a medical model perspective. The researcher accepts that the medical model and pharmacological treatments have been proven to have benefit in non-forensic contexts. It is the unsubstantiated dominance of this medical model perspective and terms in HS contexts, and the assumption of generalisability of efficacy between forensic and non-forensic environments, that the research and researcher refute. The proliferation of medical non-adherence and treatment-resistance in HS contexts regarding psychosis suggests that medical conceptualisation and treatment are simply not effective in isolation. Indeed, beyond the anecdotal, there is no evidence base for the efficacy of antipsychotic treatments in HS contexts (Reisegger et al., 2021).

The results of the organisational case analysis prove that a multifaceted approach and understanding of psychosis in HS contexts is needed for treatment for psychosis and risk to be successful. The summative results of the organisational case analysis prove that patients who were subject to C-Co

and indeed benefited from this were not treatment resistant or non-adherent in a generic sense. Yet, due to medical perspective hegemony, these terms were applied to those patients in a generic sense and continued to be applied to them despite the treatment gains that were made because of C-Co. The results of the research prove that these terms are simply not factual, that both effective treatment and adherence are possible. The results prove that adaptation rather than an unsubstantiated primacy is required, and that the term non-adherence and indeed treatment-resistance are unsustainable misnomers.

The research results also bring into question and directly challenge the medical dominance of symptom amelioration as the 'gold standard' of treatment efficacy. The results of the organisational case analysis, particularly component 6 (*An Exploratory Analysis of Pre and Post C-Co Outcome Measure Data*) demonstrate that this gold-standard is unsustainable and potentially detrimental to patient progress. The results from component 6 (the only quasi-experimental positivist statistical analysis of any individual HS treatment approach to have been conducted in HS contexts including the use of antipsychotic medication) clearly substantiate that when the patient's relationship with symptoms changes, recovery occurs regardless of whether symptoms ameliorate. In the context of medical model dominance, the assertions that the research results substantiate represent a radical, almost paradigmatic shift within the theory of how HS services may more beneficially perceive and treat psychosis and risk. They also indicate a failure of imagination and will, within HS services, to ask and answer the question of why so many HS patients are medical model non-adherent and treatment resistant as well as a failure to fully appreciate the benefits to patients and the public of treatment modality parity.

In the context of the research results, the continued dominance of the medical conceptualisation and treatment of psychosis and risk in HS contexts is difficult to reconcile. The absence of any robust experimental research substantiating the efficacy of pharmacological treatments in HS contexts and the support and weight the research results give to revisions to the NICE guidance made almost a decade ago (NICE, 2014), strengthen this concern. A systematic review of the international published literature relating to the efficacy of pharmacological treatments in all forensic contexts including HS, involving over 6000 studies, found that no conclusions could be drawn about the impact of antipsychotic treatments in forensics contexts including HS, due to substantial methodological limitations (Reisegger et al., 2021) of a similar nature to those experienced in component 6. In 2014 the NICE guidance on the conceptualisation and treatment of psychosis was revised to include a far greater emphasis on the benefits of a multifaceted understanding and

treatment of psychosis and a far greater emphasis on parity between social, psychological, and medical interventions (NICE, 2014). Further consideration of why medical model dominance persists in HS contexts is warranted.

Proponents of medical model dominance assert that levels of non-adherence typical within HS contexts sustain the need for dominance. As pharmacological treatments are the only treatments that are enforceable via the provision of medication under restraint, they are perceived as the only effective form of treatment for typically non-adherent HS patients (Mason, 1999; Adshead et al., 2005). However, this is a damaging and circular fallacy which the results of the organisational case analysis directly refute. The research results prove that there is no such concept as non-adherence or treatment resistance, only a failure to adapt treatments and adopt a more multifaceted, multi paradigmatic understanding of psychosis. Medical model dominance may also be maintained by the lack of non-medical approved clinicians working in HS contexts. At the time of thesis submission there were no non-medical approved clinicians working in any of the UK's HS hospitals. This is a contravention of the 2007 revisions to the MHA 1983 (GB, 1983; GB, 2007), the Care and Quality Control Commission good practice examples for mental health (Health Education England (HEE), 2013), and the new ways of working required to enhance the quality of care and recovery of mental health patients (HEE, 2020).

Anecdotally, the researcher was informed that only medical approved clinicians had the expertise to manage the risks posed by HS patients. Not only is this suggestion unlawful, but the proliferation of non-medical approved clinicians in acute inpatient settings where risks might be considered more complex and immediate and where Responsible Clinicians do not benefit from the level of procedural and physical security mediation evident in HS contexts, belie this suggestion. The results of the organisational case analysis indicate that the hegemony of medical practitioners as the only professionals to work as HS approved clinicians must be challenged and reconciled if more efficacious, multi-faceted treatment approaches are to gain parity.

The most likely reason for continued medical modal dominance however is the lack of a critical mass of research that robustly challenges this dominance. No other organisational case analyses, that research and robustly substantiate the efficacy of alternative or adjunct non-medical treatments with such a high level of congruent validity, have been conducted nationally or internationally in HS contexts. This research is therefore both unique and seminal but stands alone in challenging HS medical model dominance. Interestingly, as there is no robust evidence to support the efficacy of

pharmacological treatments in HS contexts (Reisegger et al., 2021), C-Co is the only HS treatment nationally or internationally of any modality with proven convergent efficacy. There is a moral and ethical obligation in the interests of more efficacious HS treatments for the researcher to not only disseminate the results of this research and promote the wider use of C-Co, but also to use the results to challenge medical model primacy as well as encourage more robust research of all HS treatments for psychosis and risk.

5.4.3.2 Challenging Dominant Theories of The Research Methods and Methodologies that Can be Deployed in HS Contexts.

The primacy of the RCT as the most robust form of evidence is pervasive in mental health treatment provision (NICE, 2014). Yet the contextual barriers in HS contexts are seen to preclude its application in HS research (Reisegger et al., 2021). The efficacy of pharmacological treatments in HS contexts is therefore only assumed based on the efficacy of pharmacological treatments established via RCTs in non-forensic contexts. The predominance of medical model treatment resistance and non-adherence evident in HS contexts and the necessity of treatment adaptation proved by the results of the organisational case analysis challenge this assumption. A different means of researching the efficacy of pharmacological and other HS treatments for psychosis and risk is therefore indicated to test assumptions of treatment transferability as well as to develop a deeper praxis-based understanding and test of the adaptations that may be required. In this context the method deployed by the research is unique and entirely original. It offers a more robust means of researching HS treatments for psychosis and risk than has ever been previously envisaged nationally or internationally. It would be interesting and worthwhile to apply the same organisational case analysis method to pharmacological and other HS treatments to determine impact more robustly and to test out new theories of how HS services might adapt treatments to enhance efficacy, like the adaptions in C-Co.

The organisational case analysis results also challenge current theories regarding what research methods and methodologies are feasible in HS contexts. Each research component within the organisational case analysis directly challenges the current theory that single, descriptive case analyses or case series are the most valid methods of individual HS CBTp research (Benn, 2002). The convergent validity achieved by the research further reinforces this challenge. The organisational case analysis proves that novel, innovative, multi-paradigmatic and exploratory research methods can be successfully deployed in HS contexts, disproving earlier theories based on

sample size limitations and contextual barriers. The feminist methodological perspective adopted by the research has proved seminal within this process by recognising, valuing, and synthesising a range of ontological and epistemological knowledge creation and ways of knowing evident in HS contexts. The objective, facet-based understanding and convergent validity of C-Co impact that has emerged, demonstrate that substantially more can be determined about efficiency in the interests of HS patients and practitioner by adopting this methodological perspective, than paradigmatic polarisation or dominance.

5.4.3.3 Challenging the Hegemony of Accreditation in Relation to CBTp Provision.

The results of the organisational case analysis prove that HS CBTp practitioners do not need to be accredited to competently deliver individual HS CBTp in a manner that has a positive impact on psychosis and risk and achieves modality fidelity. This directly challenges the long-held, dominant perception that modality fidelity, praxis competence and positive impact can only be achieved via the use of accredited, experienced CBTp practitioners (Kupiers et al., 1997). This challenge is unique to the organisational case analysis and is not explored or asserted by any other individual HS CBTp study nationally or internationally. This represents a new narrative that challenges established norms and the hegemony of organisations like the BABCP. It thereby threatens the established hierarchy, controls and norms of deference perpetuated by accrediting bodies.

However, the results from the organisational case analysis also indicated that C-Co had both a positive and negative impact on C-Co practitioners, that considerable scaffolding was needed from an accredited practitioner to support C-Co practitioner competence, that C-Co was perceived by practitioners as ‘therapy by proxy’, and that in-session responsiveness and reactivity was perceived as low due to the lack of accreditation. The researcher does not stipulate therefore that accreditation may be without benefit. The independent monitoring and maintaining of professional standards and of ethical practice are important functions of an accrediting body that may have been better served by an organisation like the BABCP rather that the HS CBTp lead (BABCP, 2022). Further research about how the negative impact on C-Co practitioners might be mediated, about the possible differences between the experiences of accredited and non-accredited practitioners when delivering C-Co, and about the impact on patients between accredited and non-accredited delivery is indicated. One of the collaborations engaged in by the researcher has been with C-Co non-accredited practitioners to develop and test a model of training and supervision based on the

outcomes of the research. This model is designed to increase positive modifiers of practitioner experience and reduce the impact of negative modifiers (section 4.8.3.4).

5.4.3.4 Substantiating Theories of Adaptation in Individual HS CBTp and Establishing C-Co as the Most Evidence-based and Efficacious of These.

C-Co represents a considerable departure from the norms of individual CBTp provision in HS contexts. C-Co is the only HS CBTp approach to have been specifically adapted for use with typically non-adherent HS patients as well as less typical adherent patients. C-Co is the only individual HS CBTp approach to systematically use chief-complaint orientation and the only approach to have had its genesis in the experiences of a service user. C-Co is the only individual HS CBTp approach nationally and internationally to have been systematically developed, widely deployed, and robustly researched with proven efficacy regarding psychosis and risk. Whilst the researcher recognises the importance of previous HS CBTp studies, none match the scope, ambition, level of patient non-adherence, and outcome of the organisational case analysis of C-Co impact. No other study of HS CBTp achieves convergent validity.

Whilst other HS studies have used adapted forms of CBTp, these adaptations have focussed on risk and index offence adaptation, not adaptation regarding non-adherence and treatment-resistance. These studies have largely been limited to single case analyses, have targeted adherent patients, and have invariably resulted in service or treatment failure (Bentall & Haddock, 2000; Cawthorne, 2019). Importantly a comparative analysis between index offence adaptation in the literature and results of the organisational case analysis suggest that forensic risk adaptations may be contra-indicated and result in treatment failure and poor service uptake with non-adherent patients (Cawthorne, 2019). The research results suggest that C-Co adaptation to address non-adherence is considerably more efficacious than any other adapted individual HS CBTp approach and that risks to self and others should already be an integral component within CBTp psychosis formulation in HS contexts rather than an adaptation per se. The research results and convergent validity establish that the adaptations within C-Co are the most evidence based and are most effective regarding individual HS CBTp nationally and internationally.

5.5 Limitations and Recommendations.

A summative synthesis via triangulation to determine convergent validity enhanced the results of individual research components and facilitated summative claims and propositional conflation between components. However, beyond seminal works, few praxis examples of triangulation protocols and their application have been published. The diversity of research to which triangulation can be applied may also preclude standardisation. Whilst the organisational case analysis invites the reader as an 'investigator', further consideration during the planning stages of the research could have been given to investigator triangulation. Similarly, *a priori* sample complementarity was not considered as an intentional condition.

The publication and wider dissemination of the triangulation protocol adopted by the organisational case analysis is recommended to add to the limited literature and to provide a praxis example for others to consider or indeed replicate. The adoption of further multi-method, facet-based individual HS CBTp research that includes triangulation to determine component convergent validity is also recommended to surmount context-specific barriers currently perceived to limit the scope and validity of HS CBTp research. This research proves that these barriers can be effectively addressed with effort and innovation. *A priori* consideration of Denzin's (1978) four types of triangulation during the planning stage of future organisational case analyses is also recommended, including sample complementarity between research components and investigator triangulation.

5.6 Chapter Summary

In this chapter the level of convergent validity achieved by the organisational case analysis was analysed using triangulation to produce a summative synthesis. A triangulation protocol was developed by the researcher for this purpose based on the works of Denzin (1978), Fielding and Fielding (1986), Yin (2003), Famer et al. (2006), and Yin (2018). A transparent approach that detailed the application of the triangulation protocol was used to empower the reader as investigator and support replication. A response to research question 7: *What was the summative impact of C-Co?* was provided based on the high level of convergent validity the organisational case analysis achieved. The high level of convergent validity achieved facilitated summative claims and propositions based on component conflation.

These summative claims, propositions, and the component results of the organisational case analysis directly challenge and refute the primacy of the medical conceptualisation and treatment of psychosis in HS contexts and substantiate the inaccuracy of the terms non-adherent and treatment resistant. The summative claims also challenge and refute theories regarding what methodologies and methods can be deployed to research individual HS CBTp, and challenge perceived norms regarding the hegemony of practitioner accreditation in CBTp provision. Importantly, the summative claims and convergent validity establish C-Co as the most evidence-based and efficacious adapted individual HS CBTp approach nationally and internationally. Indeed, the summative results of the organisational case analysis establish C-Co as the only evidence-based individual treatment for medically non-adherent and treatment resistant psychotic patients in HS contexts.

In the next chapter, Chapter 6, a summary of the thesis is provided and the impact of the research on the researcher explored.

CHAPTER 6: THESIS SUMMARY AND THE IMPACT OF THE RESEARCH ON THE RESEARCHER

6.1 Introduction

In this chapter a summary of the thesis is offered and the impact of the research on the researcher explored. The schematic of the research components which comprise the organisational case analysis (Fig. 1) is first repeated, and the research aim, and questions reiterated for ease. The meaning of the term ‘impact’ within the context of the research is also revisited. A summary of the research components linked to the thesis research questions is provided as is a summary of component limitations and recommendations. Reflections on the use of organisational case analysis are then offered and the impact of the research on the researcher then explored.

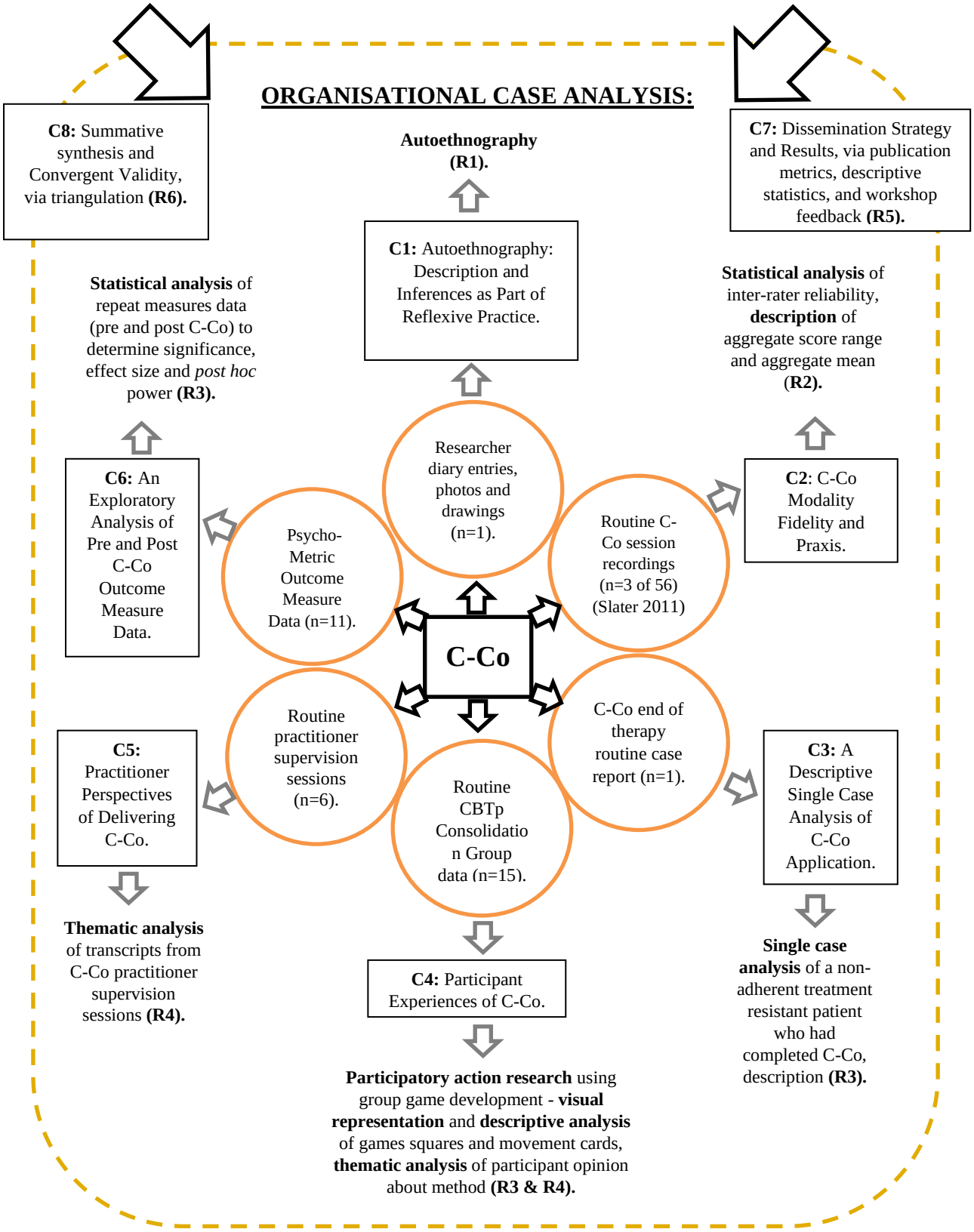
6.2 Research Schematic, Aim, Research Questions, and Definition of Impact

6.2.1 Research Schematic.

The research schematic (Fig. 1) has C-Co at its centre. Arrows point from C-Co to the different forms of data routinely collected during C-Co delivery, each representing a different facet by which to analyse impact. Three additional facets of analysis not based on routinely gathered data are also illustrated - the impact of the researcher on the research, C-Co impact via the dissemination of results, and a synthesis of the facets within the organisational case analysis into a germane aggregate to test convergent validity.

Further arrows within the schematic point to the methods of analysis deployed for each facet and corresponding research questions. An arrow to the top left of the schematic indicates the secondary method of analysis via a calculation of convergent validity via triangulation.

Fig.1 (repeated): A schematic of the organisational case analysis and research components linked to research questions (© Slater).



6.2.2 Research Aim.

To analyse the impact of C-Co using organisational case analysis.

6.2.3 Research Questions.

R1: What impact has the researcher had on the research? C1
R2: Does C-Co achieve modality fidelity and praxis competence? C2.
R3: What impact does C-Co have on patients? C3, C4 and C6.
R4: What impact does C-Co have on practitioners? C4 and C5.
R5: What impact has C-Co had via the dissemination of results? C7.
R6: What level of convergent validity was achieved by the organisational case analysis? C8.
R7: What was the summative impact of C-Co?
R8: What were the research limitations of the organisational case analysis?
R9: What recommendations for future practice and research can be made?
R10: What impact has the research had on the researcher?

6.2.4 The Meaning of 'Impact' Within the Context of the Research.

Impact is defined as; *'the striking of one body against another; collision, chiefly in dynamics, in reference to momentum*,' and *'the effective action of one thing or person upon another; the effect of such action; influence; impression,'* (OUP, 2023). In this instance the 'one body' or 'one thing' is C-Co and the 'another' in both instances are patients, practitioners and people exposed to result dissemination. Impact may be positive, negative, neutral, or multi-facetted. Impact may also be due to chance.

6.3 Thesis Summary.

This doctoral thesis robustly researched the impact of C-Co, an adapted, HS specific variant of CBTp, on non-accredited nurse practitioners delivering C-Co and on typically non-adherent and treatment resistant HS patients. C-Co is unique to the researcher and was developed solely by him representing an original contribution to HS CBTp practice. It is one of only two adapted individual HS CBTp approaches to have been systematically developed and deployed in HS contexts nationally and internationally, the only approach to use non-accredited nurse practitioners, and the

only one that has not resulted in treatment and service failure. It is an entirely original approach in that C-Co evolved from the researcher's own alienating experiences of mental health services and subsequent non-adherence. The approach and research have been the recipients of several national awards for innovation and impact.

A review of the literature was first provided which led to subsequent peer-reviewed publication (Slater & Townend, 2016). The review used an inclusive, novel, and exploratory search strategy and hermeneutic analysis. This ensured a more transparent analysis, and better representation and synthesis of both national and international published literature as well as pertinent, localised unpublished studies. An update and critical appraisal of Slater and Townend (2016) was provided. The results were limited in number, scope, sample, and methodological rigour. Most studies used single case analyse and atypical adherent patient samples. Outcomes indicated that group and individual CBTp, and CBTp informed therapeutic milieus were provided in HS contexts. Varying levels of efficacy were noted as was the need for adaptation to enhance the efficacy of individual CBTp with more typical non-adherent treatment resistant patients to avoid treatment failure. Further publication of HS CBTp research was recommended.

Organisational case analysis was used to determine impact in response to the thesis research questions. The organisational case analysis was comprised of 8 research components, with each component comprising a distinct, original piece of research. This led to several peer-reviewed publications, national and international conference presentations and collaborations, and national awards for innovation and originality. A feminist methodology was adopted. Facet theory was used to pragmatically frame data generated as part of routine C-Co delivery, facilitating the analysis of each data source within a research component to determine C-Co impact more objectively and robustly. Novel and innovative research methods were deployed for each component within a feminist methodological framework of paradigmatic pluralism and parity. A summative synthesise via a process of triangulation was used to determine component convergent validity. Constructivist, critical realist, and exploratory positivist methodologies and methods were creatively used to objectively interrogate the data for impact from multiple standpoints and to provide researcher transparency.

In response to research question 1: *What impact has the researcher had on the research?* autoethnography was used as a constructivist method to rigorously analyse and illustrate researcher bias. This resulted in 'On Being Assessed', a personal, anecdotal account of the first time the

researcher was assessed by psychiatric services. This led to a subsequent peer-reviewed publication (Slater, 2020), and reflected the anger, alienation, and non-adherence the researcher felt towards psychiatric care provision at that time and the spark of his ambition to develop better patient services for psychosis. The concept of health dissonance was introduced to encapsulate these experiences. The results indicated that the researcher lacked value neutrality in the context of the research and was emotionally invested in it. Congruent with his feminist methodological perspective, laying bare his bias on the page empowered the reader to interpret and determine for themselves how this may detract from or enhance the validity and authenticity of the research. No other HS CBTp research offers this depth of researcher transparency, making the organisational case analysis unique. Greater researcher transparency in individual HS CBTp research was recommended.

In response to research question 2: *Does C-Co achieve modality fidelity and praxis competence?* context-related barriers precluded the intended analysis. The data from an earlier work by the researcher (Slater, 2011), which deployed a positivist statistical method was instead re-interrogated within component 2 for new inferences. This re-interrogation was used to evidence that C-Co was indeed CBT, that non-accredited practitioners achieved modality praxis competence, that despite adaptation C-Co maintained modality fidelity, and that any claims of C-Co impact determined by the results of the organisational case analysis could be attributed to CBT. These additional inferences from Slater (2011) are unique to the organisational case analysis. Whilst not a direct component of this research, Slater (2011) remains the only HS CBTp research to have rigorously quantified modality fidelity and competence using a standardised and internationally recognised measure (the CTS-R), making it seminal and original in its contribution. The development of a measure to specifically assess C-Co fidelity and praxis competence was recommended as was the adoption in HS individual CBTp practice and research of a standardised and more permissible fidelity and competence measure.

Components C3, C4, C5 and C6 provided responses to research questions 3: *What impact does C-Co have on patients?* and 4: *What impact does C-Co have on practitioners?* Component 3 deployed a critical realist methodology using descriptive single case analysis to provide an in-depth praxis example of C-Co application to determine patient impact. Importantly, this analysis also illustrated the chief-complaint orientation stage of C-Co. The results indicated that C-Co had a positive impact on psychosis and risk and a transient negative impact on mood with a typically non-adherent, treatment resistant HS patient with psychosis. Whilst the use of single case analysis and case series

are prevalent within the individual HS CBTp literature, no other research offers the same depth of detail, analysis, or praxis process, making the thesis single case analysis unique. The research is also original in that it is the only single case analysis to have been conducted of an adapted and systematically delivered individual HS CBTp approach. Publication of component results was recommended.

Component 4 researched C-Co impact on both non-adherent patients, and C-Co practitioners, deploying a critical realist methodology and an innovative PAR method using collaborative group game design to determine impact. This led to a subsequent peer reviewed publication (Slater & Painter, 2016). The adopted method was completely original and resulted in 'Taking Steps', an interactive and Koestler Trust platinum award-winning game that represented and conveyed the impact of C-Co on patients and practitioners and invited others to share this experience by playing 'Taking Steps'. Feedback was elicited from players at conference to share with the patients and practitioners involved in the research and to help determine dissemination impact. A collaboration with De Montfort University also led to the development and publication of 'Taking Steps' as an app on the Android platform. The results demonstrated that C-Co had a positive and transient negative impact on psychosis and risk with typically non-adherent, treatment resistant HS patients, and a positive and negative impact on practitioners. No other research has analysed HS patient experiences of individual HS CBTp, nor the impact of adapted HS CBTp delivery on non-accredited practitioners, making the research entirely original and seminal.

A critical realist methodology and thematic analysis of practitioner supervision transcripts was used in component 5 to analyse the impact of C-Co on practitioners. The results indicated that C-Co had a positive and negative impact on practitioners. Whilst practitioners reported increases in knowledge and confidence, benefits from supervision and training, a strong sense of accomplishment, C-Co as having a high level of practice efficacy particularly regarding relationship building and engagement, they also reported low in-session reactivity, a sense of delivering therapy-by-proxy, dependence on the service lead, and increases in anxiety linked to competence. This varied impact is not reflected in the wider literature. Only one other study has analysed practitioner experiences of delivering an adapted individual HS CBTp approach (CBTp(f)). This largely reported negative impacts on practitioners (Cawthorne, 2019). As CBTp(f) and C-Co crucially differ in their adaptations and level of practitioner accreditation, the thesis research represents an original and significant addition to the limited individual HS CBTp literature. The positive impact on patients of C-Co robustly evidenced within the organisational case analysis may explain the

different reported practitioner impacts between CBTp(f) and C-Co. Publication of component results was recommended as was the development of a C-Co supervision and training model based on practitioner responses that might increase the impact of positive modifiers to practitioner experiences and decrease the impact of negative modifiers. In collaboration with C-Co practitioners this model was developed and is being tested.

To determine impact on patients, component 6 adopted an exploratory, positivist quasi-experimental methodology and provided a statistical analysis of significance, effect size, and *post hoc* power of pre and post subjective and objective outcome measure data. To the researcher's knowledge, no other such exploratory individual HS CBTp research has been conducted nationally or internationally making the research within this component entirely original and unique in its contribution. The results therefore have considerable importance and significance. Of the 26 outcome measure domains analysed, 20 achieved significance, with the majority of these achieving a large effect size. Nine domains also achieved *post hoc* power. The results indicate that C-Co had an important positive impact on the non-adherent, treatment resistant HS patients in the sample in reducing the impact of their symptoms and risk. Whilst the underlying assumptions that facilitate generalisability were not met, the achievement of *post hoc* power for some domains suggests that, were effect sizes replicated, generalisability could be achieved via a significantly smaller randomised sample than had previous been envisaged, challenging perceptions that context specific barriers precludes experimental study of intervention impact in HS contexts. Interestingly the results also directly challenged medical theories of symptom amelioration as the primary determinant of efficacy in psychosis treatment. The use of a waiting list control in future similar research and publication of component results was recommended.

An active approach to dissemination during and beyond the period of study was encouraged as part of the DPrac. A multi-modal, innovative dissemination strategy, commensurate with the researcher's feminist methodology, which aimed to create flux within what was known about C-Co and individual HS CBTp, was deployed (C7). This resulted in extensive national and international dissemination including published articles, conference presentations and workshops, awards, and collaborations. This provided additional data for analysis to provide a response to research question 5: *What impact has C-Co had via the dissemination of results?* The analysis of dissemination impact indicated that the aim of creating flux was achieved and that the impact of C-Co was positive, but also elicited constructive criticism. Praxis impact was also difficult to discern and publisher surveys and better metrics to determine publication praxis impact were recommended.

Component 8 provided a response to research question 6: *What level of convergent validity was achieved by the organisational case analysis?* A summative synthesis of research component results via a four-stage triangulation protocol developed by the researcher, was used to determine the level of convergent validity achieved by the organisational case analysis. A high level of convergent validity was achieved. This not only further validated the results achieved by individual research components through additional verification, but also facilitated and strengthened summative claims and propositional conflation between research component details, thereby providing a response to research question 7: *What was the summative impact of C-Co?* The organisational case analysis conclusively proved with a high level of validity that:

- C-Co had a positive impact on psychosis and risk in non-adherent HS patients with treatment resistant psychosis.
- C-Co had a transient negative impact on psychosis and risk in non-adherent HS patients with treatment resistant psychosis.
- C-Co had a positive impact on non-accredited nurse practitioners delivering C-Co.
- C-Co had a negative impact on non-accredited nurse practitioners delivering C-Co.

And that:

- C-Co nurse practitioners, who are non-accredited and achieve modality competence, were impacted positively and negatively by C-Co.
- A context specific adapted HS CBTp approach (C-Co) that achieves CBT modality fidelity and is delivered by non-accredited practitioners had a positive and transient negative impact on psychosis and risk with non-adherent HS patients.
- A context specific HS CBTp approach (C-Co) that is adapted using chief-complaint orientation to address high levels of patient non-adherence typical in HS contexts, had a positive and transient negative impact on psychosis and risk in HS patients whose psychosis was deemed treatment resistant.
- An innovative range of paradigmatically pluralist methods can be successfully used in HS contexts to research the impact of context specific adapted individual CBTp on non-adherent HS patients whose psychosis is deemed treatment resistant.

There were important and significant theoretical and praxis implications because of these summative findings. The dominance of medical conceptualisations of psychosis and risk, and of treatment and treatment efficacy, and the generic application of the terms non-adherence and treatment-resistance in HS contexts, were challenged and refuted on the strength of the organisational case analysis results. Dominant theories about the research methodologies and methods that can be deployed in HS contexts were also challenged and refuted on the strength of the organisational case analysis results, as was the hegemony of practitioner accreditation in relation to CBTp delivery.

In the context of the literature, the results of the organisational case analysis also indicate that C-Co is the only adapted individual HS CBTp approach, nationally and internationally, to have been systematically developed, widely deployed, and robustly researched that has proven efficacy regarding psychosis and risk with typical medically non-adherent and treatment resistant HS patients. No other individual HS CBTp research achieves convergent validity. The contribution of the organisational case analysis to professional knowledge and practice is therefore extremely significant and entirely original. Given the lack of robust research into the efficacy of other HS treatment approaches, including the use of antipsychotic medication, the results of the organisational case analysis establish C-Co as the only individual HS treatment for psychosis and risk, with typically medically non-adherent and treatment resistant HS patients, that has proven efficacy. Whilst this is an important finding, it is also concerning and more research into the efficacy of HS treatments, using innovative research practices to surmount context-related barriers, was highly recommended.

6.4 A Summary of Research Limitations and Recommendations.

The specific limitations and recommendations of the thesis literature review and research components were discussed in the literature review chapter and within the individual research component sections in chapter 4 and chapter 5. These are collated for ease below (Table 17). The limitations of the organisational case analyses as a body of work are then discussed, and recommendations made, thereby providing answers to research questions 8: *What were the research limitations of the organisational case analysis?* and 9: *What recommendations for future practice and research can be made?*

Table 17: Literature Review and Research Component Limitations and Recommendations (© Slater).		
Research Component.	Limitations.	Recommendations.
A Review of the Literature.	The adopted approach is untested beyond Slater and Townend (2016) and may be considered purely theoretical and subjective in nature. Others may be unable to replicate the iterative and hermeneutic approach used. The inclusion criteria differ from those established by NICE (2014). Little quantitative data is identified for analysis. The review may therefore be limited in scope. Results are largely qualitative and descriptive and may therefore lack generalisability.	This work has been published in a peer-reviewed leading journal (Slater & Townend, 2016) and met their criteria. A recommendation to publish and influence others about the importance of considering fugitive and published studies, and a means by which to do so, has therefore already been met. The article has created flux and led to a collaboration with Stanford University to develop their state-wide CBTp programme. A specific publication that offers greater detail about and a template for the exploratory and theoretical review strategy use is recommended.
C1: Autoethnography: Description and Inferences as Part of Reflexive Practice.	The existing guidance regarding autoethnography application is limited and contradictory. It is a subjective and purely anecdotal account. The experience cannot be generalised. The autoethnography may be anachronistic and its impact on future healthcare guidance potentially limited. The autoethnography exposes assumptions made by the researcher that health dissonance results in non-adherence and that change within mental health care provision is needed to address dissonance.	Greater transparency about the researcher in the context of the research is recommended within the HS CBTp literature. The autoethnography offers a means for doing this. Further research regarding the causes of non-adherence and health dissonance in HS populations is recommended.
C2: C-Co Modality Fidelity and Praxis Competency.	Power is not achieved - it may be problematic to make robust claims beyond the context of research and the research subject of C-Co. Context specific barriers precluded a replication of the method used in Slater (2011). Raters were not blind. The assessment tool (the CTS-R) only rates a minimum level of CBT adherence and competency and was limited in scope when applied to the more advanced level of CBT praxis necessary in HS contexts. Specific C-Co modality fidelity and practitioner praxis competence was not assessed.	The development of a measure that specifically quantifies C-Co fidelity and praxis competence is recommended. A broader adoption of quantifiable methods of fidelity and competency testing in other HS CBTp research to strengthen claims relating to causality is needed. Further exploration and standardisation of alternative means of measuring fidelity and competency within national and international HS CBTp research is required. Alternative measures like the ACCS (Muse et al., 2022) that may be more permissible should be considered
C3: A Descriptive Single Case Analysis of C-Co Application.	Comparative analyses of single case studies or case series remains problematic. Variations in modality adaptations, context, delivery, and mode of application can limit effective triangulation. The evidence is limited to a single case (n=1) and is therefore not generalisable.	Standardisation of single case analysis techniques across HS contexts or further case series to determine individual HS CBTp impact are recommended. The wider adoption and single case analyses of chief-compliant adaptations in CBTp targeted at non-adherent patients in other HS contexts using a standardised format like the one in this research is recommended.

Table 17 continued:		
C4: Participant Experiences of C-Co.	The adopted method maybe difficult to replicate. The adopted method deviates from the method norms deployed in other CBTp participant studies making comparison difficult and any inferences about generalisation problematic. The research fails to offer any definitive, quantifiable data about the impact of C-Co or HS CBTp more generally.	Other HS CBTp practitioners are encouraged to replicate the method used in this component of research to consolidate patient and practitioner experiences of individual HS CBTp. When evaluating the impact of HS CBTp on participants, other HS CBTp researchers are encouraged to adopt this or other equally innovative approaches to preclude the disadvantage more traditional methods cause HS patients.
C5: Practitioner Perspectives of Delivering C-Co.	Practitioner supervision interviews were conducted by the researcher as service lead. Despite participant validation, this may have skewed data. One of the practitioners approached declined involvement in the study which may have biased results via the exclusion of potential critical opinions.	The inclusion of standardised measures which quantify changes in practitioner competence, knowledge and related anxiety may offer a more robust analysis and are recommended as is an independent researcher to conduct practitioner interviews. A wider analysis that includes the views of practitioners delivering adapted CBTp approaches in other HS contexts is recommended as is the development and evaluation of a HS CBTp supervision and training model to enhance positive modifiers and resolve negatives modifiers in relation to practitioner experiences.
C6: An exploratory Analysis of Pre and Post C-Co Outcome Measure Data.	Longitudinal data was too inconsistent for inclusion. Not all measures were validated for forensic use. There was no control group or sample randomisation. Generalisability could not be achieved.	A waiting-list control or randomisation to further strengthen causal attribution should be used to aid generalisability. A calculation of *a prior* power could be used based on predicted effect to estimate the needed sample size for any future statistical analysis outcome measures (the effect sizes from this research suggest a sample of n=19-24 may be sufficient were effect sizes maintained). The outcome measure used for HS CBTp should be standardised across HS context to facilitate comparison of impact. Further quantitative statistical analyses of HS CBTp outcome measure data are recommended regarding the impact of both C-Co and other individual HS CBTp approaches.
C7: Dissemination Strategy and Results.	There are no recognised methods for determining the impact of multi-modal research dissemination strategies. Whilst inferences regarding flux may be made, praxis impact is difficult if not impossible to discern. The is no one standardised or recognised approach to quantifying publication impact.	Offering further opportunities for people to play 'Taking Steps' and eliciting feedback are warranted to further analyse C-Co impact. A more rigorous thematic analysis of 'Taking Steps' feedback would also support further claims. A systematic and standardised approach such as surveys by publishers to explore the impact of published works on readers and their practice is warranted.
C8: Summative synthesis & Convergent Validity.	Direct investigator triangulation was absent. Other than seminal works, few standardised approaches to triangulation or praxis examples that offer a working template have been published. *A piori* sample complementarity was not considered as a pre-requisite during the development stage of the organisational case analysis, albeit this was achieved.	Dissemination of the research protocol used in this research to summatively synthesise component results via triangulation to determine convergent validity is recommended to add to the limited literature. *A priori* sample complementarity and investigator triangulation should be factored in during the planning stages of any future similar research.

It is important to assert when discussing the limitations of the organisational case analysis that it is not a mixed-method research study. Mixed-methods research is limited by attempts to reconcile paradigmatic difference, by being defined purely by quantitative and qualitative methods and methodologies, by attempts to homogenise terminology and procedure, by polarisation regarding method primacy, and by a more iniquitous weighting towards more quantitative methods (Fàbregues et al., 2021). The feminist methodological stance adopted within the organisational case analysis dispenses and contrasts with these considerations by ascribing parity to and valuing paradigmatic, ontological, and epistemological difference. Feminism instead embraces different methodological perspectives and methods, reconciling these via a process of democratic dialogue to enhance objectivity, understanding and validity.

However, whilst this equality, value and democratic dialogue can be embraced with good effect on a micro-level within a piece of research like the organisational case analysis, dissemination and acceptance beyond the research is problematic. For feminist research to have true value and meaning and to be ascribed due importance, a wider, societal democratic dialogue is required (Longino, 1993). The very existence of feminist methodology paradoxically indicates that this is simply not yet the case. Even within a supposedly democratic society like the UK, bias, primacy, and exclusion are readily evident (Kendall, 2020) and especially so within psychiatry (Taylor, 2022). Whilst not a limitation of the organisational case analysis per se, the adopted feminist methodology, the plurality of the methods deployed, and the convergent validity achieved may not be ascribed due importance or value in an iniquitous society or a field dominated by the paternal positivist discourse of medical psychiatry.

There are also limitations that apply directly to the method of organisational case analysis. Very few praxis examples of organisational case analysis being deployed to determine treatment efficacy are evident in mental healthcare or healthcare in general. The adopted method is more typically used in business, education, government and NHS management and governance to test and further develop policies or strategies. There is very limited praxis literature about its use to determine the impact and efficacy of healthcare treatments. Its use in psychiatry to determine treatment impact and efficacy is therefore novel, theoretical, and exploratory and very likely to be contentious.

The direct proportionality between number of components and strength of convergent validity in organisational case analysis is also problematic. Considerable time and effort and numerous iterations and thesis re-writes were required before a cohesive structure and order for presenting the

organisational case analysis emerged. With little available guidance, the researcher found this process unwieldly. This was exacerbated by the need for the thesis to be the researchers work, precluding the possibility of additional investigators and investigator triangulation to lessen the investment needed in comparison to a single investigator. Farmer et al. (2006) suggest that two research components may be sufficient to triangulate. However, this would not have provided the comprehensive evaluation of C-Co the organisational case analysis provides and would not have facilitated a pragmatic investigation of all the different facets of data routinely generated by C-Co and would therefore have considerably reduced objectivity.

Due to a lack of praxis guidance the researcher did not fully appreciate the importance of *a priori* consideration of Denzin's (1978) four types of triangulation when planning the organisational case analysis. Sample complementarity and uniformity of data source across components is an example of this. The organisational case analysis is therefore limited as the researcher's praxis understanding of the method evolved and grew over the course of doctoral study as he became more experienced.

Greater use of organisational case analysis to determine the impact and efficacy of psychiatric treatments in HS contexts is recommended. As proven within this research, organisational case analysis surmounts many of the barriers that are traditionally associated with conducting rigorous and valid HS research. *A prior* consideration of Denzin's (1978) four types of triangulation in the planning stages of organisational case analysis is also recommended as is the adoption of a feminist and facet-based methodology to provide an equitable means of reconciling paradigmatic difference whilst increasing potential objectivity. The publication and dissemination of praxis examples of deploying organisational case analysis to research treatment impact in healthcare are also recommended.

6.5 The Impact of the Research on the Researcher

Oddly, this final part of the thesis was possibly the hardest to write - there was a part of the researcher that did not want the research to reach its conclusion and end. Whilst there is admittedly a strong sense of relief, there is also a sense of sorrow for the researcher that his thesis journey is reaching its conclusion. Engaging in doctoral study and writing this thesis have allowed the researcher to reflect, take stock, and consolidate both his professional and personal journeys, and better appreciate how the two are inexorably linked. He is indebted to his university mentors and viva examiners for supporting and guiding this journey. The doctoral journey has been a long one

that had its inception on a psychiatric unit nearly 30 years ago. Through the doctoral and research process the researcher feels like he has almost come full circle and feels more whole than he previously did. It has helped him to frame his journey, has given him time to reflect and understand it, has allowed him to fully appreciate and develop his methodological position, has helped him develop a greater appreciation of the emotional drivers within him that motivate him to challenge dominant medical psychiatric discourses and develop more efficacious treatments, and importantly, it has given him the skills, knowledge, language, evidence, and confidence to make such challenges. His doctoral studies have also resulted in publications, conference presentations, collaborations, and awards, as a well as international travel - experiences he would have been unlikely to have had without. His doctoral studies also contributed to him becoming a Consultant Nurse and more recently a Secretary of State Approved Clinician. Poignantly, the researcher was recently asked if he would support the development of a non-medical AC for the unit in which 'On Being Assessed' took place and is now helping the NHS Trust concerned to recruit and develop a non-medical approved clinician deployment and training strategy. There was a moment when the researcher considered putting himself forward for the role, however travel times and family considerations precluded this.

'On Being Assessed', and its dissemination via journal publication and conference presentation, whilst demonstrating impact and value beyond its purpose within the thesis, perhaps typifies how the researcher has changed and grown because of the research. He has always had some awareness that his own experiences of psychosis and health dissonance and his need to help others have been influential emotional drivers within his life and career but did not quite realise just how seminal. The autoethnographic research has enhanced this understanding and insight, allowing him to better appreciate, understand and illustrate these drivers and their effect on his methodological perspective and on him as a person, patient, researcher, and healthcare professional. The powerful effect the dissemination of 'On Being Assessed' also seems to have had on others typifies and perhaps illustrates this impact.

The researcher was extremely nervous when he first presented 'On Being Assessed' at conference and he is indebted to his friends, colleagues and most importantly his wife for supporting him and for being there. Throughout his career he has rarely disclosed his own experiences of psychosis for fear of further alienation and stigmatisation. The research journey has substantially lessened this fear. In it he has found a voice and the skills and knowledge to have that voice heard. The conference presentation, which to the researcher's surprise was delivered to a full room of

healthcare professionals and service-users, proved to be a poignant moment that facilitated growth, catharsis, and validation. It also led to a heated verbal and physical exchange between another presenter and delegates resulting in a subsequent apology from the President of Malta, the patron of the conference and the country's emergent service-user movement.

The previous presenter, a Maltese psychiatrist, stood up immediately as the researcher finished his presentation and declared to the audience that: *'One swallow does not a summer make!'*. The psychiatrist proceeded to vociferously, and loudly, critique the presentation as anecdotal and therefore meaningless in the context of 'modern' evidence-based psychiatry. The researcher felt that the ensuing ruckus, which involved the psychiatrist physically attempting to prevent delegates leaving as his frustration at others' dismissal of his argument grew, may well have been the moment the foundling Maltese service-user movement found its voice. The researcher also felt that it poignantly illustrated the tension and dissonance that continues to exist within mental health care between qualitative and quantitative epistemologies and ontologies.

The penultimate illustration of the final version of the autoethnography offered within the results chapter of this thesis is of a photograph of the researcher crouching on the John Lennon memorial in New York next to the word 'Imagine'. It was taken whilst the researcher was presenting abroad, made possible by his doctoral studies, and was taken by his wife. The last illustration is of a photo of the researcher's family. Both photographs represent the epilogue of 'On Being Assessed'. Whilst training as a psychiatric nurse in the 1990's the researcher observed that patients were often directly told by psychiatrists and nurses that psychosis was a lifelong condition, that they would need to take antipsychotic medication for the remainder of their lives, a career would be difficult, and that having relationships or a family would be unlikely or at best problematic. The writing and dissemination of this thesis have helped to confirm to the researcher that this is just not the case, nor should it be – we should all imagine. The aim of the organisational case analysis has been to research the gains that might be possible from imagining better HS CBTp services.

© Slater - Taken by the researcher's wife on a stopover in New York when the researcher was presenting at the XIV Annual Meeting of the International Association of Forensic Mental Health Services, Toronto 2014.

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APPENDICES:

A1: Documents Relating to Ethics Approval.

- Categorisation of the Research as service Evaluation (Taking Steps Pilot and Main Research)
- Local ethics approval from the research site Clinical and Audit Service Evaluation Meeting
- Approval from the research site Clinical Director
- Ethics approval from the University of Derby Social Care Research Ethics Committee

Redacted due to personal data liked to emails

Redacted due to personal data liked to emails

From: Kruppa Ilona **Subject:** RE: CASE submission

Happy to endorse in CD capacity. Template wouldn't let me type the date in the date box so I've added it next to my name instead.
Ilona

Ilona Kruppa
Clinical Director, Mental Health & National Learning Disability Directorate
Associate Director of Psychology, Forensic Services
Consultant Clinical and Forensic Psychologist

From: Middleton Luke
Sent: 20 July 2016 14:24
Subject: RE: Record Keeping Audit 2016

Hi Jonathon,

There is normally no formal correspondence follow a project receiving approval at the Clinical Audit and Service Evaluation (CASE) meeting. Although, following the presentation of your service evaluation proposal at the Clinical Audit and Service Evaluation meeting on Monday 11 July 2016, I can confirm that the group approved the project. Please see the extract from the minutes below:

4.1 Chief Complaint Orientated Cognitive Behaviour Therapy for Psychosis in Conditions of High Security: An Organisational Case Analysis – Jonathon Slater

Jonathon Slater presented the proposal to the group and explained that he had discussed the project with Shirley Mitchell prior to it being tabled at this meeting. Jonathan stated that he would like questions, queries and the group's thoughts on this project.

Jonathan explained that the project will look to identify themes and stated that an earlier version of this project had been tabled at the predecessor to CASE. The aims of the project are to evaluate the impact of Chief Complaint Orientated Cognitive Behavioural Therapy for Psychosis (C-Co) in High Secure (HS) forensic environment; specifically the Psychological therapies in the Mental Health Services.

To achieve these aims the study proposes to apply organisational case analysis to routinely generated data in order to offer a multi-modal analysis of C-Co impact with regard to the study hypothesis. Questionnaires will also be used as part of an iterative process to initially help participants reflect on their CBTp experiences.

Jonathan was asked about the sample that would be used for this project. The group were informed that the samples are included on section 6 of the proposal document. Jonathon went on to explain that the pilot produced good effect size. However, he may look at increasing this slightly.

It was highlighted that the proposal detailed a clear time plan. Jonathon confirmed that this had been produced to create a realistic timeframe. However, he would like to complete the project quicker than stated, if possible.

Jonathon confirmed that he had received feedback from Ilona prior to tabling the project at the CASE meeting and that there is an email from Ilona confirming that she is happy to endorse the project. Jonathon had also added to the proposal how data will be stored and considerations relating to specific study compounds following correspondence with Ilona. The project had also been through Dave Mason and Helen Watkinson.

The group had no issues with this project and it was agreed that it was approved.

Please could you send the Clinical Audit Department a copy of the report once the project is complete so we can add this to the portfolio of service evaluation projects completed at Rampton Hospital. Additionally, if you feel that the above extract does not provide a true representation of your proposal, I will be happy to make any amendments as advised.

Kind Regards

Luke Middleton
Clinical Audit Support

Dr Paula J Holt
Dean

Kedleston Road, Derby
DE22 1GB, UK

Approved

Date 24/11/16

Name: Jonathon Slater

Dear Jonathon

Topic: Chief Complaint Orientated Cognitive Behavioural Therapy for Psychosis in Conditions of High Security: An Organisational Case Analysis.

Thank you for submitting your application to the College of Health and Social Care Research Ethics Committee. Your study has been approved.

If any change to the study described in the application dated 25th October 2016 or to the supporting documentation is necessary you are required to make a resubmission to the Health and Social Care Research Ethics Committee.

We will also require a review of the progress of the study and notification of completion of the study for our records.

All the best.

Yours sincerely,

Lorraine Henshaw
Chair, Health and Social Care Research Ethics Committee

A2: Permissions for Reproducing Previously Published Works within the Thesis Submitted for Examination.

- Permission relating to Slater 2014
- Permission relating to Slater and Townend 2016
- Permissions relating to Slater and Painter 2016
- Permissions relating to Slater 2020

From: Peter Elliott
Sent: 14 June 2023 13:30
Subject: Re: CBT Today
Hello Jonathon
Thank you for getting in touch. Certainly, you do have permission to reference the work, and use sections within your thesis.
Good luck with the completion of your studies.
All the best
Peer
Peter Elliott

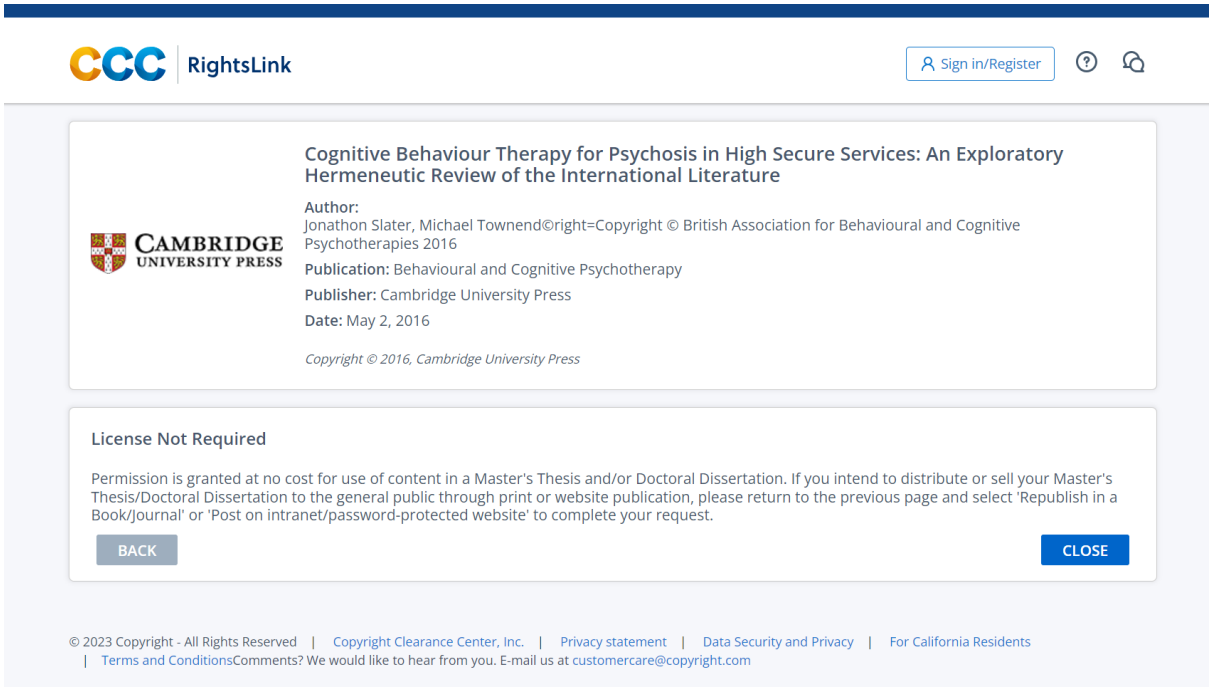
From: Jonathon Slater
Sent: Wednesday, June 14, 2023 12:19 PM
To: BABCP
Subject: CBT Today

Dear Mr Elliot

I am a doctoral student at the University of Derby in my final year. As part of my doctoral studies I have been encouraged to submit for publication. One comment piece linked to my thesis was published in CBT Today (please see below). With permission I would like to reproduce the article in full within the appendices of my thesis and to also include extracts from the published work within the main thesis text. I wasn't quite sure from the BABCP website who to approach about this so please forgive me if I have approached the wrong people – any signposting would be very much appreciated. Thank you in advance for your kind response.

SLATER, J. (2014) CBT for Psychosis in a High Security Environment CBT Today Vol. 42, No. 3, p.9

BWs Jonathon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Cognitive Behaviour Therapy for Psychosis in High Secure Services: An Exploratory Hermeneutic Review of the International Literature
Author:
Jonathon Slater, Michael Townend©right=Copyright © British Association for Behavioural and Cognitive Psychotherapies 2016
Publication: Behavioural and Cognitive Psychotherapy
Publisher: Cambridge University Press
Date: May 2, 2016
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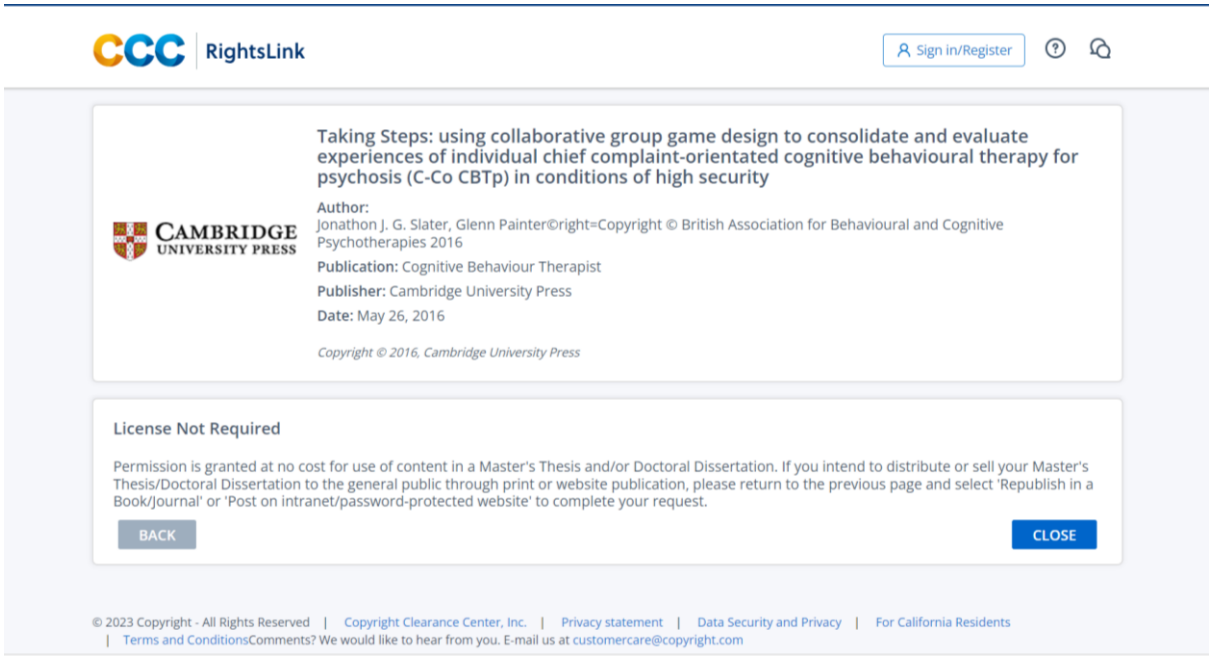
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Taking Steps: using collaborative group game design to consolidate and evaluate experiences of individual chief complaint-orientated cognitive behavioural therapy for psychosis (C-Co CBTp) in conditions of high security
Author:
Jonathon J. G. Slater, Glenn Painter©right=Copyright © British Association for Behavioural and Cognitive Psychotherapies 2016
Publication: Cognitive Behaviour Therapist
Publisher: Cambridge University Press
Date: May 26, 2016
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From: Mhn Editor **Sent:** 26 June 2023 19:26
Subject: Re: Thesis permissions

Hi Jonathon

Thanks for your email.

I'm happy to grant permission as requested.

Thanks

Phil

Editor, Mental Health Nursing

On Wed, Jun 14, 2023 at 12:09 PM Jonathon Slater wrote:

To whom it may concern:

I am a doctoral student at the University of Derby in my final year. As part of my doctoral studies I have been encouraged to submit for publication. One such article was published in your journal (please see below). With permission I would like to reproduce the article in full within the appendices of my thesis and to also include extracts and images from the published works within the main thesis text. Thank you in advance for your kind response.

- SLATER, J. (2020) On being assessed…An autoethnographic exploration of being assessed by psychiatric services: A service user and nurse perspective. Journal of Mental Health Nursing Vol. 40, No. 4, pp. 13-18.

BWs Jonathon

A3: Full Copies of Published Articles (Reproduced with Permission within the Thesis Submitted for Examination).

- Slater 2014
- Slater and Townend 2016
- Slater and Painter 2016
- Slater 2020

Whilst these articles were included in the thesis submitted for examination, except for Slater and Townend 2016 which is already available on UDORA, permissions did not extend to open access thesis publication. For reasons of copyright and ease, article links have been provided as an alternate. Pagination has remained unchanged from the examined thesis

- Slater 2014
  CBT Today Back Issues – BABCP

- Slater and Townend 2016
  Cognitive behaviour therapy for psychosis in high secure services: An exploratory hermeneutic review of the international literature

- Slater and Painter 2016
  Taking Steps: using collaborative group game design to consolidate and evaluate experiences of individual chief complaint-orientated cognitive behavioural therapy for psychosis (C-Co CBTp) in conditions of high security | the Cognitive Behaviour Therapist | Cambridge Core

- Slater 2020
  On being assessed… An autoethnographic exploration of being assessed by psychiatric services: A service user and nurse perspective | Mental Health Nursing Aug/Sep 2020

A4: NICE (2009; 2014) CBTp Guidance Summary developed by the researcher.

National Institute for Health and Care Excellence (NICE) **Psychosis and schizophrenia in adults: treatment and management** (Clinical guideline 178, issued February 2014)

A Summary of the NICE Guidance Relating to the Provision of Cognitive Behavioural Therapy for Psychosis (CBTp).

The guideline covers the treatment and management of psychosis and schizophrenia and related disorders in adults (18 years and older) with onset before 60 years. The term 'psychosis' is used within the guideline to refer to the group of psychotic disorders that includes schizophrenia, schizoaffective disorder, schizophreniform disorder and delusional disorder. Psychosis and schizophrenia are defined within the guideline as:

'…a major psychiatric disorder (or cluster of disorders) in which a person's perception, thoughts mood and behaviour are significantly altered. The symptoms of psychosis and schizophrenia are usually divided into 'positive symptoms', including hallucinations (perception in the absence of any stimulus) and delusions (fixed or falsely held beliefs), and 'negative symptoms' (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect). Each person will have a unique combination of symptoms and experiences.' – p. 4

The guideline stipulates that:

- CBTp must be offered to all people who are at risk of developing psychosis *(1.2.3.1)*
- CBTp must be offered to all people with psychosis or schizophrenia during the acute phase and later, both in inpatient settings and in the community (*1.3.4.1 & 1.4.4.1*)
- CBTp must be offered to all people with persistent positive and negative symptoms of psychosis and schizophrenia (*1.5.4.1*)
- CBTp must be offered to all people in remission from psychosis to further promote recovery (*1.5.4.1*).
- CBTp must be offered to all people who wish to engage in treatment but who do not wish to use anti-psychotic medication (*1.3.4.2*)

It is important to note that the current guideline stipulates that CBTp must be 'offered' rather than purely 'considered' as was the case in some earlier guidance. The current guideline also stipulates that individuals wishing to try psychological interventions alone must be advised that these are more effective when delivered in conjunction with anti-psychotic medication.

The guideline also specifies a format for CBTp (*1.3.7.1*). It should:

- Be delivered on a 1:1 basis over a minimum of 16 planned sessions
- Follow a treatment manual
- Include:
  - the development of a supportive empathic relationship
  - partnership working
  - people monitoring their own thoughts, feelings or behaviours with respect to their symptoms or recurrence of symptoms
  - promoting alternative ways of coping with targeted symptoms
  - reducing distress
  - improving functioning
- Focus on promoting and sustaining recovery
- Be regularly reviewed for impact
- Be tailored to each persons unique combination of symptoms and experiences
- Be delivered and regularly supervised by a therapist/healthcare professional and supervisor with an appropriate level of competence.
  - Standards for safe and effective CBT practice are set, accredited and governed by the British Association for Behavioural and Cognitive Psychotherapies (BABCP).
  - The evidence base for CBTp has been established by a mix of accredited and non-accredited professionals
  - There are guides relating to general and problem specific CBTp training competencies available online
  - GC178 stipulates that Trusts should provide access to training which equips healthcare professionals with the required competencies.

A5: Consent Forms.

- Single Case Analysis Consent Form
- Participant Experiences of C-Co Consent Forms
- Practitioner Perspectives of Delivering C-Co Consent Forms

Single Case Analysis Consent Letter:

Dear ******

I am currently undertaking a doctorate at the University of Derby.

My doctoral studies are about how we might make CBTp better by looking at what impact it currently has.

My studies include providing a practice example of Chief Complaint Orientated CBTp, the therapy you have engaged in.

With your permission I would like to use an anonymised version of your therapy report as this example. It will be included in my thesis. My thesis is the piece of written work I must submit to the University of Derby to gain my doctorate.

The case example in my thesis will also include additional details of your therapy experience that are not in your therapy report like examples of some of the behavioural experiments we conducted and examples of some of the voice work we engaged in.

I will show you the case example I put in my thesis to make sure you are happy with what I include. Anything you are not happy with I will exclude.

Content from my thesis may also be published in health-related journals. Anything that is published will be made completely anonymous. Your name will not appear, and no one will be able to link the data in the case example or any publication to you.

If you consent for me to include your therapy report and additional details in my thesis, please sign the enclosed consent form. Alternatively, I am happy to meet with you and discuss this further or simply please let me know that you do not wish to give your consent. If you chose not to consent this will not in any way prejudice your progress or the care that you receive.

You will notice that the consent form is in two parts. One for you to sign and one for your Responsible Clinician to sign. If you decide to consent, I will also approach your responsible clinician, as the person responsible for your care for their consent.

Many thanks for considering.

Best wishes.

Single Case Analysis Consent Form:

I agree and consent for my therapy report and additional details from my engagement in Chief Compliant Orientated CBTp to be included in Jonathon Slater's doctoral thesis as part of his academic studies with the University of Derby.

I understand that any information relating to me in Jonathon's thesis will be made anonymous.

I understand that Jonathon will show me the case example he puts in his thesis to make sure I am happy with what he includes. Anything I am not happy with Jonathon will exclude.

Delete as appropriate - I understand and consent to the publication of anonymised content from Jonathon's thesis that relates to me in health-related journals.

PRINT NAME:

SIGNATURE:

DATE:

Responsible Clinician countersignature:

As the above patient's Responsible Clinician, I agree to the patients information being used in the manner expressed above:

PRINT NAME

SIGNATURE:

DATE:

The CBTp Evaluation Group Consent Form
Part I: Pre-Group

You are invited to take part in a group. The group aim is to evaluate what it has been like to experience Cognitive Behaviour Therapy for Psychosis. The group hopes to achieve this by developing a monopoly type board game which reflects participants' experiences. The group will involve contributions from both patients and practitioners. Evaluating people's experiences of therapy is an important part of understanding the impact of that therapy. This understanding can be used to help consolidate people's therapy journeys. It can also help providers develop therapy to better meet the needs of those involved. However, you do not have to take part and are under no obligation to do so - not taking part will not prejudice you in anyway, nor will deciding to leave the group once you start.

If you do decide to take part the group will involve the following:

- Setting some group rules to make sure everyone feels safe and able to contribute
- Completing a short questionnaire about your CBTp experiences
- Seeing if there are experiences you want to be part of the game and sharing these with the group
- Developing pictures to represent your experiences
- Writing descriptions of the pictures you've developed, explaining how the pictures reflect your CBTp experiences
- Producing game boards with your pictures on
- Working with others to agree an order to game boards
- Working with others to develop a way of moving around the boards
- Playing the finished game and reflecting on what it's like.

Possible benefits from being involved in the group include having a chance to reflect on and share your therapy experiences and developing a board game together to reflect those experiences. Whilst its hoped there won't be any risks to taking part in the group or harmful effects, support will be available from either Jonathon, ******, your supervisor or line manager in the case of practitioners or any member of your care team for patients, should you feel upset by the group in anyway.

At the end of the group there will be a discussion about how the game might be used once the group has finished. If the group decide others may benefit from playing the game, then further consent will be sought from group members for this. Content from the group may also be published as part of academic studies being undertaken by Jonathon and in health related journals. In this event all content will be made anonymous so as to protect your confidentiality. If you have any questions please ask either Jonathon or ********.

If you agree to take part in the group, then please read and sign the consent statement below and we will contact you with information about when the group will start. If you have any questions to ask that might help you make your decision then please ask either Jonathon or ******. Thank you for taking the time to read this and for thinking about joining the group.

I agree to take part in the CBTp Evaluation Group and consent to any related materials, once these have been made anonymous, being used to evaluate and publicise the impact of the CBTp Service and being used as part of Jonathon's academic studies.

Name: (Please print your name)

Signature: (Please sign to indicate consent with the above statement)

Date:

Responsible Clinician counter-signature where appropriate:

Name: (Please print your name)

Signature: (Please sign to indicate you consent for the above to be involved in the evaluation group)

Date:

CBTp Consolidation Group: Consent Form.

The group facilitators (Jonathon Slater and Glen Painter) would like to offer others the opportunity to experience the work you have contributed to Taking Steps and ask your permission to use the materials you have developed. We believe Taking Steps has the potential to offer others an amazing insight into CBTp and offer assurances that any materials used will be made anonymous. If you agree to give your permission, then please read and sign the consent statement below. If you have any questions to ask that might help you make your decision then please ask either Jonathon or Glen. Thank you for taking the time to read this and for thinking about giving permission for others to experience the work you have completed.

I consent to my contribution to Taking Steps and the related materials I helped develop being used to offer others (including patients, carers and associated professionals) an experience of what Cognitive Behavioural Therapy for Psychosis in conditions of high security can involve:

Name: (Please print your name)

Signature: (Please sign to indicate consent with the above statement)

Date:

I am currently undertaking a doctorate at the University of Derby. My doctoral studies are about how we might make C-Co CBTp better by looking at what impact it currently has.

My studies include exploring the impact on practitioners of delivering C-Co CBTp

With your permission and consent I would like to record one of our supervision sessions where we focus on the impact of C-Co CBTp on you. The recording will be transcribed, and a thematic analysis of content completed with the transcripts from other practitioners who have also consented to take part. The thematic analysis and anonymised extracts from the transcripts will be included in my doctoral thesis. All information will be anonymised.

The analysis may also be published in a health-related journal. You are not under any obligation to consent and not consenting will not prejudice your role as a CBTp practitioner. You may withdraw your consent at anytime up until the thematic analysis is complete.

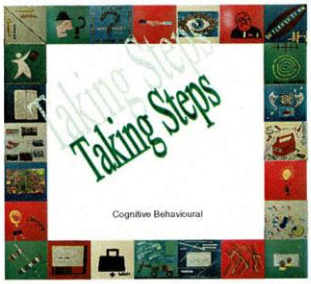
- Please sign below it you wish to consent to the above.
- Please print your name and date.

Signature agreeing to consent to the above:

Print name Date:

A6: Feedback from people who have played ‘Taking Steps’.

- Taking Steps Feedback Form
- Feedback from the GL-SIG
- Feedback from the NICE Annual Conference 2016



Feedback Card

Your comments about Taking Steps are very much appreciated and will be fed back to the people who developed and designed the boards. In the spirit of Taking Steps, written and pictorial representations of your Taking Steps experience are welcome. Thank you.

FEEDBACK CARDS
GL-SIG Responses

- A very innovative tool to demonstrate how therapy can be fluid (go back and forth). I feel that its use of individual's thoughts/artwork brings power back to the individual.

- Really enjoyed the format and the way it combined real accounts from patients. Very enthusiastic experience. Going backwards feels physically regressive, going forward feels like progress. Would like to make it into a real multi-linear narrative. You could develop a card game or use android to prototype a game system.

- Very nice – like they physically of the game. As mentioned to one of the guys, my recommendation would be to take away the "move forward " spaces, "move backward" spaces and instead work the cards so they work more like a "choose your own adventure", ie you land on a card, read it, and then can choose from 3 or 4 options what happens next. The results would take the patient to numbered squares – this would also allow for repeated experiences, positives and negatives. Also, I think the "text heading" boards should be replaced with more image-based boards. If made in foam mats, puzzle pieces would also help to make it feel more like a game.

- For me, Taking Steps was an engaging way to learn about Cognitive-Behavioural Therapy for psychosis. I'm not sure I would want to "gamify" the game as it is because it could make light of a serious process. I enjoyed reading into the pictures and found the true patients or practitioners words a reward in themselves.

- Very interesting experience, unlike anything I've done before. It really does feel like I gained an insight into the therapy process and the associated feelings from both sides. I am wondering about using the creating element to the boards with students to encourage reflection on skills development. It could be a very valuable tool if made digital and available to a wider audience of people involved with CBTp and their families, though the personal nature of the artwork may make this difficult.

- From a theoretical perspective, this is interesting as it is <u>technically</u> not a game, more a playful intervention (the participants don't have choice or control, but the narrative is used as a discussion point). This ties in with theories of play, safety and the "Magic Circle" (can give you references). Thanks (love to talk more).

- Fantastic, colourful insight that really makes you think. I imagine it is extremely useful for carers. It would be great to have more control of our journey – more options – possibly scenarios, etc. Maybe also guess if it's a practitioner or a patient. It was more fun doing it in a group – not sure how I'd feel individually. Would be great online, but I do really like the physical nature of it.

- This is a game with great potential. I liked the active moving around the board. I think if it had more interaction you could better engage the players. At the moment, it's quite prescriptive. There is no choice of chance, which is a key ingredient of a game. A "chase your own adventure" style element would work well, or completing the game

from a practitioner's perspective if you are a patient, etc. Something that allows the player an element of control.

- Doesn't seem like a game – no chance, skill, no meaningful choices. Maybe that's the point – maybe it's not important. I wonder how much extra is gained from the experience of making the game for the patients that were involved in that. Not always clear where the squares are from the point of view of patients or practitioners. How much is added by physically moving around the space? Great reference: Book of Lenses by Jesse Solelle. There is a set of cards too and I think they are available as an app on some mobile platforms.

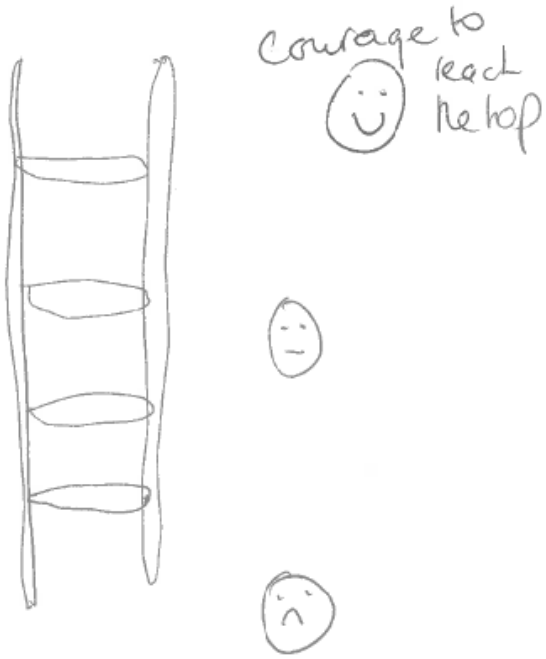
- Was confused when squares were from a practitioner perspective as cards all said, "You Stick to Patient Viewpoint". Not really a game, but that's OK. Add an element of chance, otherwise the journey keeps going backwards whatever I do, feels depressive. Blame it on the dice instead? Simplify graphics like "new horizons" - why all the colour? We looked for meaning that wasn't there. Our journey skipped 10 of the squares. Are these not relevant? I want to walk on the squares, otherwise why have big floor tiles?

Taking Steps feedback from the NICE Conference 2016

"Worth promoting to family and carers so they know the challenge their loved one has engaged with."

"Great art!"

"Offered me courage to reach the top."



"The CBT game was very helpful in enlightening us as to how it would feel to go through this process."

"The 'Taking Steps' board journey provided a useful insight into the journey of patients in CBT. I think of a treatment pathway as a circle, but this has reframed my thinking."

"Loved the graphics and the accompanying material. I hope the designers have gained insight through their hard work producing this "game" that will be invaluable to peers, staff and carers."

"Excellent! I think it would make a "family" board game with a little more thought. I feel it could be marketed and sold, maybe to help mental health charities or/and promote mental health awareness and wellbeing."

"Helped me to "ground" what the process is like for a person and the anxieties they might feel."

"It was great to see that the person's fears can be overcome and they can realise they are not being judged."

"I think being set free from shame and guilt is huge for the individual's breakthrough. I guess I didn't know it was possible to get to that core place in a person and help them walk free."

"An interesting process."

"I like the way some of the "steps" are insights into the way, not just people suffering with psychosis, people think, but how everyday people might think in new/scary situations."

"It's good to see that the experience of the practitioner has an effect on treatment too."

"A very well thought out programme which clearly leaves no stone unturned."

"I found the explanation of the thoughts behind the pictures really helped me understand how the person was feeling at that point in the process."

"Great way of explaining the process of CBT to allow the supporting network to be effective."

"Thought the board was a very practical way to explain the journey through CBT."

"Felt, as I was reading about what was being said, it could be applied to other forms of development."

"Can a deaf person be involved in this Cognitive Behavioural Therapy?"

"I feel that this shows how up and down a patient goes through on their pathway to recovery."

"The board shows the negative and positive times of how patients are feeling. This would benefit patients on their pathway to recovery."

"This game, to me, is very therapeutic."

"Really good. I think the squares are a great idea. It helped me to understand."

"It is really great. It imparts the real complexities of doing CBT or any therapy with the moves forward and backwards. As discussed, I think we should share it within the Trust, but get it translated into a board game that could be used widely."

"I really enjoyed the activity. The pictures and stories were extremely helpful and made me more aware of patient difficulties. It made me more aware of the obstacles patients' face when doing therapy (ambivalence, being able to manage their feelings, being open and testing their beliefs). It also made me aware of the obstacles the CBT programme therapists deal with (patients wanting different therapists, containing patients' fears, etc). One of the stories I read on the cards was very empowering."

"I like that the facilitators have also been able to share their experiences, positive and negative (challenges). I think patients will feel reassured hearing other stories/experiences prior to starting any future CBT programme. Can be powerful! Possibly a future idea for the game? Very visual and good representation of experiences through therapy."

"Good method to visualise the steps and reflections of different individuals (therapists and clients) as they progress through CBT. Good learning tool for professionals and potential clients who may attend CBT - shared/reassurance from experiences."

"So insightful and honest! Shows how different each person's experience really is. 'Fears' will help encourage both professionals and patients."

"I'm entertained and informed! Very good! Conveyed lots of information, but in an engaging way. Demonstrated the two steps forward and step back process well. Pictures interesting."

"It took me a little while to get how to work/play the game. I really liked the pictures and how they represented individual's expectations, experiences and achievements. It was a great way of seeing a CBT programme's journey."

A7: Awards and Feedback from Awards.

- Koestler Trust Awards for the Arts 2015 – Platinum Award certificate and feedback.
- National Health Service Outstanding Service Contribution and Recognition Scheme 2016, Winner of the Innovator of the Year Award certificate
- National Service User Awards 2018, winner of the Service Users' Award – hand sewn plaque.


KOESTLER AWARD FOR THE ARTS

KOESTLER PLATINUM AWARD

This is to certify that the person named below has submitted original, creative work to the Koestler Awards, the annual national awards scheme for excellence in the arts. The work has been chosen for a Platinum Award by the Koestler Trust's panel of experts, in recognition of its exceptionally high standard. This is the Trust's highest level of award and is given to work displaying outstanding talent. The Trust sends warmest congratulations on this extraordinary achievement.

THIS CERTIFICATE IS PRESENTED TO

JONATHON SLATER

ARTS PROJECTS

TAKING STEPS ARTS PROJECT

The Koestler Awards were established by the writer Arthur Koestler in 1962 to encourage participation in the arts, and to award and showcase innovative work.

[redacted]

Dame Anne Owers
Chair of Trustees

[redacted]

Tim Robertson MA MSc
Chief Executive

Koestler Trust
for the arts

168a Du Cane Road
London W12 0TX
Registered charity No. 1105759
www.koestlertrust.org.uk

Koestler Trust
for the arts

Koestler Awards 2015 Feedback

K number: 9569 Establishment: Lampton

Artform: **61: Arts Projects**

Title of work : Taking Steps

Feedback from judge:

'A Journey' is a fantastic idea both in terms of the collaborative production and development of the game and towards being a useful and innovative tool. The scale + beautiful mixing of the game we found to be hugely successful and that the game will continue to be used was a major factor in 'Taking Steps' being awarded the 'Platinum Award' Congratulations! Amazing work.

Judge(s) in this category:

Louise Shelley	Collaborative Projects Curator at The Showroom Gallery, London, where she runs a programme called Communal Knowledge developing collective arts projects around questions of social injustice and political arts practices.
Gemma Latty	Gemma is Exhibitions Assistant in the British Council's Visual Arts Department and works primarily on international exhibitions of British art. Previous projects include Anish Kapoor's first solo exhibition in India; British Pavilion exhibitions at the Venice Biennale in 2009, 2011; and most recently Sarah Lucas in 2015.

Please do not contact Koestler Awards judges, they will not enter into any correspondence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NHS
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Jonathon Slater
for the
Innovator of the Year Award
Congratulations and thanks from
Dean Fathers
Chair
Ruth Hawkins
Chief Executive
OUTSTANDING SERVICE CONTRIBUTION & RECOGNITION SCHEME 2016
Sponsored by
KNIGHTSBRIDGE
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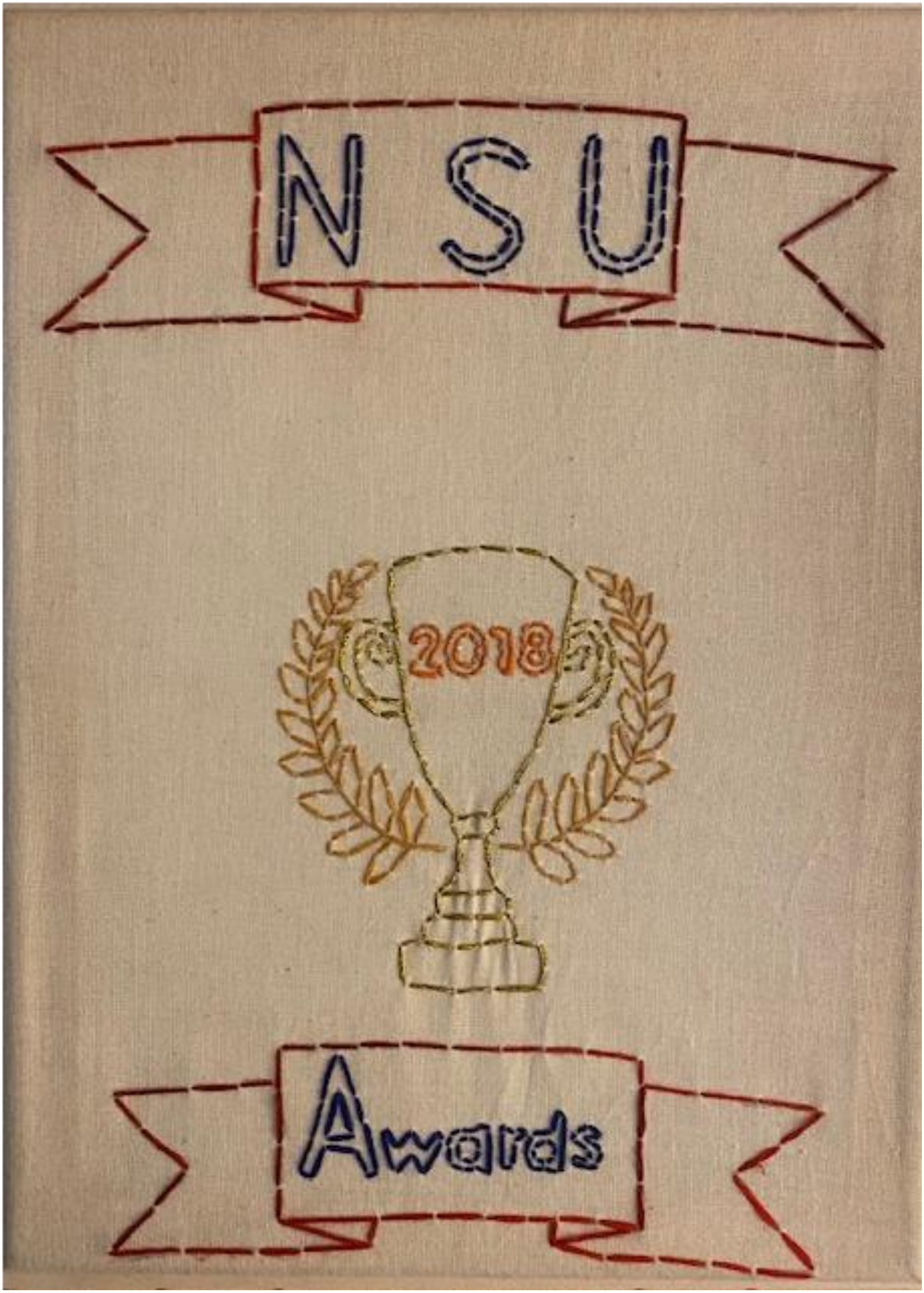
NSU
2018
Awards

A8: **redacted**

redacted as contains personal information