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Developing a Cognitive-Behavioural Therapy Treatment Programme Designed to Promote Hopefulness and Self-Esteem in Mental Health Service Users Recently Diagnosed with a Psychotic Illness

A Pilot Study to Explore Service-Users' Experiences of Accessibility, Engagement and Efficacy

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Abstract

Background

This study sits within a wider research agenda, the aim of which is to develop a novel psychological therapy programme designed to target hopelessness and compromised self-esteem in young people recently diagnosed with a psychotic illness. The aspiration is to develop a programme that is experienced as accessible and engaging and perceived to be of value. It is anticipated that that process will progress through several stages and a number of iterations. The primary objectives of this specific piece of research were to undertake a first piloting of the Therapy Programme, gather evaluative feedback from participant-service users, and fine-tune the approach. The secondary objective was to explore the perceived value of the programme with regard to 'proof of concept'.

Method

The research design combined the methodological rigour of Interpretative Phenomenological Analysis with a mixed-methods focus on data, underpinned by the philosophical paradigm of critical realism. Quantitative data was collected through the completion of outcome measures pre, during and post-therapy. Qualitative data was gathered through the facilitation of semi-structured feedback interviews with participant-service-users shortly after the completion of each of their Therapy Programmes. Participants were followed-up at 2 years from the commencement of their therapy to ascertain the subsequent trajectory of their lives and to explore reflections on their experiences of the programme from a perspective of temporal distance.

Findings

Eight Early Psychosis Service clients were recruited to receive the Therapy Programme. Three withdrew from the therapy. Another completed the Programme, but failed to complete all of the research requirements. One completer-participant experienced a psychotic relapse shortly before the end of therapy. The principal purposes of the research were the elicitation of critical reflections on the Therapy Programme and meaningful recommendations for its improvement. There was some evidence of reticence amongst participants regarding the expression of critical statements. Where more critical observations were expressed, they focussed primarily on the relative balance and chronological ordering of different elements. The consensus recommendation was for the ‘pure’ elements of the approach, including direct attention to the cognitive-constructs of hope and self-esteem, to proceed the consideration of more applied goals. There was a strong collective recommendation to allocate more attention to addressing unhelpful illness narratives. A Participant Handbook, written as a resource for those involved in the therapy, was positively received with regard to design. Participants, however, recommended significant change to the complexity of its content.

Of the four completer-participants, three showed substantial improvements in reported hope, self-esteem and wellbeing over the period in which the therapy was delivered. Those gains were sustained at follow-up. The participant who experienced a psychotic relapse showed limited improvements on all measures at the end of the treatment period, but had progressed significantly at follow-up. In each case, reported scores on the outcome measures were supported by substantial success in negotiated life-goals. Participant feedback regarding the programme, post-therapy and at follow-up, was generally very positive, with all participants identifying causal connections between the therapy, achievement of therapy and life goals, and subsequent improved outcome scores.

Limitations

To accommodate a priority focus of qualitative data, participant numbers were small and there was no access to normative or comparative data for the service user population. The limitations of the sample size were compounded by a high rate of attrition. The delay to follow-up introduced additional confounding variables. As a consequence of the study-design, therefore, quantitative data can only be regarded as providing indicative evidence of reported improvements across the measures of wellbeing. It cannot be said to evidence a causal connection between therapy and identified improvements or to support statements regarding the efficacy of the approach. Finally, although participants were recruited explicitly to be collaborators in the evaluation and betterment of the Therapy Programme, reflections appeared to be somewhat biased towards a validation of the approach and critical evaluations, although present, were limited. The credibility of these observations is, further, undermined by the design-decision to have the therapist conduct the post-therapy feedback interviews.

Conclusions

The primary objective of the research was to generate meaningful recommendations for the improvement of the Therapy Programme. That purpose was achieved. The secondary objective was to consider the programme with regard to ‘proof of concept’. Subject to the limitations detailed above, the level of improvement reported over the period in which the therapy was offered, together with the fact that those gains had not been lost at follow-up, tentatively supports an argument for further development of the programme.

Chapter 1 – Introduction

This research has been concerned with the amelioration of hopelessness and low, or compromised, self-esteem as it is experienced by individuals recently diagnosed with the first onset of a psychotic crisis or illness. Throughout this thesis this period in the person's difficulties with ill-health will be referred to as Early Psychosis. The term First-Episode Psychosis (FEP) will be employed to denote the diagnosis. Negativity about oneself (low self-esteem) and about the future (hopelessness) have been identified as trans-diagnostic. They occur in conjunction with numerous mental and physical health problems, as well as being linked to difficulties experienced in the fields of athletics, academia, social and vocational functioning. Significant to this project, they have both been implicated in the experience of psychosis – (i) contributing to aspects of vulnerability and the triggering of the onset of illness (Bell and Wittkowski, 2009), (ii) manifest within the primary symptomology of the condition (Chadwick, Birchwood and Trower, 1996; Fowler, 2000; Freeman, Garety, Fowler, Kuipers, Dunn et al, 1998), (iii) consequent to the trauma of illness (Berry, Ford, Jellicoe-Jones, and Haddock, 2013; Jackson, Trower, Reid, Smith, Hall et al, 2009; Lu, Mueser, Shami, Siglag, Petrides et al 2011), (iv) central to the illness-narratives which shape experiences of stigma (Corrigan, Watson and Barr, 2006; Yanos, Roe, Markus and Lysaker, 2008) and (v) frequently cited as having primary proximal relevance to issues of prognosis, including, both, recovery and suicide risk (Fialko, Freeman, Bebbington, Kuipers, Garety et al, 2006; McGee, Williams and Nada-Raja, 2001; Yanos et al, 2008).

This thesis describes the development and preliminary exploration of a novel, complex, psychological intervention designed to directly and conjointly target these attitudes, or experiences, of negativity when encountered in Early Psychosis. The intervention was presented and explained in a handbook that was written specifically for, and provided to, the participants in the study. In the following pages the intervention is referred to as the '***Therapy Programme***' and the written resource as the '***Participant Handbook***'.

The research agenda, including primary and secondary research questions, is discussed in detail in the following chapter. The purpose of this introduction is to set the scene for the research. It covers four areas -

1. The roots of the author-researcher's interest in this field of experience and the genesis, therefore, of the research programme.
2. The theoretical assumptions which have underpinned the preliminary development of the Therapy Programme and which define the relevance of the research undertaken.
3. The structure of this thesis with regard to the ordering, purpose and content of the chapters.
4. Issues of language, style and inclusion, the early understanding of which has been deemed important to facilitate the reader's engagement with the text.

1.1 Roots of the Research Programme

The author-researcher works in the field of Early Psychosis. Issues of hopelessness and compromised self-esteem are overtly manifest (endemic) amongst those diagnosed with a psychotic illness and especially so where that diagnosis has been made more recently. Prior research undertaken by the author, linked to a Masters level training, focussed on the Hope-Hopelessness dimension of this complex. An awareness of the relationships between attitudes to self and the future in this circumstance emerged as an unexpected outcome of that research (Pearson, 2006). The centrality of importance of the relationship between attitudes to self and the future became increasingly apparent to the author following completion of that earlier study and his subsequent attempts to develop and implement strategies for the amelioration of the hopelessness experienced by his clients (Pearson, 2010). The commitment to the research described in this thesis was a direct consequence of those experiences in clinical practice.

1.2 Key Theoretical Understandings

This work was underpinned by a complex of three understandings and three beliefs. The term ‘understandings’ is used in this context to denote a perspective that has a significant level of evidentiary support and some consensus of agreement amongst researchers within the field. In other contexts, these might be referred to as facts. In contrast, the three ‘beliefs’ are articulated primarily with reference to theory and are less well supported by evidence from prior research. These two terms have been chosen purposefully to reflect the language of critical realism, the philosophical paradigm that has underpinned the research, which promotes a balancing of perspectives of likelihood with regard to truths, with the belief that all such knowledge is constructed and situated. This paradigm encourages the researcher to embrace a critical stance towards the concept of factual or objective truth and to employ a tentative language in discussion of evidence, position or outcome.

The first ***understanding*** *is that a significant proportion of individuals who have recently been diagnosed with the first-onset of a psychotic illness or crisis are likely to experience negativity in their attitudes to themselves (self-esteem) and to the future (hope)* (Fornells-Ambrojo and Garety, 2009; Warman, Lysaker, Luedtke and Martin, 2010).

There exist interventions that have been developed specifically to address hopelessness or low self-esteem amongst other service user populations (Fennel, 1997, 1999; Hearth, 1990, 2000; Korrellboom, 2007; Snyder, 1994, 2000a), *and the second* ***understanding*** *is that it should, therefore, be possible to develop and deliver a psychological therapy, designed to offer the same benefits to those diagnosed with First Episode Psychosis.*

The third ***understanding*** *is that the specific therapeutic paradigm of Cognitive-Behavioural Therapy (CBT) can provide an effective overarching framework within which to develop such a treatment programme* (Fennel, 1997; Snyder, 1994). That last statement does not exclude the possibility that other paradigms might lend themselves appropriately to this task. Neither does it make any claims that CBT would be the best organising framework in such an undertaking. It simply proposes that there might be space within the formulatory approach of CBT to develop a hope- or self-esteem-targeted programme for this client group.

*The first **belief** of this research is that there is likely to be a proximal and reciprocal relationship between thoughts about oneself and about one's future*. In terms of mental health and therapeutic need that would suggest that individuals who experienced low or fragile self-esteem would be likely to feel less hopeful about their personal futures and those who experienced despair regarding their future would be likely to be more critical of themselves in the present.

*The second **belief**, following directly on from the first, is that changes to the experience of one, hope or self-esteem, would be likely to impact on that of the second – an association that might work with regard to, either, improvement or deterioration.* In terms of psychological therapy, it might be reasonably predicted, based on this, that any intervention which increased the person's sense of self-esteem would be likely to, also, promote a greater sense of hope for the future, and vice versa.

*The third key **belief** is that, an intervention strategy which addressed hope and self-esteem in concert would be likely to be, both, more effective and more efficient than one that addressed them separately.* This belief refers specifically to the idea that there has been a substantial overlap in the pre-existing therapies offered to address hopelessness and low self-esteem (Fennel, 1997, 1999; Hearth, 1990, 2000; Korrellboom, 2007; Snyder, 1994, 2000a) and that much of that duplication might be reduced by delivering them in coordinated concert.

1.3 Structure of the Thesis

The thesis is presented in 9 chapters.

Chapter 1 introduces the purpose and organisation of the thesis as a whole.

Chapter 2 articulates the research question – including its place within a wider research agenda.

Chapter 3 sets the clinical context for the development of the intervention. It briefly describes the diagnosis of Early Psychosis, including considerations with regard to primary symptomology, development or progression of the illness, aetiology and prognosis. In addition, it details the structure of the specialised services that have been commissioned in England to address the unique needs of this client population.

Chapter 4 is a review of the relevant literature. It is presented in seven parts - (i) An introduction to the process of the literature review, (ii) The trans-diagnostic prevalence of hopelessness and compromised self-esteem, (iii) Hope and self-esteem in Early Psychosis, (iv) Conceptualisations of hope and self-esteem, (v) Previous intervention-research for hope and self-esteem in Psychosis, (vi) Previous intervention-research for hope and self-esteem in related health fields, and (vii) Learning points and recommendations.

Chapter 5 introduces the new Therapy Programme whose piloting and improvement has been the focus of the research discussed in this thesis. It is presented in two parts - (i) An introduction to Cognitive Behavioural Therapy as the organising therapeutic paradigm, and (ii) An overview of the content and delivery of the novel Therapy Programme.

Chapter 6 describes the research methodology. It is, also, presented in two parts - (i) A delineation of the central architecture of the research design (research questions, paradigm, methodology and data-form) paying particular attention to the coherence of their integration, and (ii) A description of the pragmatics of the research process, including the minutiae of decisions made with regard to the operationalisation of the philosophical and organisational apparatus detailed in relation to processes of participant identification and recruitment, and the collection and analysis of the quantitative and qualitative data. This section also includes a discussion of the research process with regard to considerations of ethics, credibility and generalisability.

Chapter 7 describes and discusses the qualitative and quantitative data generated by the research process. Although the research questions, and consequent design, prioritised the qualitative elements of the process, the quantitative data is examined first.

Chapter 8 discusses the findings from the research. It explores emergent observations in relation to the aspirations and purposes of the study, with comparative reference to the ideas and outcomes presented in prior hope- and self-esteem-targeting intervention-research. It, also, examines the research itself with recursive consideration of the constructive processes entailed, including a critique of the approach in relation to questions of credibility, validity and generalisability. It is worthy of note that, the research was undertaken within the context of an academic training. Consequently, this discussion accommodates a concern with the researcher's own experiences of learning alongside attention to the subject matter and the process of doing of the research.

Chapter 9 presents conclusions with regard to the significance of the research outcomes, the likely implications for development in clinical practice and directions for further research.

It is important to appreciate that, although the ordering of chapters in this thesis suggests a logical and chronological progression, each chapter contained here actually represents a captured moment in the iterative dialogue between theory and research. Ideas presented in the conceptual analyses, literature review and research design have been shaped by the experience of undertaking the research and the outcomes arising from that endeavour - a reciprocity of understanding and behaviour.

1.4 Language, Style and Inclusion

As noted above, this research agenda emerged from prior exploration by the author into the subject of ‘Hope in Early Psychosis’ (Pearson, 2006). That earlier study gave rise to a model or formulation of hope (Pearson, 2010 - see Chapter 4) which implicated self-esteem as a key mediating factor. Given that history, in each of the chapters in the thesis, considerations regarding hope are examined before those relating to self-esteem. When the research project was first posited the terms ‘Hope’ and ‘Self-Esteem’ were included and these remained central to the various reviews of literature, the defining of the intervention and the applications for Ethical Clearance to be allowed to undertake the study. For that reason, those terms have taken precedence in the writing of this thesis. In much of the reviewed literature, however, the term ‘hope’ has been used interchangeably or synonymously with ‘hopelessness’ and with the ‘optimism-pessimism’ complex, and self-esteem interchangeably with ‘self-concept’, ‘self-worth’, ‘self-belief’ and ‘self-confidence’. Although there are clear definitional differences between the various pieces of language, within this thesis they are largely regarded as overlapping considerations. It is worth noting that, although all of the literature made available for client-participants referred to self-esteem, in every case those individuals instinctively adopted instead the language of ‘self-confidence’.

Finally, the research has been organised within the philosophical framework of critical realism, which aspires towards an understanding of ‘what is’, but also recognises the role of the person of the observer in the co-construction of what is experienced. That paradigm is discussed briefly with regard to the literature review (Chapter 4) and, in much more detail, in relation to the design and delivery of the research (Chapter 6). In the context of that philosophy it could be legitimately argued that the thesis might be written either in the first-person (the perspective of ownership) or in the third-person (the perspective of implied objectivity). For the purpose of consistency, and to avoid the confusion of a mixed-economy of styles, the third-person has been used throughout the thesis, except in that section of the discussion which deals with the personal learning journey of the researcher. It is, however, important to bear in mind when reading this thesis that the author was, also, the researcher, the developer of the Therapy Programme and the research therapist. The significance of those multiple intersecting roles is explored in in Chapter 7 with regard to the co-constructive processes of the emerging story of the research ‘outcomes’, and in Chapter 8 with reference to the limitations of the research design.

Chapter 2 – Research question

It was noted in the introduction that the research described in this thesis has been concerned with the development of a novel, complex psychological intervention (the Therapy Programme) whose target focus is the amelioration of hopelessness and compromised self-esteem in Early Psychosis. The Medical Research Council (Craig, Dieppe, Macintyres, Michie, Nazereth and Petticrew, 2008) have offered recommendations with regard to the stages or processes that need to be followed in the development of any complex treatment programme or intervention.

1. A preliminary identification of the parameters of the intervention with reference to appropriate theory and evidence from prior research.
2. Consultation - preferably with representative service users, as well as relevant professionals.
3. Examination of acceptability and fine-tuning of the approach through pilot testing of the intervention.
4. More extensive intervention research involving control and other comparison groups - moving from single to multi-site research and, therefore, extending beyond the personality / style of any one individual.

Although the authors have been careful to emphasise that these stages should not be seen as linear, they do acknowledge that there is a natural progression implicit in their articulation.

The processes of preliminary identification of the parameters of the intervention and consultation (Stages 1 and 2 above) were undertaken prior to the development of the research strategy described in this thesis. The relevant reviews of the literature are considered in Chapter 4. The multi-layered process of consultation, however, has been reported in a previous course-related development paper (Pearson, 2013) and has not been revisited in the thesis. The study discussed in this report has been concerned with the initial testing out of an early version of the Therapy Programme (Stage 3 above), for the purpose of improving its structure, content (including the Participant Handbook) and style of delivery. That principle purpose has been articulated in the form of two primary research questions -

1. ***How is the Therapy Programme experienced by participant-clients as it is currently constructed and delivered?***
2. ***What thoughts or recommendations might be offered by participant-clients for the improvement of the Therapy Programme?***

Each of these questions has been further subdivided into 3 component parts, relating to - (i) the content and structure of the Therapy Programme, (ii) the Process of delivery of the Therapy Programme, and (iii) the Participant Handbook.

Access to outcome data, pursued routinely as part of the treatment approach, has offered triangulating information with regard to how the Therapy Programme might have been experienced. In addition, that data, together with information regarding demographic characteristics of participants, has allowed some limited consideration of questions relating to accessibility, engagement and the achievement of therapy goals - key aspirations in the development of any new complex intervention. In this context – 'Accessibility' is defined in terms of availability, cost and understanding (linguistic and conceptual) and is measured with regard to recruitment, whereas 'Engagement' concerns the experience that the person has of the Therapy Programme, the importance that they accord it and their commitment to seeing the process through to the end.

These considerations have been articulated in relation to five secondary research questions.

1. ***With regard to accessibility, what patterns might emerge from an analysis of the demographic characteristics of those individuals who participated in the research, in comparison with those who were invited to take part, but declined?***
2. ***With regard to engagement, what patterns might emerge from an analysis of participant demographics, outcome measures and other available information in a comparison of those participants who completed the therapy and those who did not?***
3. ***With regard to the goals of therapy, what individual and collective changes in reported hopefulness, self-esteem and wellbeing might be identified over the period during which participants receive the Therapy Programme?***
4. ***To what extent might any changes in hopefulness, self-esteem or wellbeing be sustained following the completion of the Therapy Programme?***
5. ***To what extent, and in what ways, might any recorded changes be said to be clinically significant?***

In any research endeavour concerned with the development of a new health intervention considerations of accessibility, engagement and value are likely always to be important. It is argued that that position has validity even when the data generated is unable to support authoritative conclusions. The design of the study described in this thesis was such that it was not anticipated that these secondary questions would be addressed in depth and it is important to emphasise that they have, therefore, been principally concerned with description rather than interpretation. The primary research-emphasis on the gathering of qualitative feedback required that participant numbers be very small. Consequently, it was accepted that the statistical power of any analysis of quantitative data would be extremely poor and, in particular, too limited for this study to generate any conclusions regarding nomothetic efficacy or generalisation. Furthermore, given the principle research purposes described, the research design did not include a control condition, which, it was understood, would restrict the making of causal associations between participants' engagement in the therapy and any changes reported verbally or through completed outcome measures. Questions of accessibility and engagement have been examined along with the findings relating to the employed outcome measures, but specifically with reference to their relevance to the experiences of research participants and primarily for the purpose of identifying aspects of the Therapy Programme in need of improvement. Where quantitative data has been considered collectively, the focus has been on the question of whether further development of the programme could be justified - ‘proof of concept’.

Finally, it is to be noted that Ethical Approval to undertake the research was awarded by, both, the University of Derby Ethics Committee and NRES East Midlands. Letters attesting to those approvals are included as Appendix 1.

Chapter 3 – Early Psychosis

3.1 Introduction

This chapter is concerned with establishing the clinical context for the development of the new Therapy Programme in terms of the target audience - users of mental health services, recently diagnosed with a psychotic illness who were experiencing considerable negativity in their evaluations of self and the future. The chapter is written in 2 parts, covering, respectively –

1. The nature of Early Psychosis, with reference to encompassed diagnoses, core or common symptomology and considerations of aetiology, progression and prognosis.
2. The structure and content of the specialist service provision in England for those diagnosed with Early Psychosis.

3.2 The Nature of Early Psychosis

3.2.1 Diagnoses and Symptomology

The term ‘psychosis’, as it is employed in this research, is not, in and of itself, a diagnosis of mental illness, but rather a category heading, encompassing a number of distinct and definitive diagnoses, including, though not limited to, Acute and transient psychotic episode, Schizophrenia, Schizo-affective disorder, Drug-induced psychosis, and Delusional disorder (ICD10, WHO, 1992). The term is, also, employed to describe the most striking symptomology that might be regarded as common to those diagnoses and can be used to refer to comparative experiences encountered in other mental health conditions. In the period following the first manifestation of a psychotic illness presentation can evolve considerably and it can be difficult to determine a differential diagnosis with confidence. It is not uncommon for opinions as to diagnosis to change several times in these early stages, and it has been recommended that clinical staff allow some time for the picture to stabilize before committing to a definitive diagnosis (McGorry, 2004). The term ‘psychosis’ is often employed during this time as a general ‘catch-all’ to reflect the nature of experience and to sign-post to appropriate services.

Those conditions that might be referred to as ‘psychotic’ are all characterised or defined by ‘evidence’ of compromization to the person’s sense of reality. That disconnection from reality is most commonly presented in the form of disorders of perception (hallucinations) and / or disorders of thinking (delusions or thought disorder). With regard to both perceptions and thoughts an experience can only be described as representative of psychosis if it reflects a considerable change from the person’s previous character, attitudes or manner and is not consistent with their personal, familial, cultural or spiritual background. The most frequently reported hallucinations are auditory, defined as the experience of hearing a noise in the absence of an appropriate external stimulus (Strangellini and Cutting, 2003). The most prevalent auditory hallucinations are the ‘hearing of voices’ (Jones, Hansen, Moskvina, Kingdon and Turkington, 2010; McCarthy-Jones, 2012). There is evidence to suggest that persons can hear ‘positive’ voices, that are clearly hallucinatory, in the absence of any other symptoms of mental ill-health. For those who present to statutory mental health services, however, the natures of these experiences are inclined to be more negative in nature, with a tendency to derogatory, abusive and threatening content (Romme and Escher, 1989, 1993). The most frequently observed forms of delusion in the psychoses are paranoia and grandiosity. Paranoia is the belief, in the absence of externally validated evidence, that others are acting to attack the person. It has been hypothesised that there are two distinct variants of paranoia reflecting, respectively, the experience of deserved punishment (bad-me paranoia) and undeserved persecution (poor-me paranoia) (Chadwick, Birchwood and Trower, 1996). Grandiose delusions are defined as false beliefs about having inflated worth, power, knowledge or a special identity, which, again, must be firmly sustained despite undeniable evidence to the contrary (WHO, 1992).

These psychotic symptoms, or phenomena, are generally referred to as ‘positive’ in that they reflect experiences that are visible in addition to, or overlaid on top of, ‘normal’ functioning. Persons diagnosed with certain psychotic conditions, in particular schizophrenia, might also experience ‘negative’ psychotic symptoms. The term ‘negative symptoms’ is employed to reflect a loss of ‘normal’ functioning, for instance, loss of emotion, energy and motivation, as well as retardation to thought, speech and action (ICD10, WHO, 1992). These primary symptoms of psychosis are, also, almost invariably accompanied by secondary or comorbid mental illness or mental ill-health. That might include, in particular, depression and anxiety (especially social anxiety) as well as, often, a resort to unhelpful life-choices, such as substance misuse and self-harm (Birchwood, 2003; Russo, Levine, Demjaha, Di Forte, Bonaccorso et al, 2014; Upthegrove, Birchwood, Ross, Brunett, McCollum and Jones, 2010). There is, also, increasing evidence of links to trauma and the experience of Post-Traumatic Stress Disorder, either as a contributing factor to the onset of the psychosis or as a response to the experience of that onset itself (Berry et al, 2013; Jackson et al, 2009; Lu et al, 2011; Varese, Smeets, Drukker, Lieverse, Lataster et al, 2012).

3.2.2 Illness Progression, Prognosis and the Critical Period

In the early stages of the onset of a psychotic condition, the illness tends to be episodic or tidal - acute crises being followed by periods of recovery. During recovery positive symptoms will generally reduce and often disappear. It is common, however, for negative and secondary symptoms, such as low mood, high anxiety, poor motivation, reduced self-care and poor concentrate, to remain problematic. This can interfere with the person’s ability to re-engage with life, to reconnect with friends and acquaintances, to return to study or work and to manage their day to day activities (Phillips and Francey, 2004; Siddle and Haddock, 2004).

People vary considerably, both, in their symptoms and problems and in the course or prognosis of their illness. Some individuals will only experience one episode of psychosis. Others will be subject to recurrent crises. For this latter group each crisis can leave a residue of unresolved psychological trauma and social deficit. Those feelings can compound over subsequent and repeating experiences to the point that those who have had multiple episodes can begin to experience psychotic symptomology on a continuous basis. This transition from episodic to ongoing experience can occur earlier in the life of the illness in some than in others. Evidence suggests that there is a critical period of approximately 3 years following the commencement of the psychotic illness wherein events or experiences have the potential to disproportionately influence the long-term prognosis for the person (Birchwood and McMillan, 1993; Birchwood, McGorry and Jackson, 1997). This period is likely to encompass the strongest elements of psychological trauma, the undermining of sense of self, self-confidence and trust, the first significant interruption of vocational or educational careers, as well as damage to familial and social relationships. Over this early period unhealthy coping strategies can begin to take root, and unhelpful secondary beliefs progressively harden. This singularly significant time is generally referred to as ‘Early Psychosis’ or ‘First-Episode Psychosis’ (FEP).

The term ‘psychosis’, as noted, covers a number of different diagnoses, the prognoses for each of which might be quite different. The World Health Organization (Jablonsky, Sartorius, Ernberg, Anker, Korten et al, 1992) suggest that, for instance, in Schizophrenia the majority of people will recover from the first acute crisis, but that only 20% will recover fully. Most others, they suggest, will improve but have recurrent episodes or relapses. Some, they predict, will struggle to achieve much recovery at all. There is considerable evidence to suggest a very close relationship between those who respond best during the first three years (Early Psychosis) and those with the most productive long-term outcomes. It is important to note, however, that the WHO figures are based on the illness-trajectories of individuals diagnosed in past generations, prior to the recent development of more specialized mental health services, targeted towards the wellbeing of Early Psychosis service users.

3.2.3 Aetiology

There has, historically, been considerable contention in the field with regard to the question of aetiology (causation), in particular in relation to the degree that responsibility has been located in the biological, psychological or social beings of the person. Current thinking amongst mental health theoreticians, researchers and clinicians tends to support complex, multi-dimensional formulations, which integrate bio-medical understandings of genetic predisposition and affected biochemistry with a psycho-social focus on the unique experiences of the person (Henry and Ghaemi, 2004). This 'bio-psycho-social' perspective does not require any commitment to homogenic assumptions, but, rather, promotes the possibility of variation from person to person in the balance of influence of these elements. Within this framework, therefore, the picture for some might be most strongly shaped by a family history of mental illness, whilst for others there might be a more significant link to pre-morbid psychological distress or struggles with social belonging.

The most highly accepted bio-psycho-social explanation is the 'stress-vulnerability' or 'stress-diathesis' model (e.g. Lecomte, Leclerc and Wykes, 2016; Nuechterlein and Dawson, 1984; Nuechterlein, Dawson, Gitlin, Ventura, Goldstein et al, 1992; Nuechterlein, Dawson, Ventura, Gitlin, Subotnik, 1994; Zubin and Spring, 1977). At its most simple, the model proposes an interaction between a pre-morbid vulnerability (or potential to developing a psychotic illness) with the occurrence of a provocative stress or trigger. This is often presented as shown in Figure 3.1 below. The framework suggests that, whilst everyone might have a degree of potential to developing a psychotic illness, some might have a higher level of vulnerability than others. Where vulnerability is lower the degree of 'stress' required to trigger a crisis, moving from being 'well' to being 'ill', might be extremely high. When vulnerability is greater, the level of stress required would be much less. Early interpretations of this model tended to emphasise biological vulnerabilities and psycho-social triggers (Zubin and Spring, 1977). Current thinking tends towards a combination of biology, psychology and social factors in relation to both vulnerabilities and triggers.

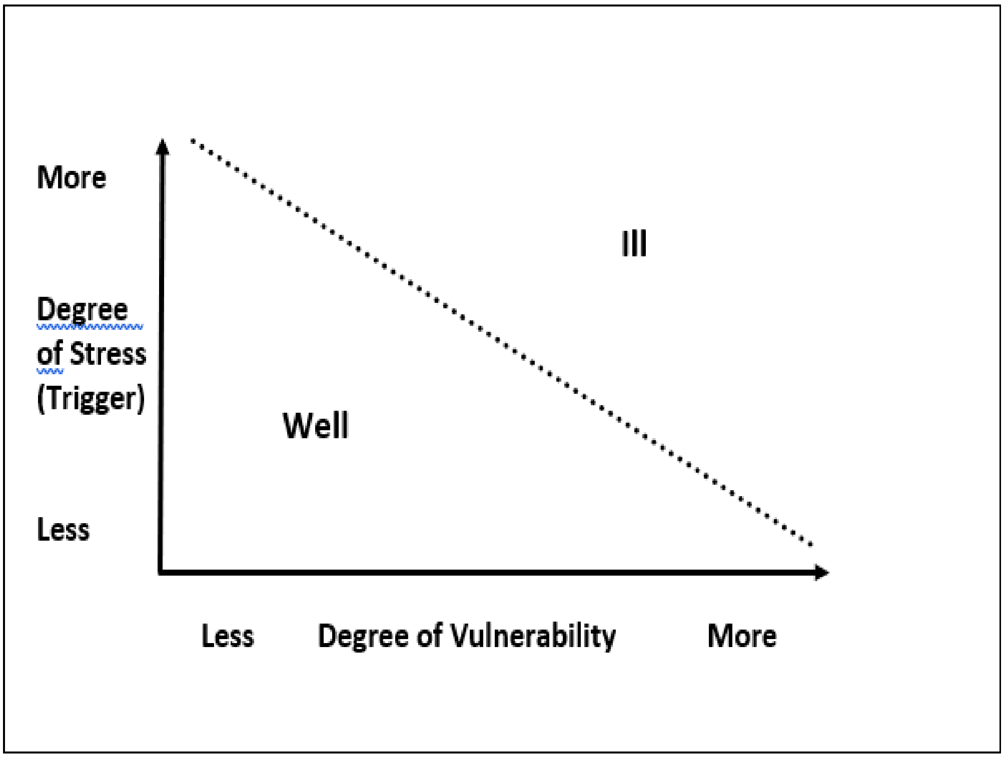


Figure 3.1 – Model of Stress-Vulnerability adapted from Zubin and Spring (1977, p110)

A more complex version of the model (Nuechterlein and Dawson, 1984; Nuechterlein, Dawson, Gitlin, Ventura, Goldstein et al, 1992) is presented in Figure 3.2 below. This model importantly acknowledges that (i) experiences can contribute to increased resilience (or protection) not merely to vulnerability, (ii) vulnerability and protective factors might reside equally in the person or their environment (including their social environment), and (iii) the experience of a psychotic crisis, and whether or how it is resolved, feeds back into those personal and environmental vulnerabilities and resiliencies.

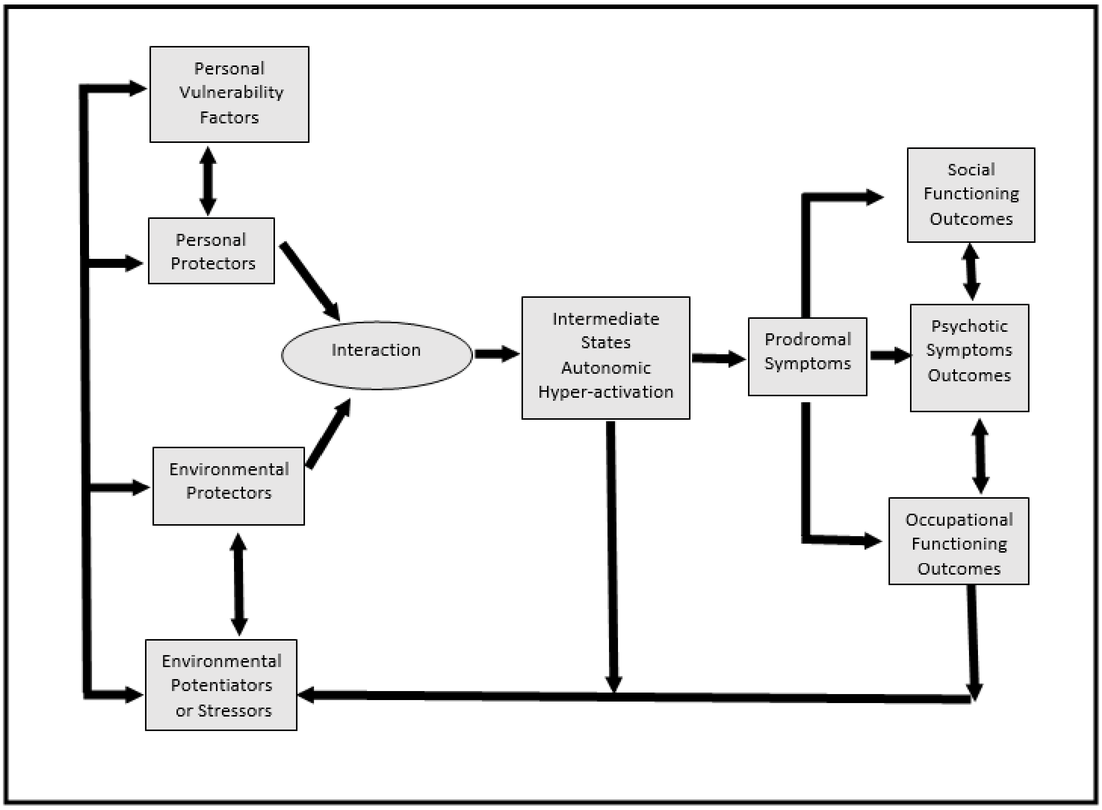


Figure 3.2 – Model of Stress-Vulnerability
adapted from Nuechterlein, Dawson, Gitlin, Ventura, Goldstein et al (1992, p392).

The bio-psycho-social model maps very closely to the distribution demographics of the psychoses with reference to age of onset, social migration, poverty and the distribution of wealth. In particular it accurately predicts highest rates of incidence at times of a ‘perfect storm’ of biological, psychological and social challenge. This includes, in particular, the time of transition from adolescence to adulthood (for both males and females), post birth and during menopause (for women), and, for both genders again, at the end of working life, with higher rates of bereavement and loss, as well as age-related physical health deterioration (Harrop and Trower, 2003).

3.3 Early Psychosis – Service Provision

The research that is described within this thesis was undertaken in a dedicated Early Psychosis Service.

3.3.1 The Shape of Early Psychosis Services

In 2004, policy was introduced in England which required a comprehensive provision of support to young people (14 to 35 years) experiencing the onset of a psychotic illness (DOH, 2001). This policy initiative was based on strong evidence regarding the disproportionate significance of the 'critical period' in determining the long-term prognosis of the individual, allied with criticisms of existing service provision. It was supported by National Institute of Health and Care Excellence (NICE) Guidance for the treatment of those diagnosed with Schizophrenia (2002). In the first instance this strategy was organized around the development of specialist 'stand-alone' Early Psychosis Services. More recently the ethos of these services has been reviewed, with a prioritising of outcomes over service structure. These outcomes have been defined in relation to a series of standards, including attention, both, to the speed of response and the quality of care provided (NICE, 2009, 2014). The provision of Cognitive Behavioural Therapy for Psychosis has been integral to this agenda throughout.

3.3.2 Early Psychosis Services - Treatment as Usual (TAU)

Participants of the research were recruited from amongst 'Users' of the specialist Early Psychosis Service within which the researcher-therapist was employed (see Chapter 6). The Therapy Programme was delivered in addition to Treatment as Usual (TAU). For clients supported within this service TAU was provided by a multi-disciplinary team. Service-users' care was coordinated by a Key-Worker (a registered mental health nurse or occupational therapist), and included the involvement of a Consultant Psychiatrist, as well as, as appropriate, Youth and Community Support Workers, Individual and Family Therapists. TAU is always tailored to the unique needs of each service user. In this service it would commonly involve medication, psychological intervention, support with regard to education and employment, opportunities for social engagement and attention to practical needs, such as finances and housing. This support is offered on a continuous basis over the period of the time during which any service user is ‘under the care’ of the specialist Early Psychosis Service. Provision of such complex packages of support for each research-participant was, consequently, ongoing during the course of their engagement with the Therapy Programme.

Within the contours of this service, the majority of treatment is provided on an ‘informal’, or voluntary, basis and ‘in the community’. Crises can result in admission to hospital, and on occasion the levels of risk might dictate that those admissions be compulsory – undertaken with respect to a section of the Mental Health Act (Parliament of the UK, 1983, amended 2007). On very rare occasions service users who have been treated in hospital under a section of the mental health act might be discharged on a Community Treatment Order, which requires non-voluntary compliance with all or part of any treatment programme offered. There is evidence to suggest that compulsory requirements to accept treatment are inconsistent with service users’ engagement with the care package or personal motivation towards collaboration. Those relationships appear to show qualities of recursivity (Kisely, 2016; Puntis, Rugkasa, and Burns, 2017).

NICE offers strong, prescriptive guidance regarding best practice in the treatments that should be provided with respect to both the primary symptomology of psychosis and those problems associated with secondary morbidity. Amongst other elements, NICE Guidance for Early Psychosis (2014), Depression (2004, 2009), Social Anxiety (2013) and Post-Traumatic Stress Disorder (PTSD - 2005) all recommend a course of Cognitive-Behavioural Therapy. In each case this would be regarded as a principle treatment, whether delivered in conjunction with, or as an alternative to, medication. Recommendations regarding the components and level of commitment of the course of therapy vary according to target condition and the specific model referred to. In particular the number of sessions recommended varies from a minimum of 8 (PTSD) to a minimum of 16 (Depression and Early Psychosis) to be provided, preferably, over a period of at least 4 months. For those clients involved in the research study the provision of the novel Therapy Programme was both ‘in addition to TAU’ and ‘compliant with’ the NICE recommendations regarding the required content of TAU.

3.4 Summary

This chapter has been concerned with establishing the clinical context for the development of the Therapy Programme and the undertaking of the study with which this thesis is concerned. It has examined the complexity of the diagnostic conditions that are included within the broad category of ‘psychosis’, the specific nature of Early Psychosis, the specialist structure of Early Psychosis Services and aspects of the particular host service from which research-participants were recruited. Questions regarding the value of addressing experiences of hope and self-esteem in those diagnosed with Early Psychosis are examined in the next chapter. There are, however, key issues of understanding and treatment of Early Psychosis which have had particular significance in the development of the new psychological intervention. These have included - (i) an appreciation of the model of stress-vulnerability, (ii) the impact of the person’s ‘illness narratives’, (iii) the complexity of interconnecting factors in the development and maintenance of the illness, (iv) the concept of relapse and relapse prevention, and (v) the significance of voluntary engagement in relation to questions of efficacy. Each of these elements is reflected in the structure of the Therapy Programme presented in Chapter 5, or the inclusion criteria for the research described in Chapter 6.

Chapter 4 – Hope and Self-Esteem – Prevalence, Conceptual Basis and Intervention-Research

4.1 Underpinning Philosophy and Methodology of the Literature Review

A central commitment in the progression of the research to which this thesis relates has been that it evidences paradigmatic and methodological consistency. It has been argued by a number of research-theoreticians that there are significant parallels between the processes of data capture and analysis relating to the investigation of literature and those applied to other forms of research (Bell, 2005; Bell and Opie, 2002; Burgess, Sieminski and Arthur, 2006; Hart, 1998, 2001; Lee, 2009; McLeod, 2001; Punch, 2005). It is important, therefore, to be explicit in identifying the philosophical paradigm that underpins the research-design and to apply it with equal rigour to the review of literature. The research has been organised with reference to the philosophy of critical realism. That paradigmatic position is discussed in detail in Chapter 6. It is described here in brief in order to orientate the reader to key elements of decision-making in the researcher's approach to the literature.

All research is informed (explicitly or implicitly) within and by a philosophy relating to the natures of knowledge (ontology) and of knowing (epistemology). Critical realism reflects a complex perspective of ontological realism and epistemological relativism (Archer, 1998; Bergin, Wells and Owen, 2008; Bhaskar, 1998; Clark, Lissel and Davis, 2008; Sayer, 1992, 1998, 2000). This posits the view that, whilst there is a 'reality out there', in which things exist, the experience of those things is shaped subjectively by the perceptual biases of the witness, the social processes by which they engage in meaning-making discussion about those ‘things’ (Burr, 1995), and the limitations and prejudices of the language that is used to try to encapsulate those experiences and understandings (Wittgenstein, 1953). There are a number of philosophies that are broadly consistent with this position. Critical realism has been adopted on the basis that it strives to offer a balancing of the risks and limitations of over-stating or under-estimating what can be known. It is defined with respect to two dimensions - ‘complexity’ and ‘construction’. The ‘complexity’ dimension suggests that all things are shaped by a multitude of intersecting factors, that can never be fully comprehended. In undertaking a review of the literature, this dimension promotes an argument for looking beyond the surface of authors’ conclusions and speaking tentatively in terms of likelihood, possibility and demi-regularity. The ‘construction’ dimension notes that whatever factors are at play, and whatever their ‘outcomes’, what is perceived represents a constructed dynamic between ‘what is’ and the perceptions, interpretations and social-storying of the observer. In the context of a literature review, this dimension proposes that attention be given to the subjectivity of the researcher-author’s relationship with their study-material, as well as the personal influences of the reviewer in their engagement with the literature, and with the imagined reader of their final report. Collectively, these two dimensions of critical realism encourage a shift in the review of literature from a search for truth to an examination of utility.

Shaw (2010) has noted that ‘conducting a literature review … ensures that there is a need for .. [the] .. project, that is, to answer previously unanswered questions.’ (p39). The research discussed in this thesis has been concerned with hopelessness and low self-esteem as experienced by those recently diagnosed with a psychotic illness or crisis. The task of the research has been the development of a new therapeutic intervention – the Therapy Programme. In the context of this project, therefore, the issue of utility, in terms of the literature review, relates to the question of whether the identified purpose of the research is justified. The chapter might, therefore, be said to be concerned with the two primary questions -

To what extent, and in what ways, might hopelessness and compromised self-esteem be regarded as meaningful and significant in the experiences of the service user population as defined?

To what extent are those experiences (needs) already being met; or could be met; by existing CBT-based psychological interventions?

The review of previous literature has had the additional purpose of contributing to the construction of the new Therapy Programme. This has been organised with reference to the secondary question -

What facets of existing intervention strategies might most usefully be incorporated into the new programme? This consideration has been progressed with reference to the composite questions - What seems to have worked? In what ways? What strategies or interventions might fit most coherently within the philosophy, time constraints and structure of the new Therapy Programme?

4.1.1 The Process of Reviewing the Literature

The relationship between the literature review and research agenda has been complex. The available literature was approached on numerous occasions over the course of the research process, shaping and being shaped by the research focus and specific questions. It was, however, explored in a more structured way at two distinct points - (i) Prior to the development of the new intervention and application for ethical approval to conduct the research, and (ii) Subsequent to the completion of the research, in relation to making sense of the study-outcomes, and in the writing and amending of the thesis.

First Review

The first extensive review of the literature was conducted in three stages – following a process of ‘funnelling-down’ from more general considerations to more specific. The first stage was concerned with establishing the breadth of relevance of the constructs. There was no structured or comprehensive search strategy implemented. The two terms, hope and self-esteem, along with associated language (e.g. hopelessness, self-confidence and self-worth) were explored within the University of Derby Athens system. There were, at this point, no additional, intersecting inclusion or exclusion criteria employed, as a consequence of which, the search generated an immense collation of articles. The intent at this stage was not to examine the material in depth, but rather to gather a sense of the importance of hope and self-esteem in relation to different conditions or circumstances (particularly with regard to health) and to identify some of the theoretical understandings and debates attached to the two concepts. This task was addressed through a process of absorptive saturation, with frequent interchanges between divergent exploration and convergent, direct questioning. Attention was given to broad themes and patterns. The second stage of this first review was concerned with exploring the relationships between hope, self-esteem and Early Psychosis. In the literature search, a ‘grid-pattern’ of these terms (and related others) was employed (see Table 4.1). As with the first stage of this first literature review, no attempt was made to capture all of the articles pertaining to these relationships. Greater depth of consideration was, however, given to material in order to develop a better appreciation of the theoretical understandings and their evidentiary bases. For this and subsequent searches the following inclusion-exclusion criteria were imposed.

> The ‘article’ was to be written in English and published in a peer-reviewed journal or as a part, or whole, of a book. ‘Unpublished’ material was not actively sought, but was examined when identified by the search and where immediately available to download as a complete document.

Table 4.1 – Literature Search – using combinations of terms relating to Hope, Self-Esteem and Early Psychosis

	Hope (Hope, Hopeful, Hopeless, Hopefulness, Hopelessness, Despair, Hoping)	Self-Esteem (Self-esteem, Self-image, Self-concept, Self-confidence, Self-worth, Self-efficacy)
Early Psychosis (Psychosis, Schizophrenia, Mental Illness)	*Hope and Early Psychosis terms*	*Self-Esteem and Early Psychosis terms*

The third stage of the first exploration of the literature was concerned with the development and evaluation of pre-existing hope- and self-esteem-targeting psychological interventions. The purposes of this review were - (i) to develop a justification for the venture with respect to the potential benefits of targeting hope or self-esteem directly, (ii) to identify gaps in the field, in particular in relation to questions of sustainability and generalisation across client populations, (iii) to explore the associations between claims of success and specific elements of intervention, and to consider what might be imported into a new strategy, and (iv) to create a map of performance (an 'evaluative standard') against which the new intervention might be compared. This review did not focus exclusively on the evaluation of interventions in the field of psychosis. In addition to the general criteria reported above, the more specific criteria for inclusion of an article were that -

> The intervention under consideration should be consistent with a cognitive-behavioural psychotherapy approach (CBT), and the study should have been directly and primarily concerned with improving hope or self-esteem, rather than changes in these aspects of experience being secondary to a focus on other symptomology or difficulties.

As before, searches were conducted using the University of Derby Athens system which simultaneously examined a number of available electronic data bases. A methodical 'grid-pattern' of key-word searches was employed (Table 4.2). Abstracts and titles were reviewed in relation to the combining of these various terms relating to hope or self-esteem with those relating to therapy. Where the title suggested the possibility that an article, book or chapter might meet the search criteria, abstracts were viewed for clarification.

Table 4.2 – Literature Search – using combinations of terms relating to Hope, Self-Esteem and Therapy

	Hope (Hope, Hopeful, Hopeless, Hopefulness, Hopelessness, Despair, Hoping)	Self-Esteem (Self-esteem, Self-image, Self-concept, Self-confidence, Self-worth, Self-efficacy)
Therapy (Therapy, Intervention, Cognitive Behavioural Therapy, CBT, Treatment).	*Hope and Therapy terms*	*Self-Esteem and Therapy terms*

If an intervention study was identified, the full text was obtained. The purposes at this stage of the review were to gather sufficient depth of evidence to - (i) answer the primary question of whether the planned therapy programme was justified, and (ii) provide information about the strategies or techniques that might be worthy of consideration with regard to the secondary question detailed above. It was adjudged that these purposes might be met by a comprehensive, but not 'systematic', search and review of the literature. Interventions that were deemed to be relevant were tracked both backwards and forwards, searching for previous studies and the roots of therapeutic techniques through direct attention to references, and following their influence into subsequent interventions and intervention studies through the citational records of 'Google Scholar'. Where interventions had been researched comparatively recently, authors were contacted directly with questions regarding unpublished reflections and observations, as well as ongoing or predicted future work.

From the earliest conversations regarding the development of the new therapy programme, there has been a commitment to ensuring a 'formulation-driven' coherence and consistency of approach. For that reason, the first review of the pre-existing intervention research was, also, particularly interested in the conceptualisations, formulations and theoretical understandings which underpinned the specific techniques or strategies employed. The tasks for that part of the review of literature were three-fold - (i) to examine the complexity and parameters of the field, (ii) to explore the underpinnings of the different interventions identified, and (iii) to provide the building blocks for an understanding of the concepts that might provide coherence and depth to the Therapy Programme under development. Where intervention-articles identified a particular conceptual basis (which was not the case on a surprising number of occasions), the review sought to explore that framework in the original, rather than rely on another's interpreted or re-constructed description.

Second Review

The second review of the intervention-research material was conducted in response to the outcomes of the research. It was progressed through three stages, from a narrow consideration of intervention-articles published in the period subsequent to the development of the trial Therapy Programme, through the inclusion of intervention-research relating to service users' narratives of self in relation to illness, and finally, to a methodical and comprehensive Systematic Review of empirical outcome studies. The Systematic Review considered the three key dimensions of the current research - (i) CBT-interventions, (ii) Hopelessness and / or Low self-esteem, and (iii) Psychosis. This last, most comprehensive, search and review paid particular attention to the question - 'To what extent are these experiences, or needs, already being met by existing CBT-based psychological interventions?' The review was significantly more detailed with respect to its focus than that carried out pre-research, and the limited, adjunctive post-research considerations, combined. The results of that search subsumed all intersecting material previously identified. The specific process of progressing the Systematic Literature Review is presented in section 4.5 (below).

The discussion of the literature in this chapter includes reflections on all of the material discovered. It is important, however, to emphasise from the outset that the development of the Therapy Programme that has been facilitated and explored in the current research was only informed by the pre-research reviews of the literature. Although the post-research reviews cannot be said to have shaped the iteration of the Therapy Programme that was evaluated, they have been hugely beneficial in helping to make sense of the outcomes of the research (both qualitative and quantitative). They have, also, contributed significantly (and will continue to do so) to the further development of the intervention.

4.1.2 Structure of the Literature Review as presented in this Chapter

It is important to note that the structure applied to the discussion of the literature in this chapter is somewhat different from the process followed in the searches and reviews conducted as reported above. The literature is presented in 6 parts –

1. The trans-diagnostic prevalence of hopelessness and compromised self-esteem.
2. Hope and self-esteem in Early Psychosis.
3. Conceptualisations of hope and self-esteem.
4. Previous intervention-research of hope and self-esteem in Psychosis.
5. Previous intervention-research of hope and self-esteem in related health fields.
6. Learning points and recommendations.

The first three parts are concerned with establishing the context for thinking about hope and self-esteem in Early Psychosis. They speak to the primary question - *To what extent, and in what ways, might hopelessness and compromised self-esteem be regarded as meaningful and significant in the experiences of the service user population as defined?* The fourth part describes the systematic literature review conducted post-research. It addresses the question - *To what extent are those experiences or needs; specifically, in relation to the psychoses; already being met by existing CBT-based psychological interventions?* The fifth part reviews those hope- and self-esteem-targeting interventions that have been utilised elsewhere in the fields of mental and / or physical health. This section of the review might be said to address the question - *To what extent could those experiences (needs) be met by existing CBT-based psychological interventions that are not currently being considered within the field of psychosis?* Where a particular intervention has been evaluated in relation to both psychosis and non-psychosis participant populations, the whole ‘thread’ has been discussed within that section that relates to the systematic review. Finally, the last part presents a summary of the learning points, with emphasis on recommendations relating to - (i) the conceptualisation of hope and self-esteem, separately and as an interacting, combined construct, (ii) the composition (content) of an intervention programme designed to concurrently address hopelessness and low self-esteem, and (iii) processes of delivery of the new therapy programme. This section of the review might be said to address the questions - *What facets of existing intervention strategies might most usefully be incorporated into the new programme?*

4.2 Prevalence of Hopelessness and Low Self-esteem

This section considers the trans-diagnostic natures of hope and self-esteem, reflecting on the multitude of physical and mental health conditions in which compromised hope or self-esteem have been implicated. For each it presents - (i) the principle specialist fields in which the construct has received attention, and (ii) the identified consequences of more positive or negative evaluations with reference to self or the future. This part might be regarded as setting the wider context of the relevance of hope and self-esteem before going on to an examination of their more specific implications for early psychosis.

4.2.1 Hope

The construct of hope has been explored predominantly, and extensively, in the fields of physical and mental health. There has, also, been some consideration given to its place in relation to education and employment, athletic achievement and social relationships. In physical health care it has been examined most intensely in battlegrounds where hopelessness is perceived to have a stronger artillery - chronic, life-threatening and terminal ill-health, including, amongst many others, traumatic brain injury (Oyesanya and Ward, 2016; Wilbur and Parente, 2008), spinal cord injury (Elliot, Witty, Herrick and Hoffman, 1991), HIV and AIDS (Moon and Snyder, 2000; Scioli, Chamberlin, Samor, Lapointe, Campbell et al, 1997), and various forms of cancer (Herth, 1990, 2001; Duggleby and Williams, 2010; Miller, 1983). The focus on cancer has included terminal lung cancer (Borneman, Irish, Sidhu, Koczywas and Cristea, 2014), breast cancer (Taylor, 2000) and prostate cancer (O'Shaughnessy, Laws and Esterman, 2015). With regard to cancer-care, hope has received attention in relation to the early stages following diagnosis, subsequent to relapses and deteriorations in health and in the final stages of terminal disease. In the field of mental health, hope has been implicated, especially, in experiences of depression in adults and children (Cheavens, 2000; Snyder, Hoza, Pelham, Rapoff, Ware et al, 1997), anxiety (Carretta, Ridner and Dietrich, 2014; Legg, Andrews, Huynh, Ghane, Tabuenca and Sweeny, 2015; Michael, 2000), eating Disorders (Irving and Cannon, 2000), post-traumatic stress disorder (Sympson, 2000), and schizophrenia and the psychoses (May, 2004; Riskind, 2006).

In addition, hopefulness has been linked with effective coping in terminal illness (Felder, 2004) and, in fact, has been identified as the single most important psychological factor impacting upon mortality in cancer treatment (Cousins, 1989). It has been shown to be predictive of fewer reported acute and chronic illnesses (Scioli et al 1997), and has been associated with a reduction in reported incidences of hypertension, diabetes mellitus, and respiratory tract infections (Richman, Kubzansky, Maselko, Kawachi, Choo and Bauer, 2005). There is strong evidence to suggest that it is a proximal mediator between loneliness and depression, and, also, between depression and suicide (Abramson, Alloy, Hogan, Whitehouse, Gibb et al 1998; Beck, Brown, Berchick, Stewart and Steer, 1990; Cooper-Patrick, Crum and Ford, 1994; Rudd, Joiner and Rajab, 1996). In mental health care it has been linked with greater collaborative engagement with treatment regimes, reduced emotional distress or trauma, better rates of recovery and better quality of life (Abramson, Metalsky and Alloy, 1989; Deegan, 1988, 1992; Perry, Taylor and Shaw, 2007; Snyder, Feldman, Shorey and Rand, 2002). It has been associated with self-worth in, both, children (Snyder, 1996; Snyder, Cheavens and Sympson, 1997) and adults (Curry, Snyder, Cook, Ruby and Rehm, 1997). Finally, at a practical level, Hopefulness has been linked with greater choice, personal control and empowerment (O'Malley, 2009), more effective problem solving (Snyder, Harris, Anderson, Holleran, Irving et al 1991), and with success in both the academic realm (Snyder, Wiklund and Cheavens, 1999) and athletics (Curry et al, 1997).

4.2.2 Self-Esteem

Low self-esteem has, over the years, been particularly associated with depression (Andrews and Brown, 1993; Franck and De Raedt, 2007; Wild, Flisher and Lombard, 2004). It has, also, however, shown strong links with a plethora of other conditions (see Table 4.3), as well as being implicated in service users' approaches to treatment, including attitudes to, or experiences of, empowerment (Fleming Cottrell and Langzettel, 2005; Tengland, 2008), hope (Abela, 2002; Ciarrochi, Heaven and Davies, 2007; McGee, Williams and Nada-Raja, 2001), motivation (Murphy and Roopchand, 2003; Standage and Gillison, 2007), engagement (Buchmann, 1997), recovery and relapse (Gumley, Karatzias, Power, Reilly, McNay and O'Grady, 2006; Knowles, Tai, Jones, Highfield, Morris and Bentall, 2007). Finally it is has been shown to influence aspects of social functioning (Tarrier, Barrowclough, Andrews and Gregg, 2004), vocational functioning (Waters and Moore, 2002), quality of life (Hansson, 2006), self-harm, suicide ideation and suicidal behaviour (Guillon, Crocq and Bailey, 2003; McGee, Williams and Nada-Raja, 2001; Palmer, Rysiew and Koob, 2003; Tarrier et al, 2004; Youssef, Plancherel, Laget, Corcos, Flament et al, 2004).

Table 4.3 – Mental Health Fields in which Self-Esteem has been Implicated as a Factor of Significance

Field	Example References
Anxiety Disorders	Karatzias, Gumley, Power and O'Grady (2007).
Obsessive-Compulsive Disorder	Wu, Clark and Watson (2006).
Eating Disorders	Johnson, Crosby, Engel, Mitchel, Powers et al (2004). Shea and Pritchard (2007).
Personality Disorders	Guillon, Crocq and Bailey (2003). Morrison and Gilbert (2001).

Body Dysmorphic Disorder	Buhlman, Teachman, Gerbershagan, Kikul and Rief (2008).
Schizophrenia and Psychosis	Barrowclough, Tarrier, Humphries, Ward, Gregg and Andrews (2003). Gumley, Karatzias, Power, Reilly, McNay and O'Grady (2006). Harrop and Trower (2003). Warman and Lysaker (2011).
Bi-Polar Disorder	Knowles, Tai, Jones, Highfield, Morriss and Bentall (2007). Scott (2001).
Substance Misuse	Caughlin and Malis (2004). Karatzias, Power and Swanson (2001).
Post-Traumatic Stress Disorder	Kashdan, Uswatte, Stegar and Julian (2006).

It should be noted, however, that research findings have not always been consistent or clear-cut and the field has a reputation for generating, at times, weak, unexpected or contradictory results (Karatzias, Power and Swanson, 2001). Even where research outcomes have been more robust, the interpretation of findings has not always shown agreement, in particular in relation to directionality (Fennell, 1997; Gumley et al, 2006) and significance (Shea and Pritchard, 2007).

4.3 Hope and Low Self-esteem in Early Psychosis

The relationship between compromised hope and self-esteem and the diagnosis of a psychotic illness is complex and unclear. There is considerable evidence to suggest a strong association between psychotic illness, hopelessness and compromised self-esteem (Barrowclough et al, 2003; Fannon, Haywood, Thompson, Green, Surguladze and Wykes, 2009; Garety and Freeman, 2013; Hall and Tarrier, 2003; Harrop and Trower, 2003; Kesting and Lincoln, 2013; Krabbendam and van Os, 2005; Smith, Fowler, Freeman, Bebbington, Bashforth et al, 2006; Udachina, Varese, Myin-Germeys and Bentall, 2014; Warman and Lysaker, 2011). The presence of negativity with regard to oneself or the future in the context of an ongoing or recently resolved first psychotic crisis might, however, represent more than one possible causal scenario.

Models of hope and self-esteem clearly and consistently suggest that attitudes towards self and the future begin to develop from early childhood (Fennell, 1997, 1999; Snyder, 1994, 2000). Over time, learning derived from experience begins to crystalize into the form of traits, which predispose the person towards particular ways of perceiving, interpreting and remembering events. These biases of expectation act as lenses through which subsequent happenings are experienced, thus fuelling a tendency towards self-reinforcing patterns of interaction with the world. Later events can unsettle the status quo, but such a re-visioning of attitudinal perspectives would require significant levels of challenge or provocation. It is argued later in the chapter, with regard to self-esteem, that some individuals are capable of employing strategies (rules for living) to mask the enactment, and possibly even the experience, of negative self-evaluation. Reported pre-morbid high self-confidence might, consequently, reflect either a genuine positivity towards self or a successfully covered-up negativity. This might, itself, indicate either unconscious self-denial or conscious dissembling to others. The presence or appearance of hopelessness or low self-esteem in the aftermath of a psychotic crisis might, therefore, represent - (i) the reinforcement of a pre-morbid negativity, (ii) the shattering of a pre-morbid positivity, or (iii) the exposure of a previously existing but ‘hidden’ negativity. In addition, where those attitudes existed pre-morbidly, they might or might not have had direct relevance to the onset of the psychosis and might represent a factor of vulnerability or a precipitating stressor. Disentangling the complexity of that picture is hampered by two factors –

1. Most research into these relationships has been undertaken retrospectively. Consequently, service-user narratives of early experiences of hope and self-esteem have been constructed through the lens of negativity associated with the recent onset of illness.

2. There is an obvious reciprocity between the symptomology of psychosis and the person's reactions to those symptoms, including perceived loss of social standing, shame, adverse social identity and fear of stigma (Barrowclough et al, 2003; Birchwood, 2003; Gumley et al, 2006; Thewissen, Lecomte, Bental, van Os and Myin-Germeys, 2008; Tiernan, Tracey, 2014).

The following section has sought to address that complexity by considering, separately, the evidence relating to the prevalence of hope and self-esteem prior and subsequent to the onset of psychosis.

4.3.1 – Hopelessness and Low Self-Esteem as Pre-morbid factors in the Onset of a Psychotic Crisis

The issue of whether hopelessness and compromised self-esteem might occur prior to a psychotic illness is not actually in doubt. The onset of psychosis shows greatest prevalence between the ages of 16 and 25, with very few young people being diagnosed below the age of 14 (Harrop and Trower, 2003). Compromised self-esteem and hopelessness, on the other hand, have both been identified extensively in much younger children, especially in conjunction with depression or social anxiety. There is some debate about the level of cognitive development required for a child to be able to process evaluations of self and the future, raising questions as to the validity of assessment of hope and self-esteem in very young (pre-school) children (Davis-Kean and Sandler, 2001; Trzesniewski, Kinal and Donnellan, 2010). There is, however, considerably more agreement that the compromising of self-esteem can manifest at the transition from childhood to adolescence (Robins, Hendin and Trzesniewski, 2001; Trzesniewski, Donnellan and Robins, 2013). There is, also, evidence to suggest that the earlier undermining of hope and self-esteem and the later emergence of a psychotic illness might have common roots. Childhood trauma, for instance, has been, associated both, directly and immediately with the emergence of negativity about self and the future, and subsequently (in later years), with a statistically significant increase in the incidence of psychosis (Jenssen, Krabbendam, Bak, Hanssen, Vollebergh et al, 2004; Varese, Smeets, Drukker, Lieverse, Lataster et al, 2012). On that basis, it has been suggested that compromised self-esteem and hopelessness might mediate the impact of early experiences (including trauma) on the later emergence of psychosis. This argument seems to be supported by the limited longitudinal research available, with tentative indications that there is a higher rate of transition to psychosis amongst adolescents with childhood experiences of low self-esteem (Bell and Wittkowski, 2009; Lutz and Ross, 2003). This perspective is, also, consistent with the stress-vulnerability model described in Chapter 3 (Nuechterlein et al, 1992).

More significant and direct theoretical support comes from the developing understandings of the psychological processes of key positive psychotic symptomology – in particular cognitive models of auditory hallucinations, paranoia and grandiosity. These models postulate that negativity towards self is ***explicitly*** manifest in the hearing of derogatory voices and the experience of 'bad me' paranoia and ***implicitly*** reflected in the presence of 'poor me' paranoia and grandiose delusions (Chadwick, Birchwood and Trower, 1996). The current dominant psychological theory of 'voice hearing' (Bentall, 1990a, 1990b; Chadwick and Birchwood, 1995) proposes that, whatever the bio-chemical precipitants of the experiences, the nature of the heard voices represents the erroneous attribution of a person's inner cognitive dialogue to a source alien or external to self. They are 'autobiographical' and embodying of the individual's past and current experiences (Blatt and Zuroff, 1989). In brief, they are deemed to reflect a combination of the person's own self-judgements and those that they fear might be held by others about them (Beck and Rector, 2003, 2005; Close and Garety, 1998; Frith and Done, 1988; Morrison, Haddock and Tarrier, 1995). Similarly, it has been posited that 'bad-me' (punishment-) paranoia is rooted in the belief that any conspiracy or attack reflects a deserved or justified punishment for personal failings or crimes, regarding which the individual is self-aware (Chadwick, Birchwood and Trower, 1996).

There is less immediate consensus regarding the experience of 'poor-me paranoia', with a number of competing theories advocated (Bentall, Corcorran, Howard, Blackwood and Kinderman, 2001; Colby, 1975; Meissner, 1981; Sullivan, 1956), including - (i) the self-protective disowning of personal responsibility, (ii) the exaggeration of an established lack of trust in others, and (iii) a decreased capacity to self-reassure, resulting in an exaggeration of threat-perceptions. The first of these, the understanding that these beliefs are a defence against compromised self-esteem, echoes the dominant theory for the delusion of grandiosity. These two delusions, collectively, express the general perspective that - 'I am more special, gifted or loved than external evidence would suggest and / or that any lack of success, ability or love is consequent to the malevolent interference of others rather than reflective of my personal failings' (Bentall, 1994; Freeman, Garety, Fowler, Kuipers, Dunn et al, 1998; Kinderman and Bentall, 1996, 1997; Smith, Fowler, Freeman, Bebbington, Bashforth et al, 2006). As such they might both be regarded as representing an active avoidance of critical self-evaluations. These theories are supported, but not proven, by research-evidence of strong associations between the experience of hearing voices (Ciufolini, Morgan, Morgan, Fearon, Boydell et al, 2015; Fannon et al, 2009), of paranoia (bad-me and poor-me) and grandiosity, and the presence of negative attitudes to self. It is unclear, however, whether self-esteem is a mediator in the aetiological onset of the 'symptoms' or a moderator in determining the emotional impact of these experiences (Fannon et al).

4.3.2 Hopelessness and Low Self-Esteem as Post-morbid consequences of the Psychotic Crisis, significant with regard to Prognosis and Recovery

A person's psychological response to a psychotic crisis might reflect a number of aspects of their experiences, including the traumatic nature of the illness events (Berry, 2015; Berry, Ford, Jellicoe-Jones and Haddock, 2013; Jackson, Trower, Reid, Smith, Hall, Townend et al, 2009), as well as their negative pragmatic consequences – in terms of interference in social, financial and occupational life. It has been suggested, however, that attitudes to self and the future are most strongly influenced by the way in which the person and others around them make sense of what has happened – the emergent illness narratives (Corrigan, Watson and Barr, 2006; Deegan, 1993; Goffman, 1963; Harter, 1999; Kleinman, 1988; Link, Struening, Neese-Todd, Asmussen and Phelan, 2001, 2002; McCay and Seeman, 1998; Watson, Corrigan, Larson and Sells, 2007; Yanos, Roe, Markus and Lysaker, 2008).

At the heart of the narratives that develop around or in relation to the psychoses, including those which propagate discrimination and prejudice, lies the question of aetiology or causation. Those evaluative understandings, however, tend to extend significantly beyond the parameters of considerations as to the relative roles of biology, psychology or social factors. They might encompass in addition, elements of judgement with regard to the responsibility of the person in the 'bringing-on' of the illness, the degree to which the illness is deemed to reflect the wider character or nature of the person, or their capacity for change in the future. In addition, illness narratives might reflect perspectives with reference to differentness, predictability and dangerousness (Kleinman, 1988). In general, an illness-narrative might be considered unhelpful if, amongst other things, it organizes the person to withdraw from social, occupational or academic investment and / or encourages thoughts or actions associated with suicide, or which result in diminished effort and compromised outcomes in life. Unhelpful illness narratives tend to be those which - (i) locate the responsibility for the illness solely within the person of the individual, and especially so when that responsibility is linked explicitly to judgements of weakness or failure, (ii) allow the illness to become regarded as the totality of the person (their identity), or, at the least, a very considerable part of it, obscuring or excluding other, contradictory stories about the self, (iii) minimize the potential of the person with regard to empowerment or define the illness as permanent, incapable of resolution or recovery, embodied in hopelessness about the future, (iv) emphasise the 'abnormality' of the person and their illness, or (v) highlight behaviours that are more unpredictable or dangerous (to the person or to those around them).

Negative illness narratives are associated with evaluations of disgrace and shamefulness and with attitudes of prejudice and discrimination (Estroff, 1989; Goffman, 1963). Where those evaluations are made by the individual they are referred to as ‘self-stigma’ or ‘engulfment’. When experienced or anticipated in the responses of others they are termed ‘public stigma’ (Yanos, Roe and Lysaker, 2010). It has been argued that public attitudes have undergone something of a ‘sea-change’ in recent years, with some improved understanding and sensitivity. A number of authors have, however, identified a continuing reality of stigma within the community, affecting, in particular, social and vocational engagement (Birchwood, Mason, McMillan and Healey, 1993; Corrigan, 1998; Corrigan and Kleinlein, 2005). Others have posited that evaluations of self and the future might be influenced more by the narratives that the person internalises, than by those they encounter or anticipate in others (Corrigan, Watson and Barr, 2006; Gumley, Karatzias, Power, Reilly, McNay and O’Grady, 2006; Ritsher and Phelan, 2004; Yanos, Lucksted, Drapalski, Roe and Lysaker, 2015). Self-stigma tends to be reflected in, both, criticisms of the worth of the person in the present, and predictions of failure, rejection and lower status in the future. Negative illness narratives, whether manifest in public- or self-stigma, are associated with more negative prognosis, through an increased risk of relapse, the undermining of recovery, and promotion of suicidal ideation (Yanos, Roe, Markus and Lysaker, 2008).

More generally, both hope (Abramson, Metalsky and Alloy, 1989; Deegan, 1988; May, 2004; Perry, Taylor and Shaw, 2007; Ridgeway, 2001; Snyder, Feldman, Shorey and Rand, 2002) and self-esteem (Lysaker, Buck and Roe, 2007; Lysaker, Campbell and Johanssen, 2005) have been shown to be key considerations with regard to increased motivation and help-seeking behaviour, improved adherence and persistence with medication and improved collaboration in psychological therapies. As a consequence, they have each been identified as contributing to, both, the initiation and maintenance of recovery (Bonney and Strickley, 2008; Ong, Edwards and Bergeman, 2006). Attitudes to the illness, with regard to definitions of self and prognosis for the future, have been identified as central to the mediation of these processes (Kleinman, 1988). There has also been some evidence of reciprocating influence, in that the concept of relapse is so invested with negative and pessimistic connotations that the fear of future relapses might actively contribute to further deterioration of hope and self-esteem (Birchwood, Mason, McMillan and Healey, 1993).

Finally, here, it is important to acknowledge the relationships between hopelessness, low self-esteem, negative illness narratives and suicide in this vulnerable group. The risk of suicide in those diagnosed with a psychotic illness has historically been very high, with Aquilar, Haas, Manzanera, Hernandez, Garcia et al (1997), Hor and Taylor (2010), Jackson and Iqbal (2000) and Power (2004, 2010) all reporting rates of successful suicide of between 5 and 10%. Both low or compromised self-esteem (Beck, Brown, Steer, Kuyken and Grisham, 2001; Beck, Steer, Beck and Newman, 1993; Harter and Marold, 1994; McGee, Williams and Nada-Raja, 2001) and hopelessness (Beck, Kovacs and Weissman, 1975; Beck et al, 1993; King, Baldwin and Sinclair, 2001) have been linked with suicidal ideation and action. Various psychological mechanisms have been proposed for these links, including, the fear of future madness (Collett, Pugh, Waite and Freeman, 2016) and the sense of diminished control or powerlessness (Fialko, Freeman, Bebbington, Kuipers, Garety et al, 2006; Tarrier et al, 2004). In general, however, it is the perceived hopelessness of the situation which appears to serve as a proximal mediator, between the negativity of circumstance and the decision to take one's own life (Beck et al, 1993; McGee et al).

4.4 The Conceptualisation of Hope and Self-Esteem

Within the expanding ocean of relevant literature there exist a plethora of contradictory, parallel, intersecting and evolving definitions, frameworks and models of the two constructs which make any analysis complicated and difficult to encompass. In approaching this review, therefore, it has been important to be explicitly organised with respect to purpose. It has not been intended that this section should be read as a definitive review of those theories, but instead that it should offer sufficient detail to illustrate the complexity of the field, explicate the competing theories underpinning various intervention programmes and begin to develop a coherent, comprehensive and robust conceptualisation to organise the new Therapy Programme.

There has been considerable debate in the literature regarding both the accuracy and value of competing models and the wider question of the validity of the pursuit of a single consensually agreed formulation. In acknowledging those disagreements, it is important to note that, with regard to this research, in accordance with the organising philosophy of critical realism, all conceptualisations of hope or self-esteem have been regarded as convenient ‘maps’ of the ‘territory’. Rather than being considered with reference to ‘truth-status’, their utility has been defined by what they enable or allow. Within that understanding, it is accepted, both, that - (i) evaluations of credibility are important in the consideration of any model or conceptualisation and that a model should be expected, therefore, to show a good fit with the ‘evidence’, and (ii) models are constructed and, thus, subject to human fallibility. Where intervention-studies have explained the theories or formulations that underpin the therapy, the detail has been extremely variable, not merely in content, but in depth and form, with three distinct levels or types of description employed.

- Brief ***definitions*** which locate the concepts within an understanding of the wider context of psychological experiences, focusing particularly on how the hope or self-esteem concepts differ from, or are similar to, analogous ideas.
- More complex ***thematic frameworks*** which offer detail regarding the elements of experience that make-up the content of the concept under consideration.
- Comprehensive ***conceptual models*** which, also, include reflections on the relationships between constituent parts, and issues with regard to development and maintenance.

It is proposed here that the most comprehensive conceptualisations of a construct, such as hope or self-esteem, would ideally include all three levels of description.

4.4.1 Conceptualisations of Hope

Definitions

Along-with the construct-dimension of optimism-pessimism, hope is defined in relation to the anticipation of future outcomes. Whereas, however, optimism and pessimism are defined simply as positive and negative outlooks on life (Dember, Martin, Hummer, Howe and Melton, 1989) or "generalised positive and negative outcome expectancies" (Scheier and Carver, 1985, p219), hope is considered to involve a greater degree of personal investment or desire in relation to those future expectancies. The Oxford English Dictionary, for instance, explicitly defines hope as 'desire combined with expectation' (Oxford Dictionaries on-line, 2018). Beyond that consensus regarding the temporal and personal dimensions of hope, however, there has been significant disagreement over questions regarding causes, conditions and inherent patterns (Morse and Doberneck, 1995; Petersen and Wilkinson, 2015). Nowotny (1991, p117) noted that 'hope has been defined as an expectation, an illusion, a virtue, an emotion and a goal.'

Table 4.4. Definitions of Hope

Author / Reference	**Definition** Hope is …
Dufault and Martocchio (1985, p380)	A 'multidimensional dynamic life force characterized by a confident yet uncertain expectation of achieving a future good, which to the hoping person is realistically possible and personally significant'.
Gottschalk (1974, p779)	An 'intense assurance that a favourable outcome is likely to occur in all activities including spiritual and imaginary events.'

Lynch (1965, p32)	A ‘fundamental knowledge and feeling that there is a way out of difficulty, that as humans we can somehow manage our internal and external reality, and that there are solutions in the most ordinary biological and physiological sense of the word.’
Miller (1983, p287)	‘Hope means anticipating success but having a feeling of uncertainty. Hope is the negation of the worst possible outcome.’
Schrank, Bird, Rudnick and Slade (2012, p555)	A ‘primarily future orientated expectation (potentially informed by negative experiences such as mental disorder) of attaining personally valued goals which will give meaning, are subjectively considered possible and depend on personal activity or characteristics (e.g. resilience and courage) and / or external factors (e.g. resource availability)’.
Stephenson (1991, p1459)	A ‘process of anticipation that involves the interaction of thinking, acting, feeling and relating, and is directed towards a future fulfilment that is personally meaningful’.
Stotland (1969, p9)	An ‘expectation about attaining a desired goal in the future, a necessary condition for action, and a subjective state that can influence realities yet to come’.

In a recent review of the literature relating to understandings of hope in psychiatry, Schrank, Stanghellini and Slade (2008) identified 49 different and diverse definitions including - Hope as an ‘essential positive phenomenon’, ‘an attribute of the individual’, ‘a state of mind’, ‘an inner power’, a dynamic life force’, ‘a motivational / emotional state’, ‘an emotional attitude’, ‘a positive emotion’, ‘an anticipation’, ‘a component of empowerment’, ‘a measure of optimism’ and ‘an expectation’ (p424-425). A number of intersecting but different definitions of hope are included in Table 4.4 above.

Thematic Frameworks

Three ***thematic frameworks*** have been identified as significant in the development of the intervention strategies examined in the following sections – (i) Farran, Herth and Popovich, 1995,

(ii) Miller, 1983, and (iii) Nowotny, 1986. The Farran, Herth and Popovich model reflects an evolution of understandings presented by Dufault and Martocchio (1985), regarding which there has been another variant – Nekolaichuk, Jevne and Maguire, 1999. In addition, although not directly operationalized in any of the interventions considered, the ideas of Morse and Doberneck (1995) have been cited as seminal by many in the field. This section examines the interconnections and differences between these six frameworks. The various thematic frameworks use different language structures and terminology to discuss the construct of hope. They prioritise different elements, and, in fact, different numbers of key factors. Nevertheless, there is considerable overlap in their ideas, not simply with regard to future-orientated expectations. Common features include -

- Aspects of self-belief (Miller, 1983; Nekolaichuk et al, 1999).
- Access to resources from within, for instance, energy, physical strength and reserve and psychological stamina (Miller, 1983).
- Access to resources from others, including both moral and practical support (Dufault and Martocchio, 1985; Farran et al, 1995; Miller, 1983; Morse and Doberneck, 1995; Nekolaichuk et al; Nowotny, 1986).
- Access to support through engagement with the spiritual (Farran et al, 1995; Nowotny, 1986).
- Motivation, commitment or determination to achieve the ‘hoped-for’ goals (Dufault and Martocchio, 1985; Miller, 1983; Morse and Doberneck, 1995; Nowotny, 1986). This factor seems to include, both, investment in the goal, and belief in its attainability.

The importance of clarity in assessment with regard to need is emphasised explicitly by Morse and Doberneck (1995), whilst being mostly implicit within the other frameworks. Morse and Doberneck, also, offer the idea that hope is always contextualised with reference to a bracing for negative outcomes. In other words, the act of hope requires the possibility of failure. Hope does not arise in relation to a ‘sure thing’. Most frameworks are presented in ways that imply a singularity in the nature of hope. Some authors, however, have proposed different types or levels of hope. Miller (1983) suggested that there were three levels or intensities to hope - (i) shallow optimism and a hope for superficial wishes and basic material goods, (ii) hoping for relationships, self-improvement and self-accomplishments, and (iii) hope arising from suffering, personal trial or captivity. Farran and colleagues (Farran and Popovich, 1990; Farran, Wilken and Popovich, 1990; Farran, Herth and Popovich, 1995), on the other hand, focused on just two - (i) 'interactive hope', which, they suggested, was reflected in relationships, expressed and enacted attitudes of warmth and responsiveness, and a climate of honest expression, and (ii) 'global hope', which referred to the person's unique sense of hope, including processes of learning from experience, the identification of capacities and strengths, and elements of specific meaning making.

Most of these frameworks were developed in relation to the profession of nursing and the care of those with life-threatening illness. The relevant authors suggested that these frameworks might be adopted by care staff to organise their approaches to patients and family members. Nowotny (1986) suggested that hope might be inspired or nurtured through helping the person to reach out to others, encouraging family and friends to visit, being available oneself to the person and acting as their advocate if required, promoting contact with wider support mechanisms to help share the load and developing more and better connections. Her model has been utilised by Rustoen and colleagues (Rustoen and Hanestad, 1998; Rustoen, Cooper and Miaskowski, 2010, 2011), in Norway, as the framework for their 'HOPE-IN' therapeutic approach (see 4.6 below). Miller (1983), also, believed in the 'instillation of hope' as a nursing intervention. Her ideas were taken up by Duggleby and colleagues for their 'Transforming Hope' intervention (Duggleby, Degner, Williams, Wright, Cooper et al, 2007; Duggleby, Holtslander, Kylma, Duncan, Hammond and Williams, 2010; Duggleby, Williams, Holtslander, Cooper, Ghosh et al, 2013; Holtslander, Duggleby, Williams and Wright, 2005). Finally, Farran and colleagues (Farran and Popovich, 1990; Farran, Wilken and Popovich, 1990; Farran, Herth and Popovich, 1995) suggested that hope might be promoted both through the enacted attitudes of caring staff - (i) an active, reality-based hope, grounded in positivity about the capacities of the client, and (ii) a more defined hope promoting activities, including, the anticipation of future stressors and activation of historically successful coping strategies, psycho-education about pathophysiological processes, encouragement of individuals to become involved in appropriate social activities, and negotiation between individuals and family members for the provision of better support. These ideas lie at the heart of the Herth intervention (1990, 2000, 2001 – see section 4.6).

Conceptual Models

The new intervention has been primarily, though not exclusively, influenced by the author's own ***conceptual model*** of hope. This was developed in the context of previous research (Pearson 2006, 2010), which was itself strongly informed by the ***conceptual model*** of Snyder (1994, 2000a). These two models are, therefore, discussed in detail. The frameworks described above were principally developed in relation to concerns of physical health. In contrast Snyder's model of hope was developed, initially at least, in the context of mental ill-health. Snyder described hope as an active, participatory, future- and goal-orientated concept, which reflected very definite, directed aspirations involving a significant degree of personal investment. Hope, he stated, was not a passive emotion, or merely a response to trial and trauma, as suggested by Farran, Herth and Popovich (1995), but rather a cognitive process through which individuals actively pursued their goals. The concept of 'goals' in this, he said, might relate to 'anything an individual desires to get, do, be, experience or create' (Snyder, Sympson, Michael and Cheavens, 2002, p108) and, therefore, might encompass virtually every life domain. Snyder identified 3 key components deemed necessary for a person to feel hopeful - (i) Goals – the need for clear, appropriate and achievable goals, reflecting the aspirations of improvement or betterment, (ii) Strategies – referred to as 'Pathway Thoughts', reflecting the need to have faith that these goals were realistically achievable, and (iii) Capability – referred to as 'Agency Thoughts', reflecting the need for the person to believe in themselves, generally, and, more specifically, in their ability to follow identified strategies to a conclusion.

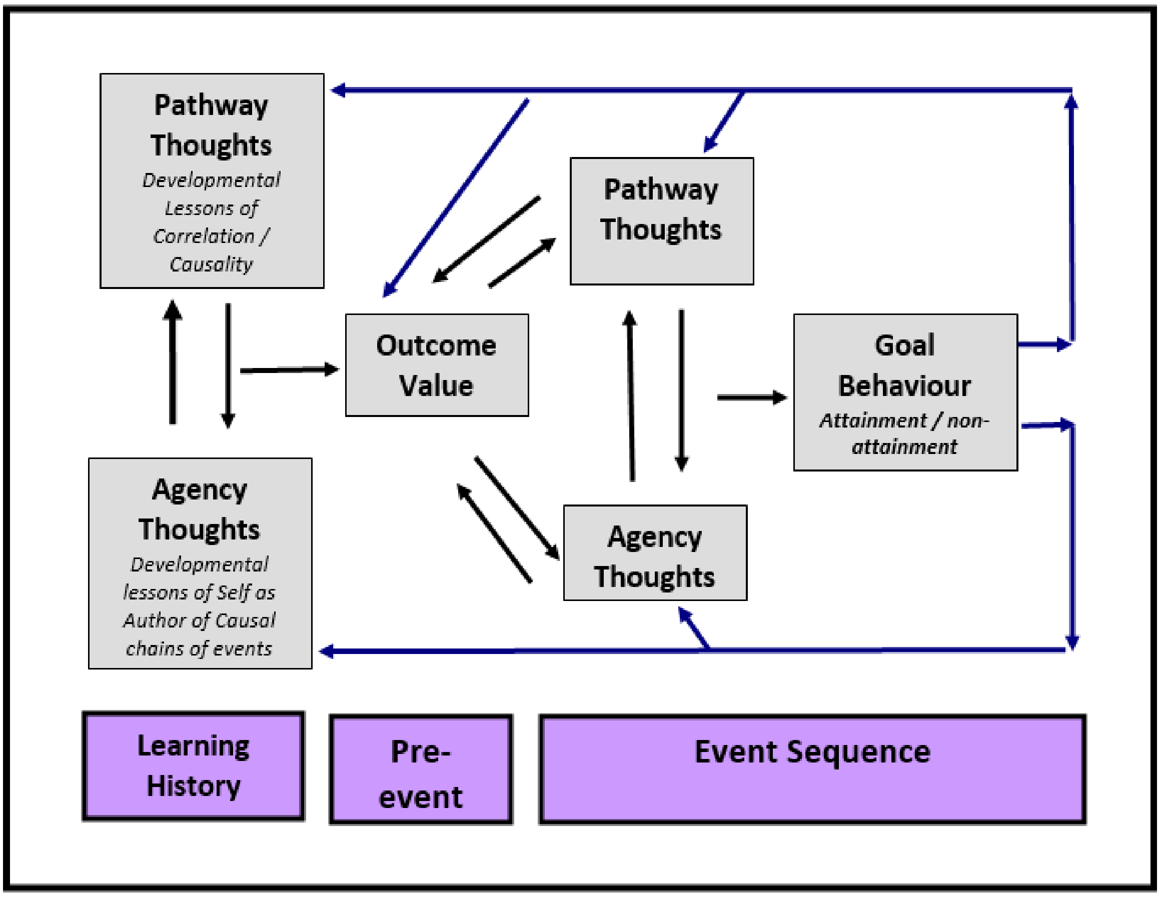


Figure 4.1 – Adapted from Snyder's Model of Hope (2000a, p12)

Snyder postulated that Agency and Pathway Thoughts were learnt, rooted in experience and, especially, in experiences of success or failure. That learning, he suggested, would have a particularised relevance. A history dominated by experiences of failure would be likely to teach less genuine hopefulness than a history of success, but the degree of influence in any particular situation would be informed by the relevance of the history to the specific goal or challenge to hand. He, also, suggested that they were potentially self-reinforcing. Negativity towards the future was associated with reduced motivation and effort, poor performance, a cognitive bias towards noticing, interpreting and remembering failures, and, ultimately, worse outcomes, which, in turn, propagated further hopelessness. Similarly, hopefulness was linked in a virtuous cycle to increased motivation, engagement, effort and success (Snyder, 1994). Snyder's model of hope is presented in Figure 4.1.

Snyder's model was the beginning point of a phenomenological study undertaken by the researcher-therapist with regard to the hope-experiences of Early Psychosis Service users and their families (Pearson, 2006, 2010). Analysis of participants' observations led to the articulation of a linked, though, also, distinct, model (Figure 4.2). The model retains Snyder's three key elements of goals, pathway and agency thoughts, though in a somewhat different relationship to each other, and replicates the circularity of process in which hope-based attitudes shape action, and outcome evaluations feedback into those perspectives. The model does, however, differ in a number of key respects. Snyder's focus on hope as a proximal mediator of goal achievement prioritised evaluations of 'self' relating to capability, competence, success and agency. In the Pearson model (2006, 2010) issues of capability and achievement are deemed likely to have particular importance, but other aspects of self-opinion, such as physical appearance, character and social position, are, also, regarded as significant. The model posits an alternative construct, self-confidence, as mediating between this complex of self-regarding thought and the state of hopefulness by which subsequent action might be organised. This perspective, whilst differing from Snyder, does resonate strongly with Miller's (1983) understanding of self-esteem as a predisposing factor for hopefulness or hopelessness. Finally, whereas Snyder's model has been presented as assertively individual, or intra-psychic, in nature, the Pearson model, also, highlights the person's interactional or relational world, including both received-esteem and other-agency. This latter point maps very closely onto Nuechterlein's ideas of the interaction between environmental and personal protectors or potentiators with regard to 'Stress-vulnerability' (Nuechterlein et al, 1992 - see Chapter 3).

The relational dimension was not, in fact, completely absent from Snyder's writings and he specifically identified the commencement of therapy as an act of hope – where that hope was about locating belief in the therapy and therapist as part of a valid pathway to goal achievement. In general, however, the significance of received-esteem or received-support and agency were not strongly emphasized by his team and not present in the Hope-intervention that was developed from his ideas (Cheavens, Feldman, Gum, Michael and Snyder, 2006; McDermott and Snyder, 1999).

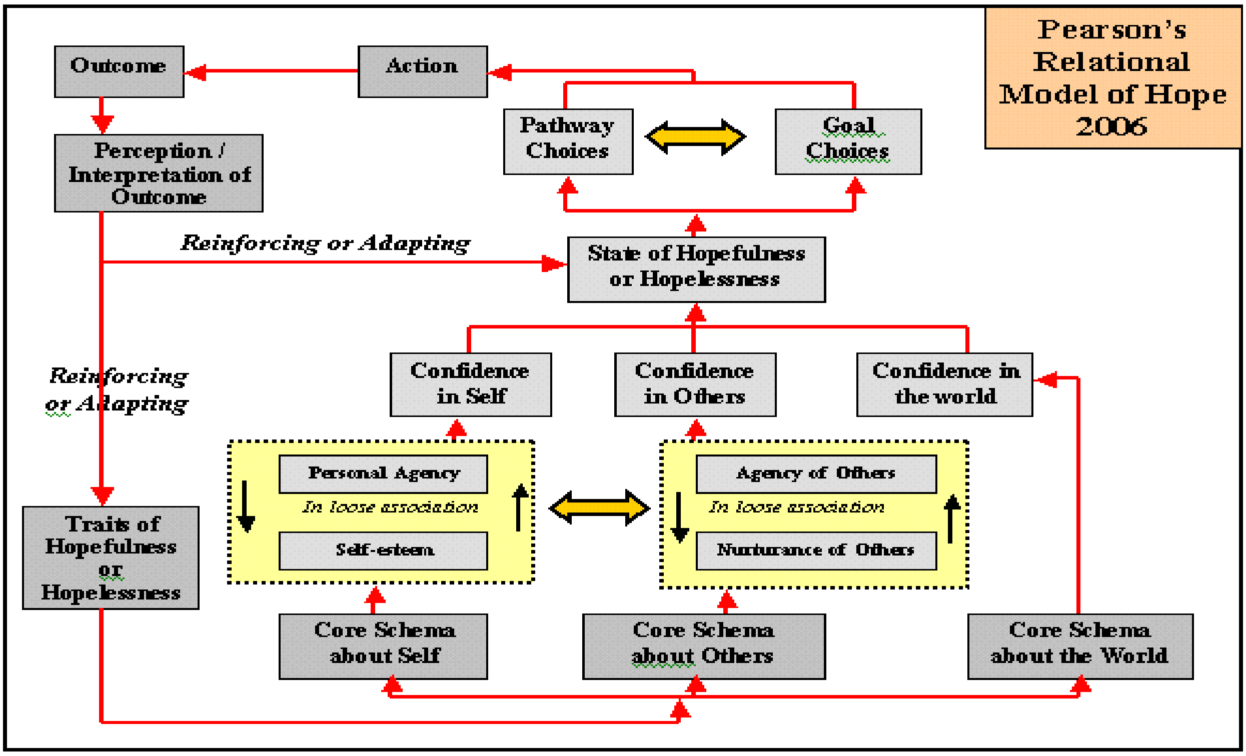


Figure 4.2 – Pearson's Model of Hope (2006; 2010, P203)

In contrast the dimension of relationships is central to several of the other frameworks described, including Nowotny (1986), Miller (1983), Dufault and Martocchio (1985), Nekolaichuk et al (1999) and Farran, Herth and Popovich (1995). It should be noted that participants in the Pearson study (2010) valued trust, reliance and confidence in others, but this was generally perceived as second-best to the capacity for self-confidence and self-reliance. It was noted that too much, or the wrong, helpfulness from others had the potential to undermine a person's self-reliance.

4.4.2 Conceptualisations of Self-Esteem

Definitions

Although the concept of self-esteem is regarded by many researchers as distinct from related constructs, such as self-confidence, self-belief, self-concept and self-worth, these terms have often been used interchangeably or collectively in the relevant literature (Fennell, 2016). The Oxford Living Dictionaries combine some of these terms, defining self-esteem as 'confidence in one's own worth or abilities' or as 'self-respect'. In the same vein self-confidence is defined as a 'feeling of trust in one's abilities, qualities and judgement' and self-worth is defined simply as 'another term for self-esteem'. In essence these constructs are all regarded as overlapping reflections upon the evaluations made by the person with respect to their self-concept – 'an idea of the self, constructed from the beliefs one holds about oneself and the responses of others' (en.oxforddictionaries.com, 2018). In this research the key measure employed to ascertain changes in attitude to self over the course of the therapy referred to 'self-concept' (Robson, 1989), the information provided for participants referred to 'self-esteem' and participants themselves almost invariably used the terms 'self-confidence' and 'self-belief'.

Although the literature relating to self-esteem is at least as contentious as that reflected upon with regard to hope, there is less disagreement concerning definitions, frameworks and conceptualisation and more regarding its importance (Zeigler-Hill, 2013), the significance of various dimensions (DeHart, Pena and Tennen, 2013; Ditzfeld and Showers, 2013; Jordan and Zeigler-Hill, 2013; Kernis, 2003; Rosenberg, 1965, 1979), and the relevance or healthiness of its pursuit (Park and Crocker, 2008, 2013). Apart from the intervention-thread connected to the work of Melanie Fennell (e.g. Fennell, 1997, 1999; McManus, Waite and Shafran, 2009; Rigby and Waite, 2006), the literature relating to self-esteem-targeting interventions is characterised by a significant absence of detail regarding the conceptual models upon which the interventions are based. What is more, the interventions described in these threads (predominantly group-work in delivery) tend to be generic (off the shelf) rather than bespoke to the individual. As a consequence, the relevant articles offer only very limited personal formulations or conceptualisations by which the reader might be enabled to understand the underpinning theory.

The earliest reflections upon self-esteem in western psychology and philosophy are attributed to William James (1890). James suggested that a person's evaluations of themselves, for good or bad, were a product of the relationship between their aspirations and achievements. He suggested a formula or ratio to express this view.

$$\textbf{Self-Esteem} = \frac{\textbf{Success (Perceived Achievement)}}{\textbf{Pretensions (Hopes, Expectations or Standards)}}$$

He posited that this rule would apply to all or any given area of life ('extensions of self'), but only if the 'pretensions' should be of significance. 'Extensions of self' were defined as -

> 'the sum total of all that he can call his, not only his body and his psychic processes, but his clothes and his house, his wife and his children, his ancestors and his friends, his reputation and works, his lands and horses, and yacht and bank account. All these things give him the same emotions. If they wax and prosper, he feels 'triumphant'; if they dwindle and die-away he feels cast down – not necessarily in the same degree for each thing but in much the same way for all' (cited Coopersmith 1967, p30).

Such worth, he said, although uniquely personal, would be subject to communal standards of success and status. Mead, elaborating on the concept of the 'social self', suggested that the individual internalises and then adopts the ideas and attitudes expressed by key others

Table 4.5 Definitions of Self-Esteem

Author / Reference	**Definition**
Coopersmith (1967)	'By self-esteem we refer to the evaluation which the individual makes and customarily maintains with regard to himself: it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, successful and worthy.' (p4).
Fennell (1997, 1998a)	Low self-esteem is 'a learned, negative, global judgment about self' (1998a, p210).
James (1890, p306, cited in Pyszczynski and Kesebir, 2013).	Self-esteem refers to a 'certain average tone of self-feeling which each of us carries about with him'.
Pyszczynski and Kesebir (2013)	Self-esteem is 'an orientation toward the self, a feeling born from the *I's* evaluation of the *me,* a general sense of satisfaction and happiness with what one is, does and has…….self-esteem has two, albeit intertwined, dimensions - one based on a sense of competence, power and efficacy, and one based on a sense of virtue and moral worth' (p124).
Rosenberg (1965, 1979)	Self-esteem refers to the value-laden judgments with which the person views themselves as an object – their 'self-concept'. It is an attitude of approval or disapproval of self.
Zeigler-Hill (2013)	Self-esteem is 'the evaluative aspect of self-knowledge that reflects the extent to which people like themselves and believe that they are competent' (p2).

in his life – based on direct comment, but also observation and interpretation of action, and, in doing so, that person's judgements-of-self become indivisible from those received from, or perceived in the judgements of, others (1934 – also cited by Coopersmith, 1967). Table 4.5 (above) presents examples of contemporary definitions of self-esteem.

Thematic Frameworks

Although, as noted, there has been generally little priority given to the articulation of organising frameworks or conceptual models in the literature on intervention-research, one thematic framework has been particularly influential in the development of the new intervention - Rosenberg (1965, 1979; Rosenberg, Schoenbach, Schooler and Rosenberg 1995). Rosenberg and colleagues (1995) have suggested that much of the disagreement in the field regarding the understanding of self-esteem has arisen from 'muddled conceptualisation' – a lack of clarity, consistency or even specificity in defining the construct. They noted, in particular, a tendency to confuse 'Global Self-Esteem' with 'Specific Self-Esteem'. The regarded 'Global Self-Esteem' to be a predominantly affect-driven generalised evaluation of self, whereas 'Specific Self-Esteem' was deemed to be a more cognitively-orientated view of self with respect to specific attributes. Rosenberg suggested (1967, 1979) that it was essential to understand, both, the nature of specific self-appraisals, including aspects of content, dimensions of experience and processes of development and the relationships between those particularised judgements, and the person's global self-esteem. Consistent with James' (1890) reflections upon 'extensions of self', Rosenberg argued that an appreciation of the breadth of the self-esteem construct required the imposition of a structure or typological organisation of composite elements. He proposed a 4-dimensional framework - (i) Physical attributes – primarily physical appearance, but also athleticism and physical capability, (ii) Competencies and capabilities - including perceptions of self with regard to agency, rooted in a history of success or failure, (iii) Character or personality – including judgments of self in relation to values and questions of morality, and (iv) Social standing – including status and belonging. He noted that this structure was neither exhaustive nor straightforward. He acknowledged the obvious intersection or overlap between these different elements. He argued that these factors might operate in an ecology of mutual influence, with the potential for some learning or influence from one aspect of evaluation to another. More recently it has been suggested (Ditzfeld and Showers, 2013) that individuals have a differential tendency towards 'evaluative compartmentalization .. [or] .. integration' (p23). Those more organised towards 'compartmentalisation' show less mutuality of influence between the different elements.

Those more inclined to ‘integration’ experience much greater generalisation from one element or context to the next. The significance with respect to mental health, Ditzfeld and Showers observed, is that ‘compartmentalisation’ is likely to prevent the rapid spread of negativity in situations of challenge, but might impede the pace of recovery. ‘Integration’, on the other hand, might be more helpful for learning and extrapolating from success, but more risky in exposing the person to contagious cognitive-infection.

Rosenberg (1965) further suggested that evaluations with regard to each particular aspect of self might be subject to different dimensions, including direction, strength, importance, clarity, salience and stability. The combination of the first three of these dimensions, direction, strength and importance, gives a weighted evaluation with regard to any specific element and Rosenberg argued that it is this particular complex which defines the influence that those judgements have on the thoughts, emotions and actions of the person. A negative view of self, even if held strongly, is more likely to be significant and impactful if it matters. Equally, an important aspect of self is more likely to exert influence if the judgements made are clear and strong. Rosenberg argued that the generalised judgement that a person makes about themselves (their global self-esteem) reflected a cumulative aggregation of all of those weighted judgements held with regard to particular aspects of one’s self and achievements - a balancing of the weighted positives and negatives. In addition, the dimension of stability appears to have particular significance in relation to mental health problems, with an expanding body of research supporting the suggestion that fragility of self-esteem might be more predictive of emotional disorder than level of self-esteem alone (e.g. Franck and De Raedt, 2007; Kernis and Goldman 2005; Knowles et al, 2007; McElwee and Haugh, 2010; Thweissen, Lecomte, Bentall, van Os and Myin-Germeys, 2008). Fragile high self-esteem has been elsewhere described as an ‘explicit’ (manifest or enacted) high self-esteem, which is covering up an ‘implicit’ (felt) low self-esteem (DeHart, Pena and Tennen, 2013). Whereas stable low self-esteem might militate against motivation and action, fragile high self-esteem is believed to be more likely to organise a frenetic drive towards the protection or preservation of the person’s sense of self.

Rosenberg argued that attitudes toward ‘self’ develop and are sustained through a combination of social comparison, or reflected appraisal, and self-attribution (usually as a function of temporal comparisons). These processes, he suggested, would be shaped by cognitive biases of perception, interpretation, memory and projected identity (Beck, 1967; Rapee and Heimberg, 1997; Wenzel, Werner, Cochran and Holt, 2004). There are, he argued, reflexive relationships between the relative accessibility, including clarity, specificity and latency, of a person’s memories and future images of self, and their immediate experience of themselves. These elements of reflected appraisal and social identity clearly locate the person’s self-esteem within an interpersonal context (Barrowclough et al, 2003; Hogg, 2010; Meier, Semmer and Hupfeld, 2009; Park and Crocker, 2008; Reid and Hogg, 2005; Wood and Wilson, 2005).

Conceptual Models

Within the reviewed literature relating to the direct targeting of self-esteem, there was only one intervention-thread which offered a clear conceptualisation of self – that associated with Fennell (1997, 1998a, 1998b, 1999, 2004, 2016). She described low self-esteem as ‘a learned, negative, global judgment about self’ (p210). She noted that it might be ‘habitual’ and ‘outside of awareness’, and that it tended to involve ‘complimentary underestimations of strengths, assets and qualities and overestimations of weaknesses, deficits and flaws’ (1997, p2). Her model was introduced in 1997 and, then, presented in more detail in 1999 in a self-help guide. It encompassed an integration of developmental and maintenance considerations. A revised edition of the guide (2016) included some small amendments to the representation of the maintenance processes. A diagrammatic representation of Fennell’s original model is included below in full (Figure 4.3), with the moderated section detailed in Figure 4.4.

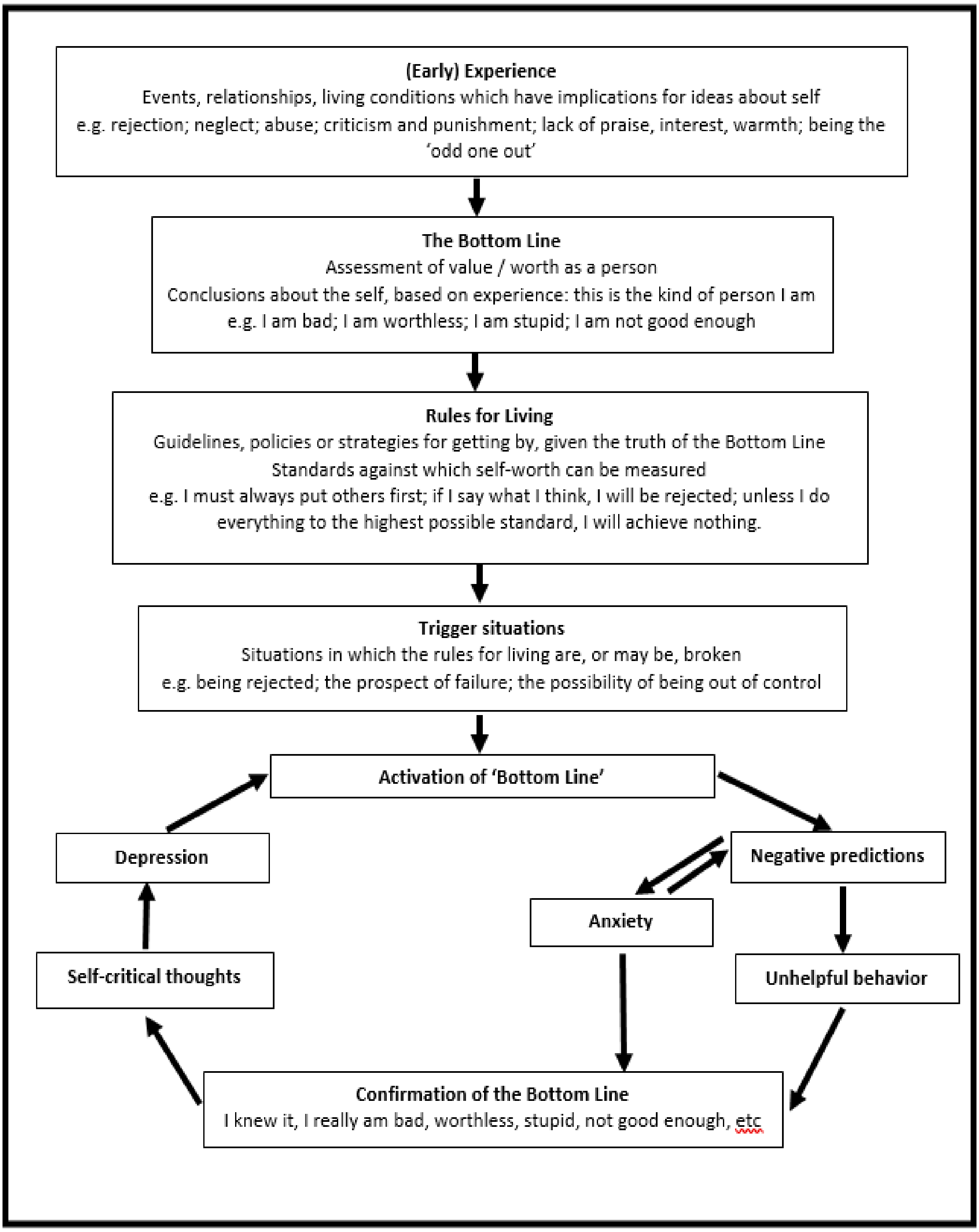


Figure 4.3 – Adapted from Fennell's Conceptual Model of Low Self-Esteem (1999, p33)

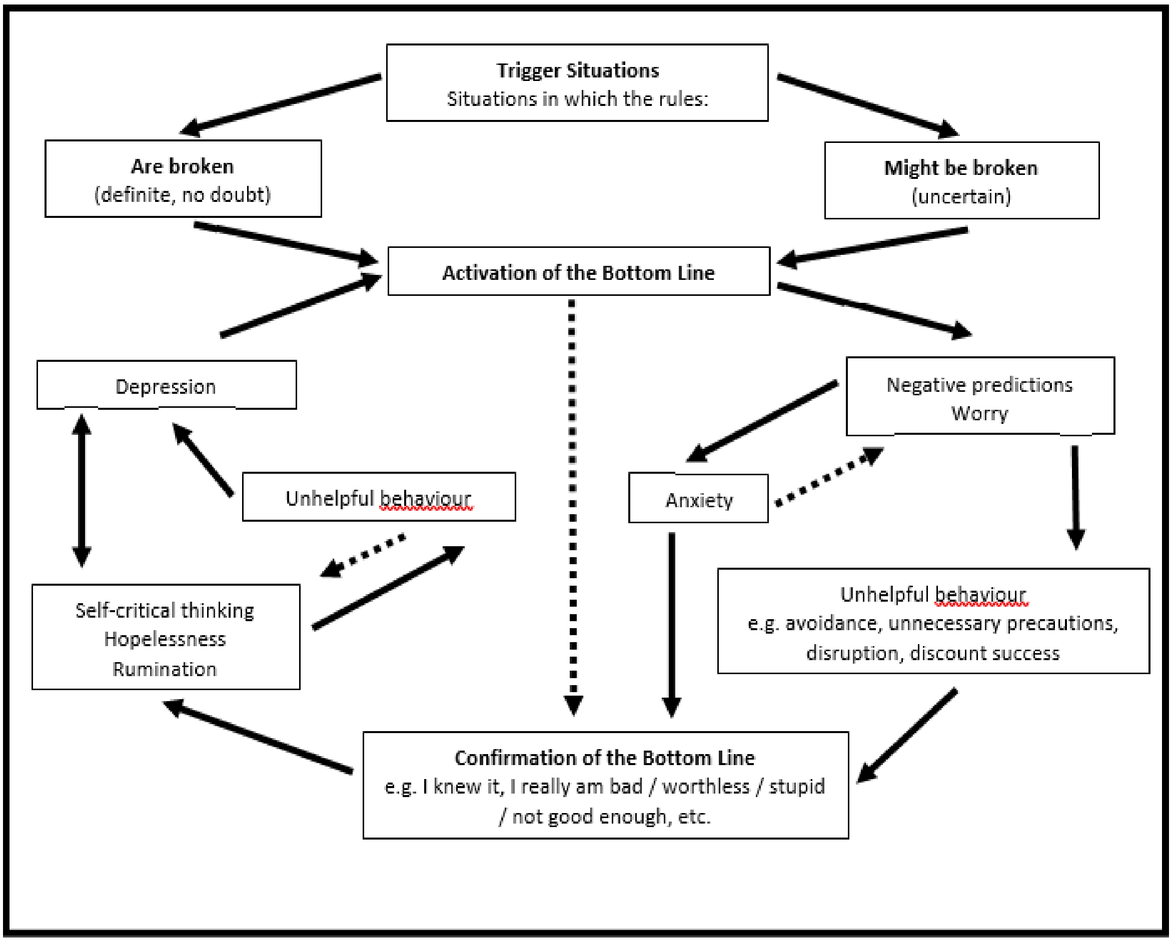


Figure 4.4 – Adapted from Fennell's (2016, p77) – Amendments of Maintenance Processes in her Conceptual Model of Low Self-Esteem.

The developmental component of the model is very consistent with Beck's seminal conceptualization of the development of depression (1967). Beck (1967) and Fennell (1999, 2016), both, suggest that significant early experiences lead to the formation of core schema about self (referred to by Fennell as the 'bottom line') which, in turn, shape the construction of dysfunctional attitudes - necessary 'rules for living'. These 'rules for living' are regarded as functional - beneficial in the short-term, but not resolving of the underlying tendency to self-negativity. In the context of a 'trigger situation', in which the rules for living didn't work or couldn't be applied, it is suggested that the 'bottom line' would be activated, leading to a cycle of negative predictions, anxiety and unhelpful behaviours, confirming the 'bottom line' and encouraging more self-critical thoughts and depression. In the updated edition of the self-help guide (2016), Fennell recognised the additional possibility that the trigger situation might threaten, but not break, the ‘rules for living’, but with, nevertheless, a consequent activation of the ‘bottom line’ (Figure 4.4). Fennell stressed that self-esteem was not a unitary phenomenon and would vary from person to person dependent upon the aversiveness and consistency of formative experiences, availability of rescue factors, and the power and consistency of ‘current maintainers’. Dimensions of variance included intensity, degree of conviction, breadth, sensitivity, level of investment, level of consequent disability, and access to positive alternatives.

4.5 Previous intervention-research of hope and self-esteem in Psychosis – To what extent is ‘need’ currently being met?

4.5.1 Introduction

This section is concerned with considerations of how and to what degree the experiences of hopelessness and / or low self-esteem in those recently diagnosed with a psychotic illness might be being met by existing CBT-based intervention programmes. This question has been examined through a systematic review of the relevant literature. The review was undertaken with reference to the PRISMA guidelines (Moher, Liberati, Tetzlaff and Altman, 2009). A summary of Moher and colleagues’ ‘Checklist of items to include when reporting a systematic review or meta-analysis’ (p5) is included in the appendices (Appendix 2A). A literature review can, of course, only consider what has been published, in terms of interventions that have been documented, described and evaluated with regard to outcomes. It cannot ascertain the extent to which these interventions have been taught, or learnt, and implemented in wider clinical practice. As noted in the introduction to this chapter, questions regarding hope- and self-esteem-targeting interventions that have been examined in other contexts are addressed in section 4.6. This part of the chapter examines the relevant literature with regard to a number of dimensions.

- The extent to which psychological interventions have been developed specifically to target hopelessness and / or low self-esteem.
- The extent to which hopelessness and low self-esteem are conjointly or separately addressed by any such interventions.
- The extent to which these interventions might have been evaluated specifically with regard to ‘early psychosis’.
- The content, structure and process of delivery of these interventions.
- Their efficacy with regard to changes in the key outcome variables of hope (or hopelessness) and self-esteem, with particular attention, where data has been available, to questions of the sustainability of benefits achieved.

Shaw (2010) observes that there are two essential components to the doing of a successful systematic review - (i) the methodical and thorough search of the existing evidence base / literature, and (ii) the critical evaluation of that evidence.

4.5.2 Literature Search – Search Strategy – Identifying the Search terms

The first step in conducting a systematic literature review is to establish the search terms that might effectively garner the best ‘catch’ of desired material. The CHIP analysis tool has been recommended as an aid to defining appropriate search terms (Shaw, 2010). CHIP provides a framework of considerations with respect to -

- The **C**ontext of the research (where it might take place?) and, therefore, of those articles / texts that might have greatest relevance.
- The **H**ow of the research methods that are likely to be employed – or in relation to which the researcher might be most interested with regard to previous studies.
- The primary **I**ssues with which the research is likely to be concerned (which might break down into a network of intersecting questions).
- The **P**opulation of participants with which the study might be concerned.

For the purpose of this literature review - (i) The **Context** was unspecified. The research was to be undertaken within a specialised Early Psychosis Service, within the NHS in the UK. The search of the literature, however, was not restricted to any specific type of service or, indeed, any country, (ii) The **How** was concerned with questions of efficacy, with a particular focus on empirical evaluations. It was deemed important, however, to also identify associated qualitative evaluations and theoretical discussions, (iii) There were three **Issues,** or factors, identified - Cognitive Behavioural Therapy, Hopelessness and Self-esteem, and (iv) The primary **Population** target was service users recently diagnosed with a psychotic illness. Although the most focussed levels of the intended search were concerned specifically with Early Psychosis, the more widely-focussed levels opened up the search to wider definitions of Psychosis and Mental Illness (see Table 4.6 below).

Key search terms or words were identified with regard to each of these areas. The list of terms was identified through the methodical consideration of associated synonyms and, given that both ‘hope’ and ‘self-esteem’ represent ‘continua’ or ‘spectrum’ constructions, antonyms. The identification of relevant synonyms and antonyms was progressed through reference to www.thesaurus.com (searched between 20/7/19 and 23/7/19). Within this on-line thesaurus, some of the key words examined, in particular for hope and self-esteem, have multiple different meanings with intersecting, but diverse, associated clusters of synonyms and antonyms. Each word was considered with reference to its appropriateness or possible value to the literature search. Decisions regarding those to be considered further were informed by the researchers previous reading of the relevant literature. Where a synonym or antonym was considered to have the potential to add something to the search, that word was subject to the further identification of synonyms and antonyms. This process continued until the search achieved saturation.

Shaw has noted (2010) that, in any literature review, the identification of the search strategy is an iterative process of trial and error, and that it will always represent a balance between comprehensiveness and specificity. The challenge, she suggests, is to find a combination of terms sufficient to capture as many of the relevant texts as possible, with the least confusion from extraneous material. Search terms relating to the health context and form of therapy were defined with relative clarity. The terms 'Early Psychosis' and 'First Episode Psychosis' are used synonymously. Within the field of 'Early Psychosis' there are no other terms that are employed as universal collectives. For this very specific target, therefore, no other terms were deemed likely to generate any relevant texts that would not be forthcoming from the use of these two phrases. Within the wider field of 'psychosis', however, there are multiple alternate forms that might be employed – including specific definitive diagnoses which fall within the umbrella of psychosis, the term 'psychotic' and the broader categorisation of 'mental illness'. With regards to the term 'Cognitive Behaviour Therapy', although the spelling of 'cognitive' never varies, 'behaviour' can, also, be written as 'behavioural', and either word might be spelt in the English form (as above) or the American – 'behavior' and 'behavioral'. In addition, 'therapy' can sometimes be represented as 'psychotherapy'. This variant tends to be associated with texts written in the UK and using English spellings. 'Cognitive Behavioral Psychotherapy' would, therefore, be an unlikely term to find. Finally, it is frequently referenced in its abbreviated form – CBT. There are no synonyms or antonyms listed for CBT in any of its spellings / variants, however, the therapeutic paradigm of CBT includes or overlaps with a broad spectrum of approaches, many of which might be referred to as CBT or as a definitive approach in their own right; for instance, Rational Emotive Behaviour Therapy, Dialectical Behaviour Therapy, Acceptance Commitment Therapy, Compassionate-focussed Therapy and Mindfulness. The decision was made not to include any of these approaches by name within the search. The generic terms 'psychotherapy', 'psychological therapy' and 'therapy' were, also considered. It was felt, however, that CBT was an internationally recognised and valued approach, and that the more unspecific terms were unlikely to capture any additional relevant papers, but would be likely to unhelpfully extend the breadth and complexity of the search process. These generic terms were, therefore, not included. Exploration of the synonyms and antonyms of hope and self-esteem identified an extensive, unwieldy array of words and terms. In order to condense these lists, those terms considered least likely to be helpful in locating additional texts (not listed through other searches) were subjected to a series of preliminary 'filter' searches, in which each term was searched exclusively in conjunction with the generic term 'therapy'. For each of these searches, titles and, where necessary, abstracts, were considered with regard to the following criteria -

- Does the text cover the development or evaluation of a CBT-based psychological therapy, specifically designed or utilized to address the construct under consideration?
- If so – would that text also be identified in a search using any of the primary search terms below (eg. Hope, hopeless, self-esteem, etc)?
- Is the text published in English?

It is important to stress that these preliminary 'filter' searches were designed only to consider the unique-value of the search-terms to the wider process. These searches were not intended, at this stage, to identify or gather relevant texts. Whether a search term might generate a relevant text was not significant, only whether any such identified texts would be missed by those other search terms whose inclusion was already established. The final list of all search terms relating to the 4 factors (Cognitive Behaviour Therapy, Hopelessness, Self-esteem and Psychosis) that were taken forward into the electronic literature search are presented in Table 4.6.

Table 4.6 – Final Search Terms Relating to the Four Issues of Interest

Issue	Final Search Terms
Hope / Hopelessness	Hope, Hopeful, Hopefulness, Hopeless, Hopelessness, Despair, Pessimism, Pessimistic, Optimism, Optimistic, Entrapment, Demoralization, Future Expectancies, Future Expectations, Encouragement
Self-Esteem	Self-esteem, Self-confidence, Self-worth, Self-concept, Engulfment, Stigma, Self-respect, Self-acceptance
Psychosis	Early Psychosis, First-episode Psychosis, psychosis, Schizophrenia, Schizo-affective Disorder, Delusional Disorder, Mental Illness, Psychotic
Cognitive-Behavioural Therapy	Cognitive Behaviour Therapy, Cognitive Behavior Therapy, Cognitive Behavioural Therapy, Cognitive Behavioral Therapy, Cognitive Behaviour Psychotherapy, Cognitive Behavioural Psychotherapy, CBT, Therapy

4.5.3 Literature Search – Search Strategy – Undertaking the search

It was noted in the introduction to the chapter that, for the purpose of the systematic literature review, the four factors (hopelessness, self-esteem, CBT and Early Psychosis) might be organised with respect to three dimensions, each of which might be said to be represented by more than one perspective. These are presented below in Table 4.7. The research was concerned with the development of a CBT-based therapy programme, designed to conjointly address hopelessness and low self-esteem in those diagnosed with Early Psychosis. Consequently, the literature search with the greatest specificity was -

(Variants of CBT) and (Variants of Hope / Hopelessness) and (Variants of Self-esteem) and (Early Psychosis or First Episode Psychosis).

The related literature search with the greatest comprehensiveness was -

(Variants of CBT) and ((Variants of Hope / Hopelessness) or (Variants of Self-esteem)) – with no specification of diagnostic focus.

Table 4.7 – Dimensions of the Literature Search with composite perspectives

Dimension	Alternate Perspectives
The specific nature of the therapy	• Variants of the term 'CBT'
The conjoint or separate targeting of hopelessness and low self-esteem	• (Variants of Hope / Hopelessness) *and* (Variants of Self-esteem) • (Variants of Hope / Hopelessness) *or* (Variants of Self-esteem)
The diagnostic or institutional context of the intervention	• Early psychosis or First Episode Psychosis • Variants of the term 'Psychosis' • No specification of diagnostic focus

All other permutations of combining the three dimensions reflect intermediary degrees of fit with the primary research focus. Table 4.8 (below) presents a full list of the 6 alternative possible search strategies with reference to degree of specificity. In this analysis '1st Degree' represents the closest fit and '4th' Degree represents least close fit. Each strategy is numbered for ease of reference.

Table 4.8 – Alternate possible search strategies with reference to Degree of Specificity to the Research Focus

Search Strategy No	Search Strategy	Degree of Specificity to the Purpose of the Research
1	(Variants of CBT) **and** (Variants of Hopelessness) **and** (Variants of Self-esteem) **and** (Variants of Early Psychosis)	1st
2	(Variants of CBT) **and** (Variants of Hopelessness) **and** (Variants of Self-esteem) **and** (Variants of Psychosis)	2nd
3	(Variants of CBT) **and** ((Variants of Hopelessness) **or** (Variants of Self-esteem)) **and** (Variants of Early Psychosis)	2nd
4	(Variants of CBT) **and** (Variants of Hopelessness) **and** (Variants of Self-esteem) **No** specification of Focus-condition	3rd
5	(Variants of CBT) **and** ((Variants of Hopelessness) **or** (Variants of Self-esteem)) **and** (Variants of Psychosis)	3rd
6	(Variants of CBT) **and** ((Variants of Hopelessness) **or** (Variants of Self-esteem)) **No** specification of Focus-condition	4th

Shaw (2010) predicts that search strategies with greater specificity are likely to generate lists with significantly lower numbers of potentially relevant texts than searches with more generic terms. In addition, in considering the comprehensive multi-stepped search strategy (above) it was anticipated that those searches that investigated the conjoint targeting of hopelessness and low self-esteem (numbers 1, 2 and 4 in the above list) would be likely to identify few relevant articles. The decision was made to conduct these searches progressively, beginning with those reflecting greatest specificity and working outwards. It is important to note that LibraryPlus - the electronic search engine at University of Derby - offers two options within its 'Advanced Search' function - 'Find all my terms' and 'Boolean Phrase'. These two search processes generate overlapping, but distinct, outcome lists. All of the searches identified above were, therefore, undertaken using both search processes –

resulting in a total of 12 searches. There were no requirements within the review with regard to the age / date of publication of the texts. It was, however, a stipulation that the text be available in English, either as the original language of publication or an official, approved translation, and published in a peer-reviewed journal. Grey literature (including Masters and Doctoral Dissertations and Theses) was not included in the search.

Table 4.9 – Preliminary Outcomes of the Search Strategy with regard to relevant texts identified and reasons for rejection of those not deemed relevant

Search	N	Potentially Appropriate
Search 1 - Boolean	6	2
Search 1 – Find all my terms	13	4
Search 2 - Boolean	84	21
Search 2 – Find all my terms	140	32
Search 3 - Boolean	82	15
Search 3 – Find all my terms	187	22
Search 5 - Boolean	266	30
Search 5 – Find all my terms	465	64
Search 7 - Boolean	1299	102
Search 7 – Find all my terms	2269	158
Search 10 - Boolean	1038	80
Search 10 – Find all my terms	1798	91

In the first instance titles and, occasionally, abstracts were considered with regard to the relevance of the text to the subject of CBT-based psychological interventions, specifically for hopelessness and / or low self-esteem in psychosis. In spite of the specificity of the search terms employed, a substantial number of articles identified in each list were not considered to be relevant. Table 4.9 (above) presents the number of articles identified by each search (N) and the number that were felt to show sufficient possibility of relevance to warrant downloading and reading in more detail (‘Potentially Appropriate’). Texts were not included where they were duplications, not written in English, not specifically about hopelessness or self-esteem, and / or not any sort of psychological therapy. Articles that referred to psychological interventions for hope or self-esteem evaluated in non-psychosis contexts were identified as relevant to other parts of the literature review, and were also downloaded.

This search generated, in total, 331 articles that were deemed sufficiently promising to warrant further, more detailed consideration as to whether they met the review criteria. These texts were downloaded and examined. Articles were only to be included in the final analysis if they were concerned with the evaluation of a Cognitive-Behavioural Therapy-informed intervention that targeted experiences of compromised hope or self-esteem in individuals diagnosed with a psychotic illness or as having experienced a psychotic episode. To narrow down the collated texts they were subjected to five filter questions. The order of exclusion from the analysis was -

1. ***Is the text concerned with those diagnosed with a psychotic disorder?***

The author’s research has been concerned with service users who are engaged with, and supported by, a specialist Early Psychosis Service in England. Those services tend to prioritise response to individuals diagnosed with a non-affective psychosis (Acute and Transient Psychotic Crisis, Schizophrenia, Delusional Disorder, Drug-induced Psychosis) over affective psychosis (Bi-polar Disorder, Schizo-affective Disorder, Psychotic Depression). In particular, individuals tend not to be accepted into the research-host specialist service if Bi-polar Disorder or Psychotic Depression have been diagnosed prior to referral, but do offer treatment to those individuals for whom this diagnosis is made after the care package has commenced. Not all articles discovered by the search identified the definitive diagnoses of research participants, or distinguished between affective and non-affective psychosis. Consequently, texts were not excluded on these grounds. Both hopelessness and low self-esteem have been identified as transdiagnostic (see earlier). Some interventions developed to specifically target these difficulties have been evaluated with different diagnostic groups, not only psychosis. Where such a thread was identified, the intervention and psychosis-relevant evaluations have been presented in this systematic review, with an acknowledgement of the wider utility of the approach.

2. ***Is the text primarily concerned with the amelioration of hopelessness and / or low self-esteem?***

The complex, multi-layered search strategy described above was constructed to identify texts in which the key factors - hopelessness, self-esteem, CBT and Psychosis - were all named. The electronic search strategy could not specify the importance with which those various elements were examined within the text. It was a requirement of the review that these issues be accorded significant attention, as the primary or secondary consideration within the text. Articles were excluded at this stage if the references to hope or self-esteem were deemed peripheral to the main thrust of the narrative.

3. ***Is the text concerned with the evaluation of efficacy of an intervention programme?***

Within any text, the association of CBT, hope and / or self-esteem might reflect a concern with - (i) an intervention designed specifically to address hopelessness and / or low self-esteem, (ii) an intervention designed to address a component or direct associate of hopelessness and / or low self-esteem, e.g, empowerment, self-stigma or demoralization, (iii) an intervention designed to address a condition of which hopelessness and / or self-esteem is regarded as a central component, e.g, depression, social anxiety, recovery or suicide, or (iv) an intervention designed to address a condition, the progression of which might be reciprocally influenced by and influencing of hopelessness and / or self-esteem, e.g, employment, psychotic symptoms or relapse. In addition, articles relating to each of those considerations might be concerned with describing an intervention, discussing its development, or evaluating its implementation. Furthermore, where evaluation was the central consideration, the focus might be qualitative or quantitative, and, in the latter case, progressed using instruments designed specifically to measure hope or self-esteem, or with measures more generic in nature. The development of the new therapy programme, and, consequently, the literature search, were predicated upon the premise that psychological interventions would be most likely to be successful when they were clearly derived from a theoretical understanding of underlying mechanisms. As such, the literature search was most interested in those articles which evaluated an intervention that had, in some way, or to some degree, been modified specifically to address service users' experiences of hopelessness or low self-esteem, and which had been evaluated using, either, a dedicated hope or self-esteem measure, or the hope or self-esteem subscale of a more broad-focused instrument. This prioritisation of interest meant that articles were excluded at this stage of filtering if there was no clear description included of any elements of therapy specifically concerned with ameliorating the balance of positive and negative evaluations of self and / or the future, or where evaluations of change in response to therapy did not specifically include recognised and validated measurements of hope and / or self-esteem. This criterion was implemented irrespective of reference to the two constructs in the title of the article, abstract or discussion. The principle review, whose conclusions are discussed below, was concerned with empirical intervention studies. Articles exploring those interventions in other ways were, also, examined and some conclusions incorporated into the review. They have not, however, been numbered within the tables. It was noted in the introduction to this chapter that the systematic review was concerned with questioning the degree to which service users' particular needs were being met by existing targeted interventions. It is acknowledged that hope and self-esteem might improve secondarily in the context of an intervention designed and delivered to address some other difficulty, or through the implementation of particular service philosophies. It was not, however, considered proportionately useful to the thrust of the review, the conducting of the research or the development of the new Therapy Programme, that these incidental or organisational occurrences be considered here.

4. *Is the intervention programme being evaluated organised within the precepts of Cognitive-Behavioural Therapy?*

Cognitive Behavioural Therapy (CBT) was a key organising term within the search. The vast majority of articles identified that considered a psychological intervention used CBT as the therapeutic paradigm. CBT is a structured, proactive approach to therapy that is organised primarily with regard to change in cognition (beliefs, thoughts or attitudes) and action (behavioural strategies and life style choices). It can be delivered in individual or group formats. Texts that examined the exposure of participants to psycho-education or positive role models, but did not incorporate additional psychological interventions designed to help the client to engage cognitively with their experiences were excluded from the analysis.

5. *Is the intervention programme under consideration concerned primarily with the improved wellbeing of mental health service users?*

Feelings of hopelessness and compromised self-worth can be contagious within families (Redlich, Hadas-Lidor, Weiss and Amirav, 2010). It might be argued, consequently, that interventions which target hopelessness and low self-esteem in family members might impact indirectly on these experiences as felt by the service user. Nevertheless, where intervention research had been concerned primarily with the amelioration of these difficulties amongst 'carers' (e.g. Redlich et al), texts were excluded from the systematic analysis.

In addition to the articles which delineated specific intervention studies, the literature search identified five research protocols for intervention studies and four literature searches of intersecting considerations. Of the research protocols identified - two concerned computer- or on-line social media-delivered interventions (Alvarez-Jimenez, Bendall, Koval, Rice, Cagliarini et al, 2019; Wykes, Joyce, Velikonja, Watson, Aarons et al, 2018), neither of which was deemed to be consistent with the review-criteria, one (Steel, van der Gaag, Korrelboom, Simon, Phiri et al, 2015) concerned a study that had not yet been reported upon in the peer-reviewed press, one (Schrank, Riches, Coggins, Rashid, Tylee and Slade, 2014) related to a study, whose preliminary findings had been published in an article already identified by the literature search, and one (Pijnenborg, Van der Gaag, Bockting, Van der Meer and Aleman, 2011) identified a study, which had been reported upon, but which the search had missed. This last article was added to the review.

The four reviews included two *systematic* literature reviews by Schrank and colleagues (Schrank, Bird, Rudnick and Slade, 2012; Schrank, Brownell, Tylee and Slade, 2014) which explored, respectively, intervention studies relating to hope and to positive psychology, and two *critical* reviews (Mittal, Sullivan, Chekuri, Allee and Corrigan, 2012; Yanos, Lucksted, Drapalski, Roe and Lysaker, 2015) which related specifically to interventions that addressed self-stigma. The Schrank, Bird, Rudnick and Slade systematic literature review (2012) was concerned with self-management strategies and interventions for the inspiration or nurturing of hope. It followed on from a series of articles by the lead author, with various colleagues, which explored the conceptualisation and measurement of hope, and its relevance to those diagnosed with a serious mental illness. The systematic review was very broad in its aims – wanting to explore (i) the use of different hope measures in research, (ii) correlations of hope with other variables, for instance perceived recovery, self-efficacy, self-esteem, empowerment, spirituality, quality of life and social support, (iii) self-management strategies to manage hope and (iv) interventions to improve hope. Within that review, the authors identified eight intervention studies which examined hope as a primary or secondary outcome. Of those, only three (McCay, Beanlands, Zipursky, Roy, Leszcz et al, 2007; Fukui, Starnino, Susana, Davidson, Cook et al, 2001; Barbic, Krupa and Armstrong, 2009), also, met the criteria for the current literature review. The first had already been identified and considered. The other two were new papers, missed by the electronic literature search as they did not include any of the key search terms in their titles. These are, in fact, the only two papers included in the current review which explored interventions directed at hope, but not, also, self-esteem. They have been included in the review detailed below. Of the other five identified, two were not principally concerned with a psychosis-participant group (Cheavens, Feldman, Gum, Michael and Snyder, 2006; Tollett and Thomas, 1995), but did describe hope interventions deemed relevant for consideration in the next section of this chapter. Of the remaining three, two explored the effectiveness of different service delivery modalities (Salyers, McGuire, Rollins, Bond, Meuser et al, 2010; Segal, Silverman and Temkin, 2010) and the last (Vreeland, Minsky, Gara, Toto, Kosseff et al, 2010) was concerned primarily with attention to strategies for managing physical health care in psychosis. Consequently, none met the criterion of being informed by Cognitive-Behavioural Therapy. The second review by Schrank and colleagues (Schrank, Brownell and Slade, 2014) reflected a development in the lead author's interest away from the specificity of a singular consideration of hope to a broader interest in positive psychology. This review was concerned with interventions that focused on the change of emphasis from negative appraisals of self, others, the world and future to more positive appraisals – through shifted attention, re-interpretation and a modified balance of remembering. The systematic review identified 18 articles which met its authors' criteria for inclusion. In spite of the delineation of 'mental illness' as central within the title, abstract and introduction, inclusion criteria were very unspecific with regard to diagnoses or treatment contexts of participant service-users. Consequently only 1 of the 18 named articles was concerned with the experiences of 'people with schizophrenia' (p100) or other psychosis. That article (Meyer, Johnson, Parks, Iwanski and Penn, 2012) had already been identified by the electronic search of the current review.

The other two reviews identified by the electronic search were both concerned with interventions that addressed self-stigma, defined by Yanos et al (2014) as those which 'explicitly target .. negative views about the self that are related to being diagnosed with a severe mental illness and / or being in mental health treatment.' They noted, further, that 'interventions that focus on self-stigma aim to increase self-esteem, hope and self-efficacy (which have all been consistently found to be inversely associated with self-stigma)' (p172). The reviews by the two teams had different criteria with regard to inclusion, with, consequently, only moderate overlap of the articles identified as relevant. The authors of the second review (Yanos et al, 2014), in fact, presented their approach as a rectification of the errors that they adjudged to have compromised the process and conclusions of the former (Mittal et al, 2012). In, what they described as, a 'comprehensive review' of the literature, Mittal et al (2012) identified 14 studies that evaluated interventions or strategies designed to reduce self-stigma amongst people with mental illness. Of these, 3 had already been identified (Fung, Tsang and Cheung, 2011; Knight, Wykes and Haywood, 2006; McCay et al, 2007) and 6 did not meet the 'psychosis' criterion for the current review. The 5 previously missed articles, which were reported by the authors to be concerned with self-stigma in Schizophrenia or serious mental illness, were followed-up. Only 1 of these met the criterion of being significantly concerned with hope or self-esteem (MacInness and Lewis, 2008). Another article identified in the review (Aho-Mustonen, Tiihonen, Repo-Tiihonen, Ryynanen, Miettinen and Raty, 2011) stated that their group psychoeducation programme included specific 'hope-promoting strategies' (p166), but those strategies were not detailed in the description of the intervention, or mentioned in any other way. In addition, change in self-esteem was measured as a secondary consideration, but there was no mention in the discussion of the purpose of the intervention, or description of its content, of any elements concerned with evaluations of self. Consequently, it has not been included in this review.

Rather than focus on individual papers, the review by Yanos and colleagues (2014) was concerned with identifying particular self-stigma targeting therapy programmes and their associated research threads. They reported on 6 intervention approaches:– (i) Healthy Self-Concept (HSC - McCay et al, 2006, 2007), (ii) Self-stigma Reduction Program (SSRP - Fung et al, 2011), (iii) Ending Self-Stigma (Lucksted et al, 2011), (iv) Narrative Enhancement and Cognitive Therapy (NECT - Yanos, Roe and Lysaker, 2011), (v) Coming Out Proud (COP - Corrigan et al, 2013), and (vi) Anti-stigma Photo-Voice Intervention (ASPVI - Russinova, Rogers, Gagne, Bloch, Drake and Mueser, 2014). The named interventions and referenced papers were followed-up. The HSC, SSRP and NECT had already been identified by the current review, which had, also, already 'discovered' all of the identified papers, as well as some that had been published more recently. The ESS papers were found to be not consistent with the current review on the grounds that the authors had not considered the relationships between narratives about illness (self-stigma) and those about self (self-esteem) or the future (hope). Interestingly, the lead author of the ESS intervention and research thread was one of Yanos' co-author-colleagues for the 2014 review which was so explicit in stating the links between these three constructs. The final two approaches, COP

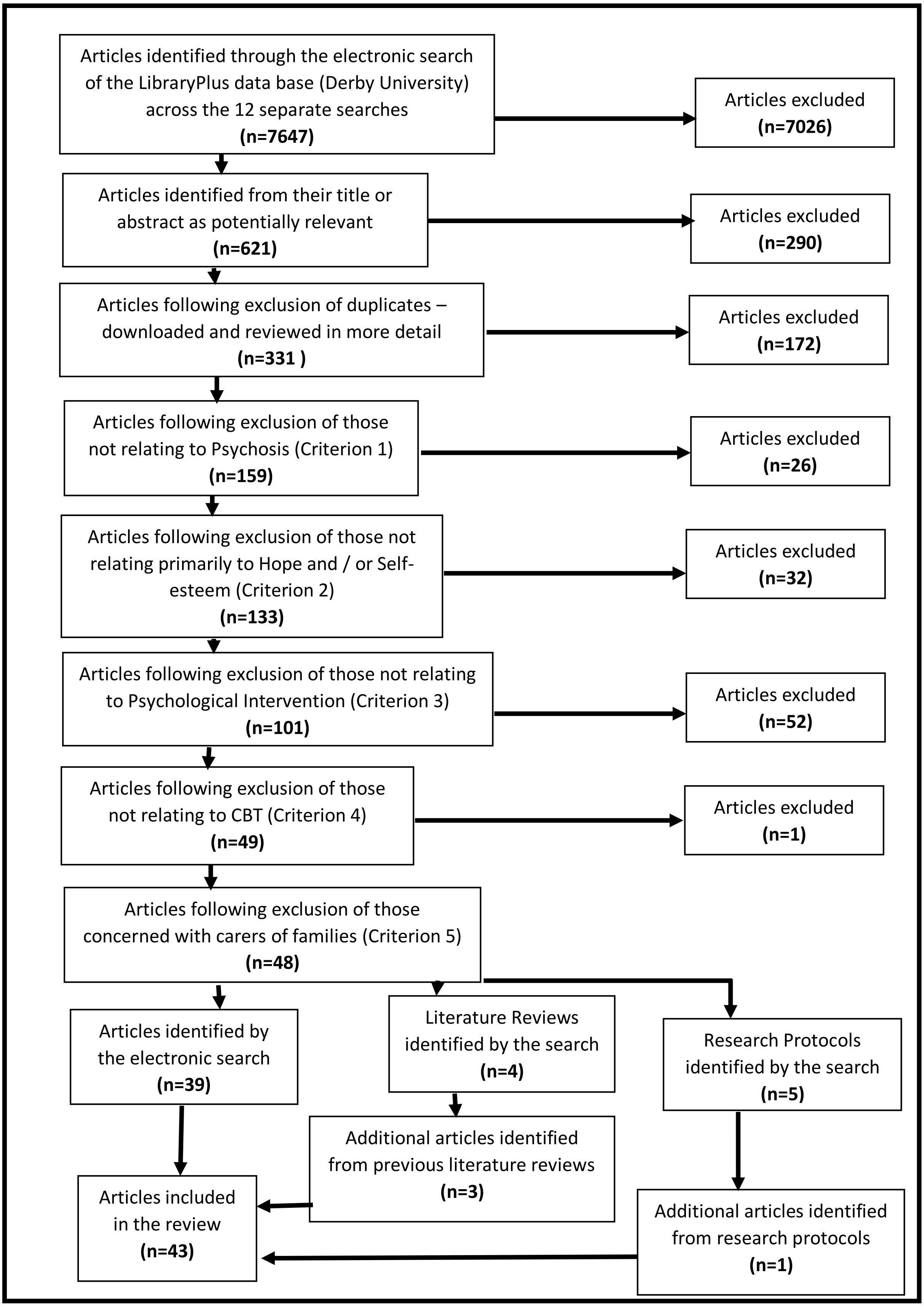


Figure 4.5 PRISMA flow diagram of the systematic search

and ASPVI, were adjudged to be not consistent with criterion 4 of the current review, in that the programmes were not informed by the tenets of CBT.

There were no relevant articles identified in the first and second literature searches (see above) which were not also identified in the very comprehensive and systematic process described for this one. A PRISMA flow-diagram of the literature search (Moher et al, 2009) is presented in Figure 4.5 (above).

4.5.4 Results of the Systematic Review

Framework of Analysis – lenses and characteristics

The development of the novel therapy programme, under consideration, has been organised with reference to three key 'lenses' or dimensions.

- That evaluations of self and the future are likely to be mutually influential, and consequently, that therapeutic attention to them as a conjoined complex might be more beneficial than attention to them as separate constructs.
- That the defining of hopelessness and self-esteem as the 'target problem' for therapy might benefit from the facilitation or implementation of a therapy programme that was informed, at least in part, by a clear normative conceptualisation of the conjoined complex, and which utilised strategies designed specifically to address nodal issues within that conceptualisation.
- That the needs of individuals diagnosed with the recent onset of a psychotic illness, whilst overlapping with those of service users elsewise diagnosed, are likely to have aspects of specificity that required a tailored approach to intervention.

These three perspectives shaped the purpose of the systematic literature search and review, and provided the principal lenses through which identified texts were examined. At the beginning of the process it was anticipated that the dimension relating to the conjoint or separate consideration of the two constructs might serve as the primary, or over-arching, lens. The search, however, generated only two articles which considered, specifically, hope-targeting interventions (Barbic, Krupa and Armstrong, 2009; Fukui, Starnino, Susana, Davidson, Cook, Rapp, and Gowdy, 2001) neither of which focussed on hope as the variable of priority. Rather, they were each concerned with a broader idea of recovery, with regard to which, hope was adjudged to be a central element. In addition, some interventions within a single research thread (e.g. NECT) were examined in separate papers and studies with reference to either self-esteem on its own (Hansson and Yanos, 2016), or in conjunction with hope (Yanos, Lysaker, Silverstein, Vayshenker, Gonzales, West and Roe, 2019). As a consequence, it was decided instead to organise the structuring of the review, in the first instance, through the lens that related to the degree of hope or self-esteem-specificity with which an intervention was developed. Figure 4.6 (below) identifies the principle structure within which included papers have been explored. It is important to note that, whilst there is considerable intersection between considerations regarding the focus of construction of an intervention and the focus of study of the utilisation of that intervention in clinical practice, they are not the same. The principal lens was the purpose of the intervention (as developed) not its application.

The organising question for the review has been the degree to which the hope- and self-esteem-related needs of early psychosis service users might already be being served by existing interventions. The primary considerations with regard to the review of papers, therefore, have been the nature and efficacy of hope- and self-esteem-targeting interventions studied, specifically, with respect to early psychosis or, secondarily, the more generic psychosis-pathway (*Intervention characteristics and outcomes*). In order to explore questions of degree of relevance or generalisability of research findings to the specific service user population under consideration, it has been important to determine the characteristics of the participant groups of the various studies (*Participant characteristics*).

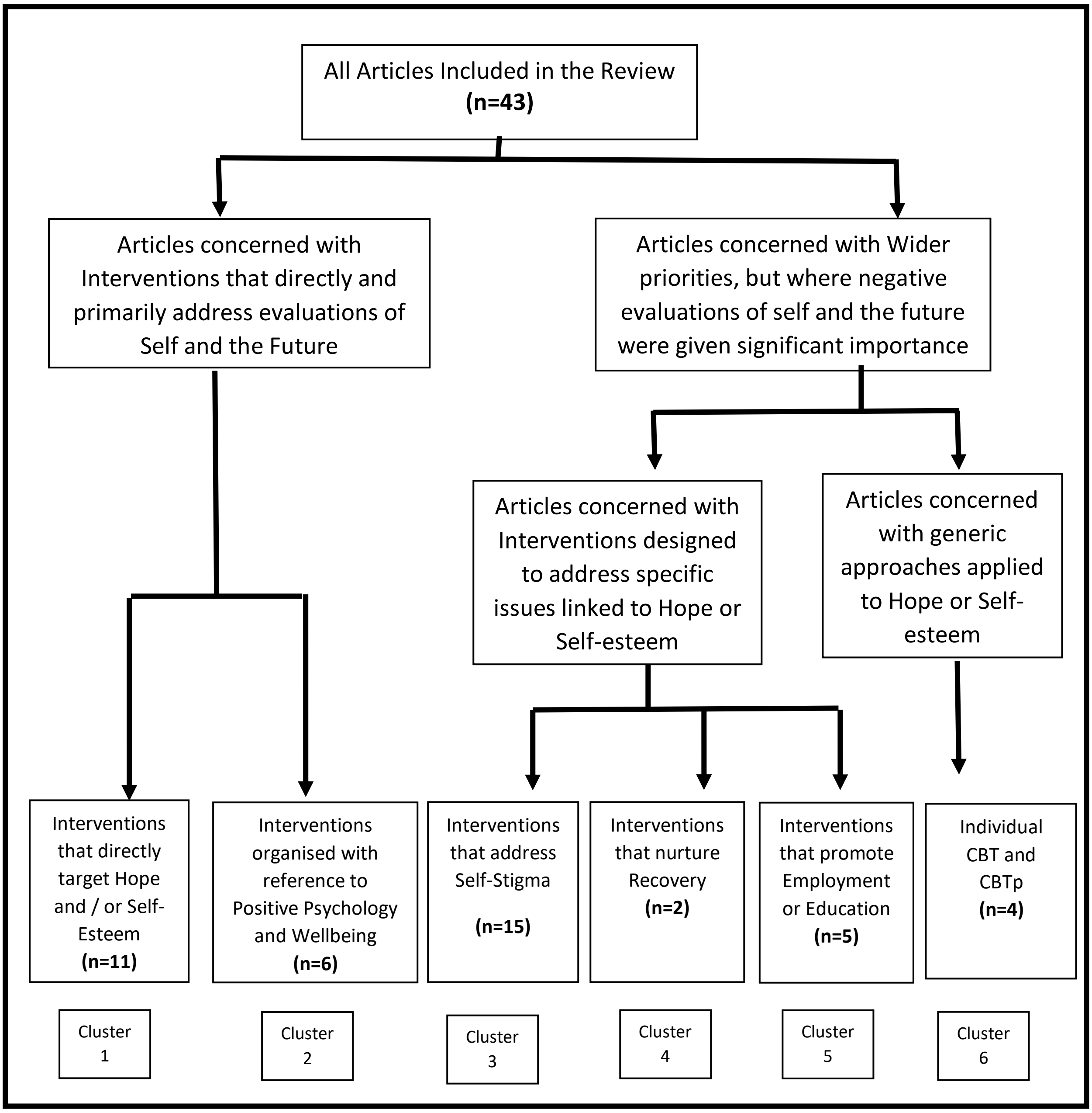


Figure 4.6 Principal Organising Structure of the Literature Review

Finally, to contextualise the study outcomes with regard to credibility, it has also been necessary to examine the research methodologies employed, with particular attention to the ways in which the researchers have endeavoured to reduce or examine their own biases within the process (*Study characteristics*). In the review that follows, relevant papers have been organised in relation to the 6 clusters identified in Figure 4.6, and have been examined with reference to the 3 sets of characteristics noted above. The discussion of each cluster includes 3 tables summarising this data for the studies assigned to that grouping.

With regard to Intervention Characteristics, the tables include, programme title, mode of delivery (individual or group), time-investment (length and frequency of meetings), rates of attrition, and outcomes – evaluated as both ‘percentage change from baseline’ and ‘percentage change across the range of the outcome measure’. These latter two indices have been included as the methodology of choice in order to allow a visual comparison of the changes achieved by very different instruments. It is acknowledged that, whilst neither of these statements of change might be regarded as the ‘correct’ or ‘right’ mechanism, the concomitant employment of both representations might be considered to offer a more triangulating perspective, and, therefore, to add more credibility to the comparisons entertained. All ‘experimental’ interventions considered in this review were delivered in addition to ‘Treatment as Usual’ (TAU). The recording of Participant Characteristics has focussed on age, gender, length of time since first onset of psychosis (where reported), and baseline level of hope and / or self-esteem. This last factor has been particularly important, as it addresses the question of ‘level of need’. It should be noted that several of the studies included in this review did not define inclusion-exclusion criteria with respect to baseline hope or self-esteem scores and outcome results are likely to have been significantly influenced by moderate to high self-esteem, in particular, as recorded in the mean baseline scores of participants. Finally, the Study Characteristics that have been prioritised have included the primary setting of the research, in terms of country, participant numbers, and study design with regard to comparison groups, randomisation and ‘blinding’ strategies. For each study, the relevant table includes a brief summary of the study-limitations noted by the authors themselves.

In order to simplify the presentation of data in the summary tables, abbreviations have been used in the column headings and in relation to the outcome measures employed. In addition, the tables have not included relevant references for the various instruments. The abbreviations relating to column headings are explained in Table 4.10 (below).

Table 4.10 – Abbreviations used in the Column Headings in the Summary Tables 4.11 to 4.29

Abbreviation	Translation
PT / T	Programme title or thread
I / G	Individual or Group delivery of intervention
N / D / L	Number and duration of appointments and length of course
RoA	Tate of attrition of participants from the intervention programme
B(R)EoT	% Change from Baseline (across the range of the measure) at End of Therapy
B(R)Fup1 (etc)	% Change from Baseline (across the range of the measure) at Follow-up 1 (etc)
U / S	Information unspecified in the report
G	Gender of participants - % Female
Age	Mean (Standard Deviation) in Years
DoI	Duration of Illness in Years
Psych	% of Participants diagnosed with a psychotic disorder
AAL	Author-acknowledged limitations to the study design
N (Total)	Number of participants in the experimental condition (Number of participants in the study in total)
RCT	Randomized Controlled Trial
FEP	Participants with First Episode Psychosis

Sixteen different Hope or Self-Esteem measures were employed across the studies described in the papers discussed in this review. Variations in the nature of those measures include - (i) the direction of scoring utilised by the scales - whether problem-scored (e.g Beck's Hopelessness Scale - BHS – Beck, Weissman, Lester and Trexler (1974) or inverse-problem-scored (e.g. Robson's Self Concept Questionnaire – RSCQ – Robson, 1989), and (ii) the range of scores - whether zero is a *central point* (e.g. the Self-Esteem Rating Scale, which has negative and positive self-esteem subscales, that combined together creates a range of -60 to +60 – SERS-SF – Lecomte, Corbiere and Laisne, 2006) or a *beginning point*. In addition, some measures, have been employed using different scoring ranges by different researchers (e.g, Rosenberg's Self-Esteem Scale, which is a 10-item, 4-point Likert scale, that can be scored 0-3 or 1-4 per item, giving a range of 0 to 30, or 10 to 40 – RSES - Rosenberg, 1965). To allow comparison, for the calculations of 'percentage change from baseline' the reported scores have been 'adjusted' to an inverse-problem scored scale, with a range beginning from zero. Example 1 - a reported score of +19 on the SERS combined scale (inverse-problem-scored, range of -60 to +60) would have been 'adjusted' to 79. Example 2 - a reported score of 15 on the BHS (problem-scored, with a range of 0 to 20) would have been 'adjusted' to 5. The various outcome instruments are presented in Table 4.11. (Note – this 'adjustment' only applies to the specific calculation noted. The scores reported in the various tables are the raw scores).

Table 4.11 – Outcome Measures of Hope and Self-esteem employed in the studies included in the Literature Review: Abbreviations, full titles, references and scoring system.

Instrument	Reference	Hope (H) or Self-Esteem (SE)	Problem scored (PS) or Inverse-problem scored (IPS)	Items	Item Range	Total Range
RSCQ	Robson's Self Concept Questionnaire (Robson, 1989)	SE	IPS	30	0-7	0-210
SERS-SF	Short Form (Lecomte, Corbiere and Laisne, 2006)	SE	2 subscales IPS and PS – add for total score	10 and 10	0-6	-60 to +60
SIPAD-SE SIPAD-SI	Self-Image Profile for Adults (Butler and Glasson, 2004)	SE	2 subscales both PS	30 rated x2	0-6	0-180
ISE	Index of Self-esteem (Hudson, 1982)	SE	IPS	25	0-4	0-100

IHE	Integrative Hope Scale (Schrank et al, 2012)	H	IPS	23	1-6	Mean per item
BHS	Beck's Hopelessness Scale (Beck et al, 1974)	H	PS	20	0-1	0-20
MES	Modified Engulfment Scale (McCay and Seeman, 1998)	SE	PS	30	1-5	30-150
MHS	Miller Hope Scale (Miller and Powers, 1988)	H	IPS	40	1-5	40-200
SADHS	Snyder's Adult Dispositional Hope Scale (Snyder et al, 1991)	H	IPS	8	1-4 or 1-8	8-32 or 8-64
SSHS	Snyder State Hope Scale (Snyder et al, 1996)	H	IPS	6	1-8	6-48
CCMIS	Chinese Self-stigma of Mental Illness Scale (Fung et al, 2007)	SE	PS	15	1-9	15-135
BCSS	Brief Core Schema Scales -ve self and +ve self (Fowler et al, 2006)	SE	2 subscales IPS and PS	6 and 6	0-4	0-24 and 0-24
CFSEI	Culture Free Self Esteem Inventory (Battle, 1992)	SE	IPS	30 (?)	0-1	0-30 (?)
RSES	Rosenberg Self Esteem Scale (Rosenberg, 1965)	SE	IPS	10	0-3 or 1-4	0-30 or 10-40
HHI	Herth Hope Index (Herth, 1991)	H	IPS	12	0-3 or 1-4	0-36 or 12-48
QuickLL	QuickLL (Lecomte and Leclerc, 2004)	SE	IPS	2	1-3	Mean per item

Cluster 1 - Interventions that directly target Hope and / or Self-Esteem

Eleven papers have been included in this cluster. They relate to five research threads – each concerned with the evaluation of one specific intervention. Relevant data has been summarised in Tables 4.12 (Intervention Characteristics), 4.13 (Participant Characteristics) and 4.14 (Study Characteristics) by thread. All of the interventions explored in this cluster relate to the amelioration of low self-esteem. None are concerned with hope.

The most prolific intervention thread included in this cluster is concerned with an intervention strategy developed by Nick Tarrier (2002) and evaluated, in the first instance, by himself and Pauline Hall (2003). The thread includes the original description of the intervention together with 6 papers, describing a total of 5 studies (Chatterton, Hall and Tarrier, 2007; Hall and Tarrier, 2003, 2004, 2005; Lathwaite, Gumley, Benn, Scott, Downer et al, 2007; Oestrick, Austin, Lykke and Tarrier, 2007). In the first articulation and exploration of the intervention, Hall and Tarrier (2003, 2004; Tarrier, 2002) were concerned with low self-esteem as secondary to the development of a Serious Mental Illness. In consequence they focused on the accrual of a multiplicity of negative factors, including negative views of self, of mental illness, of circumstances and the future, social reaction and stigma, the criticism or hostility of family environment and the reciprocating effects of hopelessness, suicidal ideation and self-harm. Subsequent papers (Hall and Tarrier, 2005; Chatterton, Hall and Tarrier, 2007) show evidence of a move towards a formulation more akin to that of Fennell (see section 4.4, above). Neither the Oestrich et al (2007) nor Laithwaite et al (2007) papers give any discussion of formulation and none of the papers in this thread consider the wider conceptualization of the self. The intervention was delivered in both individual (6-8 sessions) and group therapy (twelve 2.5 hr sessions) formats, but otherwise was facilitated consistently across all studies in the thread, appearing to be largely invariant in nature, rather than formulation-driven or unique to the idiosyncrasies of the individual. It was brief and focused, a single technique targeting a single nodal-point in the person's evaluation of self – the promoting of positive self-appraisals. Participants were asked to articulate hitherto largely neglected, positive qualities about themselves. These were reinforced progressively through the elicitation and rehearsal of specific memories, and the monitoring of supportive evidence in 'everyday life'.

The second research thread included in this cluster is associated with Lecomte, Leclerc and Wykes. The thread might be described as having developed in two parts or strands. The first includes an originating text (Reasoner, 1992), the initial study by Lecomte and colleagues (Lecomte, Cyr, Lesage, Joyce Wilde, Leclerc and Ricard, 1999), a follow-up study led by Borras (Borras, Boucherie, Mohr, Lecomte, Perroud and Huguelet, 2009) to which Lecomte acted as supervisor and an adaptation by Wykes and colleagues (Knight, Wykes and

Haywood, 2003). Reasoner’s work was written as a handbook for school-based educators. Lecomte et al’s study developed Reasoner’s ideas into a classroom-based course for adults diagnosed with schizophrenia. The treatment consisted of a 24-session group psycho-educational course, run over 12 weeks, covering aspects of self, relating to security, identity, belonging, purpose and competence. Although primarily didactic in nature, its facilitation, also, involved discussion, games, tests and experiential exercises. Lecomte’s classroom-based approach is unique within both the hope and self-esteem intervention literature. It has potential significance with regard to strategic service developments relating to a ‘Recovery College’ local to the researcher-therapist.

Table 4.12 – Cluster 1 – Interventions that Directly Target Hope and / or Self Esteem – Summary of Intervention Characteristics

Study	PT/T	I/G	N/D/L	RoA %	B(R) EoT	B(R) Fup1	B(R) Fup2
Hall and Tarrier (2003)	Hall and Tarrier	Individual	7 sessions U/S, 7 weeks	8.3	69.5 (28.2)	63.7 (25.8) **12/52**	X
Hall and Tarrier (2004) 1-year Follow-up	Hall and Tarrier	Follow-up	Follow-up	N/A	X	X	34.1 (13.8) ***1 year***
Hall and Tarrier (2005)	Hall and Tarrier	Individual	7 sessions, 1 hour, 7 weeks	0	95.3 (38.6)	95.3 (38.6) ***3/12***	61.2 (24.8) ***1 year***
Laithwaite et al (2007)	Hall and Tarrier	Group	10 sessions, 2.5 hours, 10 weeks	0	*RSCQ* 15.4 (7.5) *RSES* 26.9 (13.1) *SIP-AD-SI* 10.2 (6.2) *SIP-AD-SE*	*RSCQ* 13.7 (6.6) *RSES* 22.8 (11.1) *SIP-AD-SI* 8.2 (5.0) *SIP-AD-SE*	X

					9.5 (7.1)	8.2 (6.1) ***12/52***	
Oestrich et al (2007)	Hall and Tarrier	Individual	8 sessions U/S, 8 weeks	30.4	30.2 (13.8)	27.1 (12.4) ***3/12***	X
Lecomte et al (1999)	Lecomte	Group	24 sessions, U/S, 12 weeks	29.4	3.1 (5.0)	2.0 (3.3) ***6/12***	X
Knight, Wykes and Haywood (2006)	Lecomte	Group	7 sessions, U/S, 6 weeks	9.5	8.5 (4.1)	7.6 (3.7) ***6/52***	X
Borras et al (2009)	Lecomte	Group	24 sessions, 1.0 hours, 12 weeks	20.4	*Immediate* 36.7 (15.8) *Delayed* 1.7 (0.8)	*Immediate* 26.1 (11.3) *Delayed* 21.6 (9.4) ***1 year***	X
Van der Gaag et al (2012)	COMET	Individual	7 sessions, U/S, U/S	28.2	*U/S*	X	X
Freeman et al (2014)	Freeman	Group	5 Sessions, U/S, 8 weeks	0.0	35.2 (12.3)	29.0 (10.2) ***4/52***	X
Kunikata, Yoshinaga and Nakajima (2016)	CBGTRS	Group	12 sessions, 2.0 hours, 24 weeks	7.3	15.4 (7.4)	16.2 (8.0) ***4/12***	21.0 (10.4) ***1 year***

The follow-up study (Borras et al, 2009) and adaptation by Knight, Wykes and Haywood (2003) were both delivered as group therapy programmes. The latter included elements relating to the discriminatory narratives of mental illness (self- and public-stigma), the development of coping strategies and the nurturing of empowerment through assertiveness-training and access to advocacy. The ‘Lecomte’ research thread has a second part, reflecting a move in focus to a broader consideration of wellbeing. Although the nurturing of self-esteem remains a key consideration, it no longer defines the intervention as a whole. Articles pertaining to that evolution of the intervention are discussed in the section below concerning ‘Cluster 2’ (see Figure 4.6).

The third research thread was concerned with Korrelboom’s COMET (Competitive Memory Training) intervention for self-esteem. This approach has been explored and discussed across a number of articles - the unpublished formal intervention protocol developed for conducting the COMET research and five different evaluations of the intervention (Korrelboom, van der Weele, Gjaltema and Hoogstraten, 2009; Korrelboom, de Jong, Huijbrechts and Daansen, 2009; Korrelboom, Marissen and van Assendelft, 2011; Korrelboom, Maarsingh and Huijbrechts, 2011; van der Gaag, van Oosterhout, Daalman, Sommer and Korrelboom, 2012).

Table 4.13 – Cluster 1 – Interventions that Directly Target Hope and / or Self Esteem – Summary of Participant Characteristics

Study	G	Age	DoI	Psych	Hope	SE
Hall and Tarrier (2003)	52	38 (10.0)	15.4	100	X	*RSCQ* 85.18 *Moderate-to-very low*
Hall and Tarrier (2004)	Follow up	Follow up	Follow up	Follow up	Follow up	*RSCQ* 85 (median) *Moderate-to-very low*
Hall and Tarrier (2005)	100	52	>20	100	X	*RSCQ* 85 *Moderate-to-very low*
Laithwaite et al (2007)	0	35.3 (8.8)	Duration of illness U/S. 7 years in a Secure Hosp setting.	100	X	*RSCQ* 101.53 *RSES* 14.6 *Both Mildly low* *SIP-AD (SI)* 109.4 *SIP-AD (SE)* 46.6 *Moderately high*

Oestrich et al (2007)	25.0	U/S	8.5	100	X	*RSCQ* 96 *Moderately low*
Lecomte et al (1999)	24.2	40.6 (10.7)	16.4	100	X	RSES 29.9 *Mild-to-moderately high*
Knight, Wykes and Haywood (2006)	47.6	39.3 (8.8)	13.44	100	X	*ISE* 51.72 *Neither low nor high*
Borras et al (2009)	30.0	41.0 (9.0)	18.9	100	X	*SERS* I -8.2 D -8.1 *Mildly low*
Van der Gaag et al (2012)	46.2	40.4 (12.0)	13.3	100	X	*SERS* 1.1 *Neither low nor high*
Freeman et al (2014)	26.7	41.9 (11.5)	U/S	100	X	*RSCQ* 73.9 *Very low*
Kunikata, Yoshinaga and Nakajima (2016)	56.1	42.8 (11.4)	53.7% had a DoI >10	60.9	X	*RSES* 24.85 *Neither low nor high*

Two further papers were identified, but were published in a Dutch language journal (Directieve Therapie), with no resource for English translations (Korrelboom 2000; Olij, Korrelboom, Huijbrechts, de Jong et al, 2006). Only one of these, however, (van der Gaag et al, 2012) has been concerned with the implementation of the approach with participants appropriate to the literature review. The outcome data relating to the exploration of the approach in other contexts has been included in the discussion below. Korrelboom's approach might be described as a more complex and developed version of that examined by Hall and Tarrier (2003). The intervention was based on a belief that positive attitudes to self were losing in 'retrieval competitions' with more negative self-views and thus people might feel low in self-esteem even when they knew that they had character traits or capabilities of value. The goal of therapy, rather than being concerned with changing negative beliefs, was targeted towards encouraging positive and functional memories in the most creative, powerful and effective way possible. It involved multiple simultaneous strands of intervention – including the creative use of inspirational music, confident and assertive body posture, and the expression of positive self-statements, written and verbalised. Emerging positive self-views were strengthened through counter-conditioning in progressively challenging virtual and real scenarios. Korrelboom stressed that COMET was designed for use with clients whose self-esteem was only moderately low and more amenable to change - 'those people who in fact 'know' (realize) that their negative judgment of themselves is too severe' (2006, p1). Where negative self-judgments were rooted in reality, he suggested that other 'self-improvement' strategies might be necessary.

The fourth thread in this cluster concerns the work of Freeman and colleagues (Freeman, Pugh, Dunn, Evans, Sheaves et al, 2014). The 2014 paper reported a pilot study to explore the benefits of a new 8-week, group-therapy programme, organised in relation to CBT,

Table 4.14 – Cluster 1 – Interventions that Directly Target Hope and / or Self Esteem – Summary of Study Characteristics

Study	Country	N (Total)	Design	AAL
Hall and Tarrier (2003)	UK	12 (25)	RCT	Small sample size. Heterogenous participant group. One therapist only. High rate of refusal to participate.
Hall and Tarrier (2004)	Follow up	Follow up	Follow up	Small sample size. High attrition rate.
Hall and Tarrier (2005)	UK	1 (1)	Single Case Design	U/S
Laithwaite et al (2007)	UK	15 (15)	Cohort Study	Small sample size. No matched control-group. Self-report measures employed. Measures not validated for participant population. Assessments were completed with the assistance of the programme facilitators. Not independent.

Oestrich et al (2007)	Denmark	23 (23)	Cohort Study	No comparison control group. Assessors were not blind to the aim of the study. Intervention delivered in a controlled hospital environment. Small sample size and high attrition rate.
Lecomte et al (1999)	Canada	51 (95)	RCT	U/S
Knight, Wykes and Haywood (2006)	UK	21 (21)	Waiting-list control	Small sample size. Study design (waiting list control) not the most powerful to assess effects. Comparatively brief follow-up period.
Borras et al (2009)	Switzerland	54 (54) I-28 D-26	Immediate (I) vrs Delayed (D) Start	Sample size selected based on practicality factors rather than power analysis. Absence of a control group.
Van der Gaag et al (2012)	Netherlands	39 (77)	RCT	Small sample size. High attrition. High rate of reluctance to participate. No follow-up.
Freeman et al (2014)	UK	15 (30)	RCT	U/S
Kunikata, Yoshinaga and Nakajima (2016)	Japan	41 (62)	Non-Randomised CT	Not RCT, so cannot claim high reliability. Small sample size. Insufficient assessment of baseline predictors of treatment outcomes.

targeted towards those diagnosed with schizophrenia or other psychoses, and concerned with diminishing negative ‘thoughts’ and building positive ones. These characteristics implied considerable overlap with the intended parameters of the intervention under construction. The article emphasised the focus on addressing low self-esteem, including the normalization of negative self-views and the promotion of positive self-evaluations through attention to areas of strength and experiences of success. The approach was said to use a combination of cognitive strategies (including positive data logging), activity scheduling and proactive, positive engagement of others as allies. Reference was made to a guiding manual (Freeman and Freeman, 2012). That book, however, presented a significantly more broad and generic approach, in which the relative allocation of attention identified self-esteem as being only a minor consideration.

Finally, the cluster includes an article by Kunikata and colleagues (Kunikata, Yoshinaga and Nakajima, 2016), reporting on their intervention programme - Cognitive Behavioral Group Therapy for Recovery of Self-Esteem (CBGTRS) - developed and delivered in Japan. Their 12-session intervention includes elements of 'psychoeducation, cognitive reconstruction and rebuilding the negative self-image' (p459), together with more behavioural attention to improving problem-solving skills, assertiveness training and effective goal-setting. The authors prioritise reference to Fennell in their discussion of self-esteem as a clinical concern (see section 4.4) and to the research thread associated with her work in the justification for their intervention. They do not, however, offer any clear conceptualisation or formulation of their own and do not explain the developmental roots of their programme. No follow-up study has been published as yet.

The Hall and Tarrier intervention is, from its description, the simplest with regard to delivery. It has, also, been associated with the most dramatically positive gains by the end of treatment. However, four of the five studies included follow-up data (from 3 – 12 months) and, in each case, the drop-out rate of participants and drop-off of initial gains was quite substantial. The initial study (2003, 2004), for instance, achieved mean gains at the end of therapy of 69.5% from baseline and 28.2% across the range, but these scores had reduced, respectively, to 34.1% and 13.8% twelve months later. Furthermore, the rate of loss of participants to the study was so great as to require a change from mean to median figures for the follow-up analysis. These results were particularly striking in the context of participants diagnosed with a Serious Mental Illness, extended duration of illness (mean DOI of 21.86 years) and advancing years - criteria that might be regarded as promoting chronically compromised self-esteem. The second Hall and Tarrier study (2005) achieved even more striking results (95.29% improvement from baseline post treatment, sustained at 61.18% at 12 months), but the single participant had a diagnosis of Bi-polar Disorder and was, at the time of treatment, an inpatient progressing towards discharge. Both of these circumstances might be expected to be reflected in dramatic shifts in cognition and affect. The results, therefore, need to be regarded with considerable caution. Both the Oestrich et al (2007) and Laithwaite et al (2007) investigations achieved good results, the former including a 'clinically significant' improvement by the end of therapy and sustained at 3 months follow-up. The second compared outcomes across 3 different measures. Although two of the measures - Rosenberg's Self-Esteem Scale (Rosenberg, 1965) and Robson's Self Concept Questionnaire (Robson, 1990) - showed fairly high levels of correlation in their percentage variance, the results of the SIP-AD (Butler and Glasson, 2004) were very disparate. In addition, in contrast to the other two instruments, the data from the SIP-AD suggests that participants' baseline levels of self-esteem were in the moderate high range, questioning either the utility of the measure, or the relevance of the intervention to the participant group. This result reinforces questions about the degree of validity with which comparisons of the outcomes of different studies might be made.

The analysed outcome data of the Lecomte, Leclerc and Wykes thread show a striking degree of ambiguity. The Lecomte et al (1999) study achieved very minimal improvements in self-esteem (only 2.04% change from baseline post-treatment, increasing to 3.31% at 3-month follow-up), which compares poorly with the gains reported elsewhere. Baseline means, however, were in the moderate to high range of the measure employed. The Knight, Wykes and Haywood (2006) study, also, achieved only limited gains (7.9% change from baseline, mostly sustained after 3 months). These changes were determined by the authors to be statistically significant (albeit only at the p=0.044 level). However, 47.4% of participants were reported to have demonstrated a clinically significant gain in self-esteem, and there were, also, more substantial improvements reported in several other aspects of symptomology. The Borras et al (2009) study is, perhaps the most complicated, using 7 intervention groups allocated according to two independent variables (treatment context and immediate / delayed commencement). The data was subjected to multiple-regression analysis. Self-esteem showed sensitivity to the timing of treatment, whereas other secondary variables were more responsive to the treatment context. The only groups which showed statistically significant improvements in self-esteem were all from the 'immediate start' condition (though not all of the groups who received that condition). Amongst the 'delayed start' groups, one measure (SERS-SF – negative subscale – Lecomte, Corbiere and Laisne, 2006) actually showed a degree of deterioration over the course of treatment.

The Korrelboom intervention (COMET) was very similar in purpose to that of Hall and Tarrier, but more complex and multi-faceted. The only study that has been conducted within the relevant field (psychosis) does not present any raw data. The results of a 'multiple mediator analysis' are reported and the authors conclude that 'self esteem … fulfilled all the criteria for full mediation' (p165). There is, however, no available data by which the reader might draw their own conclusions, or with which the approach might be compared with others. The COMET intervention has been examined with regards to low self-esteem experienced in relation to other mental health needs. Those studies show, in general, moderately good improvements in self-esteem over the course of treatment, including one study (Korrelboom, de Jong et al, 2009) in which a high percentage of participants achieved clinically significant change. Gains were less striking than those results achieved by Hall and Tarrier. Only two of the investigations sought to provide follow-up data. In one (Korrelboom, van der Weele, Gjaltema and Hoogstraten, 2009) the drop-out rates were so high that the demographics of the final group of completers were almost unrecognizable from those of the starters. It might be extrapolated from follow-up data available from the second (Korrelboom, Maarsingh and Huijbrechts, 2011) that this approach provided a more sustained improvement than that associated with Hall and Tarrier, but that conclusion needs to be treated with caution.

Very positive gains were achieved in the Freeman study, both from baseline and across the range of the measure, with change at the end of therapy of 35.2% (12.4%). These gains were mostly sustained at 1-month - 29.0% (10.2%). This was, however, a very short-term re-evaluation and any conclusions to be drawn from the results suffer from a lack of more extended follow-up. The Kunikata et al (2016) study, on the other hand, shows more modest gains at end of therapy (15.4% from baseline and 7.4% across the range), but those results were improved upon at 4-month follow-up, and, again, at 1-year – 21.0% (10.4%).

The current study is concerned with the hope and self-esteem needs of those diagnosed with a first episode of psychosis (FEP). In Chapter 3 (above) this was defined as being within the age range 14 to 38, and a duration of diagnosed illness of less than 3 years. None of the studies reported in Cluster 1 of the review was defined as targeting FEP participants. The age of participants in studies had a range of 35.3 (Mean) and 8.8 (standard deviation) to 52 (single case). Although some of these individuals might have met the age criteria for FEP, the lowest mean duration of illness (time since first diagnosed) was 8.5 years. These were not FEP service users. Earlier in the chapter it was noted that self-esteem and hope can be become compromised in response to the onset of psychosis, and those perspectives can become more entrenched as the illness continues. Consequently, any conclusions drawn regarding the application of these self-esteem interventions to a more enduring-psychosis participant group have to be considered with caution before generalising to an FEP client group.

Cluster 2 - Interventions organised with reference to Positive Psychology and Wellbeing

The second cluster of included articles is concerned with interventions that address a broader concept of positive wellbeing, in which hope and / or self-esteem plays a significant role, but within a more wide-ranging approach. This cluster includes three research strands – relating to Lecomte, Meyer and Schrank. Relevant data has been summarised in Tables 4.15 (Intervention Characteristics), 4.16 (Participant Characteristics) and 4.17 (Study Characteristics) by thread.

The first strand to be included in this cluster relates to a collaboration between Lecomte, Leclerc and Wykes, with the subsequent development of a Group Therapy Programme for Cognitive Behaviour Therapy with Psychosis (Group CBTp – Lecomte, Leclerc, Wykes and Lecomte, 2003). The programme has been evaluated across three outcome studies (Lecomte, Leclerc, Corbiere, Wykes, Wallace and Spidel, 2008; Lecomte, Leclerc and Wykes, 2012; Lecomte, Leclerc, Wykes, Nicole and Baki, 2015; Lecomte, Leclerc and Wykes, 2018; Naeem, Johal, McKenna, Rathod, Ayub, Lecomte et al, 2016). The first two papers present the original and follow-up evaluations of one study; the second two papers report on different elements of a subsequent one. The Naeem et al study has examined the feasibility of the approach with reference to the broad needs of FEP service users, however, changes in neither hope nor self-esteem have been reported upon, so the paper has not been subject to detailed analysis within this review. In addition, several papers have progressed qualitative examinations of factors impacting upon the efficacy of the approach – including the therapeutic alliance (Lecomte, Laferriere-Simard, and Leclerc, 2012) and context challenges (Spidel, Lecomte and Leclerc, 2006). Most recently the programme has been detailed in a manual (Lecomte, Leclerc and Wykes, 2016). Group CBTp has been included in this literature review because it emerged in direct relation to the work undertaken by each of the collaborators with respect to self-esteem. In the group programme, however, low self-esteem has been regarded as merely a component part of a wider complex of issues experienced in relation to the onset of a mental illness. As a consequence, attention to narratives of self takes up a significantly reduced space within the therapeutic process, and evaluations of changes in self-esteem have not always been key to the delivery of the approach. As with the programme from which it was developed, Group CBTp is manualised and delivered in 24 sessions over the period of 3 months. Group activities are divided into 4 areas - (i) Stress and how it affects me, (ii) Testing hypotheses and looking for alternatives, (iii) Drugs, alcohol and how I feel, and (iv) Coping and competence. Addressing low self-esteem (and hopelessness – Lecomte et al, 2003) is progressed implicitly throughout the programme, through the attitudes and style of the facilitators, the encouragement of normalisation and through the creation of more positive narratives of illness. The issues are, also, addressed more explicitly in the third section – ‘how I feel’.

The Meyer research thread consists, at this time, of only one paper (Meyer, Johnson, Parks, Iwanski and Penn, 2012). The paper describes the evaluation of their ‘Positive Living Group’, a 10-session, group-based intervention. It is based upon Seligman et al’s ‘Positive Psychotherapy’ (Seligman, Rashid and Parks, 2006), but adapted specifically for treating those diagnosed with schizophrenia. The approach focuses on improving psychological wellbeing, and building positive feelings, behaviours and cognitions. Hope and optimism, self-determination and self-respect are central themes. The programme includes attention to strengths, a rebalancing of negativity through nurturing of appreciation and gratitude, positive goal-setting and mindfulness. A key part of the adapted intervention was the introduction of a ‘booster session’ designed to remind participants of the content of the intervention and to encourage them to practice the taught-behavioural strategies.

Table 4.15 – Cluster 2 – Interventions organised with reference to Positive Psychology and Wellbeing – Summary of Intervention Characteristics

Study	PT/T	I/G	N/D/F	RoA %	B(R) EoT	B(R) Fup1	B(R) Fup2
Lecomte et al (2008)	GCBTp	Group	24 sessions, U/S, 3 months	12.0	10.1 (5.8)	11.2 (6.4) ***6/12***	X
Lecomte et al (2012) Follow-up	Follow-up	Follow-up	Follow-up	Follow-up	X	X	11.5 (6.5) ***1 year***
Lecomte, Leclerc et al (2015) Lecomte, Leclerc and Wykes (2018)	GCBTp	Group	24 sessions, U/S, 3 months	53	*QuickLL* 2.3 (1.5) *SERS* U/S	*QuickLL* U/S *SERS* -1.4 (-0.9)	X
Meyer et al (2012)	Positive Living	Group	10 sessions, U/S, U/S	18.8	*SDHS* 17.7 (9.1) *SERS* 14.7 (9.2)	*SDHS* 18.5 (9.5) *SERS* 15.2 (9.5) ***3/12***	X
Schrank et al (2015)	WELLFOCUS	Group	11 sessions, 1.5 hours, 11 weeks	8.5	*IHS* 6.9 (4.2) *RSES* 8.5 (6.3)	X	X

As with Meyer, the Schrank research thread consists of only one intervention study (Schrank, Brownell, Jakaite, Larkin, Pesola, et al, 2015), but it sits within the context of a series of articles which illustrate the progression of Schrank's ideas, from an initial focus on the amelioration of hopelessness, to, again, a much wider concern with positive psychology and wellbeing. The work is current and there is reason to expect further developments. In addition, the intervention is targeted towards those diagnosed with a serious mental illness, which makes it the closest in nature to the novel Therapy Programme; at least, of the 'Hope' interventions examined. The Schrank thread includes a systematic review of the literature regarding the conceptualisation of hope (Schrank, Stanghellini and Slade, 2008), its direct targeting with psychological interventions (Schrank, Bird, Rudnick and Slade, 2012), the relevance of hope to psychiatry (Schrank, Haywood, Stranghellini and Davidson, 2011), evaluation of a new outcome measure – the 'Integrative Hope Scale' (Schrank, Woppman, Grant-Hay, Sibitz, Zehetmayer and Lauber, 2011), as well as the introduction and evaluation of a new intervention – 'WELLFOCUS PPT' (Schrank et al, 2015). Schrank and colleagues defined hope as 'a primarily future orientated expectation (potentially informed by negative experiences such as mental disorder) of attaining personally valued goals which will give meaning, are subjectively considered possible and depend on personal activity or characteristics (e.g. resilience and courage) and / or external factors (e.g. resource availability)' (2012, p555). They suggested that hope might have significance in mental ill-health, with respect to recovery, resilience, and the capacity for human adaptation and psychological change. Their WELLFOCUS PPT intervention was delivered as a group therapy, with 11 sessions of 90 minutes each. The articulated goal was to increase wellbeing through increasing positive experience, amplifying strengths, fostering positive relationships and creating a more meaningful self-narrative.

Of the two Group CBTp studies, the first (Lecomte, Leclerc et al, 2008; Lecomte, Leclerc and Wykes, 2012) achieved modest gains, sustained over time, with a small progressive increase. The second (Lecomte et al, 2015; Lecomte, Leclerc and Wykes, 2018), however, showed very little benefit, with one measure, the QuickLL (Lecomte and Leclerc, 2004), showing a small deterioration in scores over the course of course of therapy, which was not followed-up, and the second measure (SERS) showing negligible change to 6 months follow-up (with no ‘end of therapy’ data reported). The results seem, perhaps, to have been compromised by the use of QuickLL, a potentially insensitive instrument, with only two items (scored 1-3) relating to self-esteem, and not validated for use with groups. In addition, neither of these studies used self-esteem scores within their inclusion-exclusion criteria, and both showed baseline means of moderate to greater self-esteem. The Meyer intervention (2012) achieved more substantial gains in, both, self-esteem and hope, and those gains were sustained, and marginally improved, at 3-months review, which has been linked, in part, to the ‘booster session’. As with Lecomte and colleagues, the Schrank et al study (2015), targeting those diagnosed with schizophrenia, was also compromised by very high baseline scores in both hope and self-esteem. Only small percentage gains were achieved, from baseline and across the range - 3.0% (1.8%) for hope and 5.8% (4.3%) for self-esteem. No follow-up data has yet been published. The authors attributed the disappointing scores to poor participant attendance at the groups, but did not evaluate that possible ambivalence with regard to the questions of accessibility and engagement.

Table 4.16 – Cluster 2 – Interventions organised with reference to Positive Psychology and Wellbeing – Summary of Participant Characteristics

Study	G	Age	DoI	Psych	Hope	SE
Lecomte et al (2008)	35	24.9	3.22	100	X	*SERS* 8.5 *Neither low nor high*
Lecomte et al (2012) 12 month Follow-up	Follow-up	Follow-up	Follow-up	Follow-up	Follow-up	*SERS* 8.1 *Neither low nor high*
Lecomte, Leclerc et al (2015) Lecomte, Leclerc and Wykes (2018)	30.0	26	100% FEP	100	X	*QuickLL* 2.29 *SERS* 17.44

						Both - mild to moderately high
Meyer et al (2012)	56.0	39.6 (12.0)	U/S	100	*SDHS* 20.93 *Neither low nor high*	*SERS* 1.57 *Neither low nor high*
Schrank et al (2015)	44.7	43.0 (11.0)	13.0	100	*IHS* 4.02 *Mild to moderately high*	*RSES* 22.4 *Mild to moderately high*

Table 4.17 – Cluster 2 – Interventions organised with reference to Positive Psychology and Wellbeing – Summary of Study Characteristics

Study	**Country**	**N (Total)**	**Design**	**AAL**
Lecomte et al (2008)	Canada	48 (129)	RCT Control and Comparison Groups	Lack of specific medication information. Absence of cost analysis. Lack of accurate information re substance abuse.
Lecomte et al (2012)	Follow-up	Follow-up	Follow-up	High attrition rates. Small sample size, lacking in statistical power.
Lecomte, Leclerc et al (2015) Lecomte, Leclerc and Wykes (2018)	Canada	66 (66)	Cohort Study	Key instrument not yet validated with large groups. Only included two items relating to self-esteem. Small sample size. No control-group. High attrition rates. Missing data. Homogeneity of participant group.
Meyer et al (2012)	USA	16 (16)	Cohort Study	Small sample. Self-selected. Uncontrolled study design. Participants reported difficulty understanding the exercises. Self-report measures – risk of social desirability or demand

				effects. No control for multiple statistical tests.
Schrank et al (2015)	UK	47 (94)	RCT	Non-random sampling. Clinical rather than research diagnoses. Unblinded outcome evaluation. No active comparison-group. No monitoring of other concurrent psychological interventions.

Evaluation of participant characteristics across the studies included in this cluster, indicates that the Group CBTp intervention (and outcomes) have more relevance to the FEP participant population for which the novel intervention programme has been developed. Both the Meyer (Meyer et al, 2012) and Schrank (Schrank et al, 2015) studies relate to participants with a much older mean age (39.6 and 43) and longer duration of illness (13 years in the Schrank study; unspecified by Meyer et al). There was, in addition, recurring reference to concerns regarding ‘missing’ information – missing data, failure to comprehensively assess diagnosis, and lack of attention to potentially significant confounding variables, e.g. levels of substance misuse amongst participants. Qualitative participant-feedback collected by Meyer’s team included the worrying suggestion that the exercises had been too complicated and that participants had engaged in the therapy without a conceptual understanding as to purpose. The authors stressed the importance of therapists paying particular attention to the process of therapy and therapeutic relationship to ensure that client-participants were engaged meaningfully in a collaborative endeavour.

Cluster 3 - Interventions that address Self-Stigma

Self-stigma (or engulfment) has been defined as ‘the phenomenon by which negative stereotypes about mental illness (dangerousness, incompetence and inability to recover) are accepted and incorporated into the identity of people who have been diagnosed with severe mental illness’ (Yanos, Lucksted, Drapalski, Roe and Lysaker, 2015, p171). It has also been referred to as taking on an ‘illness identity’ (Estroff, 1989; McCay, Beanlands, Leszcz, Goering, Seeman et al, 2006). Self-stigma is believed to restrict previously held or hoped for identities, and has been linked to, both, hopelessness (Lysaker, Davis, Jones, Strasburger and Hunter, 2007; Ritsher and Phelan, 2004) and diminished self-esteem (Corrigan, Watson and Barr, 2006; Yanos, Roe, Marcus and Lysaker, 2008). Yanos, Roe and Lysaker (2010, 2011) have stressed the importance of focussing on interventions that specifically target negative self-evaluations consequent to being diagnosed with a severe mental illness.

The cluster of articles which relate to self-stigma report on 14 studies in 14 papers, relating to 7 separate research / intervention threads - (i) Promoting Healthy Self-Concepts (HSC - McCay and Beanlands, 2006; McCay, Beanlands, Zipursky, Roy, Leszcz, et al, 2007), (ii) Narrative Enhancement and Cognitive Therapy (NECT – Yanos, Roe and Lysaker, 2011), (iii) Self Stigma Reduction Program (SSRP – Fung, Tsang and Cheung, 2011), (iv) Cognitive Therapy and Psycho-education for Self-Stigma (CTPESS - McInnes and Lewis, 2008), (v) CBT for Internalised-Stigma or Cognitive Therapy for Self-Stigma (CTSS – Morrison, Burke, Murphy, Pyle, Bowe, et al, 2016), (vi) Be Outspoken and Overcome Stigmatizing Thoughts (BOOST – Best, Grossman, Milanovic, Renaud and Bowie, 2018) and (vii) REFLEX – a Social Cognitive Group Treatment for Impaired Insight in Psychosis (Pijnenborg, de Vos, Timmerman, van der Gaag, Sportel, et al, 2019). Relevant data has been summarised in Tables 4.18 (Intervention Characteristics), 4.19 (Participant Characteristics) and 4.20 (Study Characteristics) by thread. All of the interventions explored in this cluster relate to the amelioration of low self-esteem. Some of the papers relating to HSC, NECT and CBTIS, also, address questions of hopelessness.

The Promoting Healthy Self Concepts (HSC) intervention thread includes two papers (McCay and Beanlands, 2006; McCay et al, 2007). The principal authors have, more recently, moved on to other considerations (McCay, Carter, Aiello, Quesnel, Langley, Hwang, Beanlands et al, 2015) and this approach does not appear to have been progressed by any other researchers. The thread relating to Narrative Enhancement and Cognitive Therapy (NECT – Yanos, Roe and Lysaker, 2011), on the other hand, is much more extensive, including five intervention studies (Yanos, Roe, West, Smith and Lysaker, 2012; Roe, Hasson-Ohayon, Mashiach-

Eizenberg, Derhy, Lysaker and Yanos, 2014; Hansson and Yanos, 2016; Hansson, Lexen and Holmen, 2017; Yanos, Lysaker, Silverstein, Vayshenker, Gonzales et al, 2019), along-with a number of qualitative investigations regarding the experience and significance of self-stigma (e.g. Lysaker, Tsai, Hammond and Davis, 2009; Roe, Hasson-Ohayon, Derhi, Yanos and Lysaker, 2010; Yanos, West, Gonzales, Smith, Roe and Lysaker, 2012). The intervention has been explored in the USA (Yanos et al, 2012; Yanos et al, 2019), Israel (Roe et al, 2014) and Sweden (Hansson and Yanos, 2016; Hansson et al, 2017). In addition, Lysaker has contributed to the work by Moritz (Moritz, Mahlke, Westermann, Ruppelt, Lysaker et al, 2018 - see below), as well as being is a key protagonist with regard to the Indianapolis Vocational Intervention Program (IVIP) which is discussed as part of Cluster 5. There are two intervention research papers in the 'Self-stigma Reduction Program' (SSRP) thread. The research concerns an intervention developed by Fung and colleagues at the University of Hong Kong, delivered within Hong Kong and the Chinese mainland (Fung, Tsang and Cheung, 2011; Young, 2018). Although Moritz and colleagues have articulated their ideas across more than one paper (Moritz and Jelinek, 2009; Moritz, Ahlf-Schumacher, Hottentrott, Peter, Franck et al, 2019) their Meta-Cognitive Therapy (MCT+ - Moritz, Mahlke, Westermann, Ruppelt, Lysaker et al, 2018), as with the Cognitive Therapy and Psycho-education Program (MacInnes and Lewis, 2008), BOOST (Best, Grossman, Milanovic, Renaud and Bowie, 2018) and REFLEX (Pijnenborg, de Vos, Timmerman, van der Gaag, Sportel et al, 2019) interventions, has each only been subject to one evaluation study. Morrison, along with colleagues, has written prolifically with regard to the development of CBT for Psychosis (e.g. Morrison and Barratt, 2010). The thread relating to the implementation of these ideas in addressing Self-Stigma includes three evaluation studies (Morrison, Birchwood, Pyle, Flach, et al, 2013; Morrison, Burke, Murphy, Pyle, Wood et al, 2016; Wood, Byrne, Enache and Morrison, 2018), along with a further exploration of the wider significance of self-stigma to recovery from psychosis (Wood, Byrne, Burke, Enache and Morrison, 2017). The first of the evaluation studies did not include hope or self-esteem as key, measured variables and, so, has not been included in this review. The REFLEX study (Pijnenborg, de Vos, Timmerman, van der Gaag, Sportel et al, 2019) is a little different, being, in fact, primarily concerned with insight rather than self-stigma, so its inclusion within this cluster might be questioned. The authors, however, make a direct association between poor insight and self-stigma and the REFLEX intervention is designed to improve insight, functioning and symptoms through attention to ‘stigma-sensitivity, perspective taking and self-reflection’ (p362). Whereas, therefore, the previous interventions considered within this cluster have been mostly concerned with the relationship between self-stigma and self-esteem, with hope occasionally considered as part of the mix, this study addresses a triadic relationship between self-stigma, self-esteem and insight. The authors suggest, following Lysaker et al (2007), that individuals with high self-stigma are more inclined to depression and to negative evaluations about themselves and about the future when insight is better. On the other hand, poor insight is associated with poorer social functioning and greater symptomology. Their intervention is designed, therefore, to promote insight through self-reflection, whilst simultaneously combating negative illness narratives and nurturing self-esteem.

Apart from the research associated with Moritz (Moritz et al, 2018) and Morrison (Morrison et al, 2016; Wood et al, 2018) all of the interventions are primarily group based in delivery and largely invariant in content. Fung, Tsang and Cheung (2011) utilised a combined individual and group programme, but their paper emphasises the group-content, with little attention to the individual meetings. The time investment of the group therapy approaches varied from 5 sessions to 20 and from 1 to 1.5 hours each time. The individual therapies of Moritz and Morrison were both 12 sessions. Mittal and colleagues (2012) noted in their review of the self-stigma intervention research, that all of the programmes that they were able to identify approached the therapeutic tackling of self-stigma in one of two ways, either by (i) attempting to ‘alter stigmatizing beliefs and attitudes’, or (ii) encouraging ‘participants to accept the existence of stigmatizing stereotypes without challenging them and … enhance stigma-coping skills through improvements in self-esteem, empowerment, and help-seeking behaviour’ (p979). They noted that the trend in intervention-development was from the former to the latter. In the current review, interventions, including those considered by Mittal et al, predominantly displayed a mixed economy of these approaches. HSC, for instance, is defined in terms of promoting an improved sense of self through the development of a ‘personally acceptable interpretation of the illness experience’ (McCay, Beanlands et al, 2007, p3), a position consistent with Mittal’s observations. This is, however, combined with strategies to develop ‘a sense of future, hopes and dreams’, and ‘meaningful life goals' (p3), which seems more consistent with Mittal's second approach. Similarly, NECT is significantly concerned with developing a new narrative of self and illness, alongside strategies to promote a 'greater sense of self-efficacy, control and hope' (Yanos, Lucksted, Drapalski, Roe and Lysaker, 2015, p175). The most recently reported programme, REFLEX (Pijnenborg et al, 2019), does indeed prioritise the learning by clients that 'a diagnosis is just a label, saying little about them' (p364), consistent with Mittal's proposed trend, but the approach, also, makes reference to the disputation of stigmatising beliefs, which position appears to challenge, both, attitudes to the validity and importance of the person's illness narratives. Morrison's individual 'cognitive therapy for internalised stigma' clearly addresses both sets of cognitions, within a particularised formulation of the individual's experiences. This last point is of significance. All of the group interventions were delivered as invariant and manualised procedures, adapted to the presentation of clients in the room, but largely indifferent to personal formulations of need. All relied heavily on processes of psychoeducation. The two individually delivered approaches, Moritz et al and Morrison et al, were explicitly rooted in individual conceptualisation and, although, psycho-education was involved, it was a small part of a more interactive, collaborative and explorative style.

Table 4.18 – Cluster 3 – Interventions that Address Self-Stigma – Summary of Intervention Characteristics

Study	PT/T	I/G	N/D/F	RoA %	B(R) EoT	B(R) Fup1	B(R) Fup2
McCay and Beanlands (2006)	Promoting Healthy Self-concepts	Group	12 sessions, 1.5 hours, 3 months	10.3	*MES* 21.4 (8.6)	X	X
McCay, Beanlands et al (2007)	Promoting Healthy Self-concepts	Group	12 sessions, 1.5 hours, 3 months	29.3	*MHS* 6.7 (4.0) *MES* 19.3 (10.3)	X	X
Yanos et al (2012)	NECT	Group	20 sessions, 1.0 hours, 20 weeks	28.6	*BHS* U/S (1.3)	*BHS* U/S (2.7)	X

					RSES U/S (6.0)	*RSES* U/S (6.0) ***3/12***	
Roe et al (2014)	NECT	Group	20 sessions, 1.0 hours 6 months	28.0	*SADHS* 8.1 (5.6) *RSES* 11.1 (7.3)	X	X
Hansson and Yanos (2016)	NECT	Group	20 sessions, 1.0 hours, 20 weeks	35.4	*RSES* 20.3 (10.3)	X	X
Hansson et al (2017)	NECT	Group	20 sessions, U/S, 20 weeks	22.6	*RSES* 15.8 (7.8)	*RSES* 17.5 (9.1) ***6/12***	X
Yanos et al (2019)	NECT	Group	20 sessions, U/S, 20 weeks	20.0	*OPD Group* *BHS* 12.3 (7.0) *RSES* 15.2 (7.7) *Comp Group* *BHS* -17.6 (-10.5) *RSES* 1.1 (0.7)	*OPD Group* *BHS* 1.8 (1.0) *RSES* 15.2 (7.7) *Comp Group* *BHS* 2.5 (1.5) *RSES* 1.7 (1.0) ***3/12***	*OPD Group* *BHS* 7.0 (4.0) *RSES* 16.6 (8.3) *Comp Group* *BHS* -5.9 (-3.5) *RSES* 7.3 (4.3) ***6/12***
Fung et al (2011)	Self-Stigma Reduction Programme	Group and Individual	12 Group sessions and 4 individual, U/S, U/S	0	*CSSMIS SE* 41.1 (17.9)	*CSSMIS SE* 47.2 (20.5) ***2/12***	*CSSMIS SE* 43.6 (19.0) ***4/12*** 34.0 (14.8) ***6/12***
Young (2018)	Self-Stigma Reduction Programme	Group	10 sessions, 1.5 hours, 10 weeks	18.2	*RSES* 8.9 (4.2) *CSSMIS SE*	X	X

					6.1 (5.0)		
MacInnes and Lewis (2008)	CT / Psycho-education	Group	5 sessions, U/S, 6 weeks	0	RSES 5.8 (3.9)	X	X
Morrison et al (2016)	Morrison CTSS	Individual	12 Sessions (Max), 1.0 hours, 4 months	26.7	*BHS* 100.3 (32.3) *SERS* 18.9 (10.5)	*BHS* 64.5 (20.8) *SERS* 25.8 (14.3) ***3/12***	X
Wood et al (2018)	Morrison CTSS	Individual	1-2 sessions, 1.0-2.0 hours, 2 weeks	13.3	SERS -1.4 (-1.2)	SERS -2.9 (-2.4) ***1/12***	X
Moritz et al (2018)	MCT+	Individual	12 sessions, unspecified, 6 weeks	15.2	RSES U/S	X	X
Best et al (2018)	BOOST	Group	8 sessions, 1.0 hours, 4 weeks	33.3	RSES 39.6 (16.9)	X	X
Pijnenborg et al (2019)	REFLEX	Group	12 sessions, 1.0 hours, 6 weeks	5.2	*SERS* 21.6 (2.7)	*SERS* 2.0 (0.3) ***6/12***	X

The greatest rates of positive change to end of therapy, with regard to hope, were achieved by Morrison et al (2016) and, with regard to self-esteem, by Fung et al (2011), followed closely, by Best et al's (2018) BOOST. The HSC (McCay and Beanlands, 2006) approach achieved better results generally than NECT (Yanos et al, 2012), though, interestingly, NECT was more successful when conducted in Sweden (Hansson and Yanos, 2016) than in its context of origin (USA). It is, however, of note that engagement with the NECT programme, in relation to rates of attrition, was determined with respect to measurements of 'exposure', where exposure related to level of attendance. In their 2019 study, Yanos and colleagues defined 'completion' as attendance at a minimum of 6 sessions of the 20 offered. In the two evaluations completed in the USA, average exposure levels were recorded as 13.4 (Yanos et al, 2012) and 10.8 (Yanos et al, 2019) respectively. The Israel study measured completion as exposure to 3 sessions (of 20). The authors noted that completers attended ‘most’ sessions, but didn’t specify numbers. Of the more successful programmes delivered in Sweden, however, the first had mean exposure levels of 17 (Hansson and Yanos, 2016). Exposure levels were not recorded in the second (Hansson et al, 2017). It seems not unreasonable to hypothesise that greater gains might have been consequent to greater exposure. Young’s (2018) adapted (and abbreviated) version of Fung et al’s (2011) SSRP did less well than the original, which might reflect the principle of ‘developer-effects’ (that programme developers generally achieve better results than those who take up their work) or, possibly, limitations associated with the contracted programme content – in particular the reduced time for discussion. This second possibility speaks to the question of ‘efficiency’ – how to achieve the largest benefit with the least cost. The worst outcomes, an actual reduction in self-esteem, were associated with Wood et al’s (2018) hyper-brief, 2-hour intervention. Three of the NECT studies (Hansson et al, 2017; Yanos et al, 2012; Yanos et al, 2019) reported follow-up results, along-with Fung et al, 2011, Morrison et al (2016), Wood et al (2018), Pijnenborg et al (2019). Of these Morrison’s CTSS and Fung’s SSRP appear to have been associated with the highest level of sustained change. Of note, Morrison evaluated changes in both hope and self-esteem. At follow-up (3 months only) participants’ mean scores for hope had dropped from an increase from baseline of 100.3% to an increase of 64.5%. Participants’ self-esteem, however, had continued to improve – rising from 18.95% (from baseline) to 25.8%.

All of the studies were concerned primarily or exclusively with service users with a diagnosis of psychotic illness or disorder apart from Hansson et al (2017) and Young (2018). In their studies only 64.9% and 39.4%, respectively, of participants had been given these diagnoses. Only the studies by Morrison et al (2016) with 47% FEP service user-participants and Best et al (2018) with 100% FEP service-user-participants were defined as being concerned with the service user population with which the current study was interested.

Table 4.19 – Cluster 3 – Interventions that Address Self-Stigma – Summary of Participant Characteristics

Study	G	Age	DoI	Psych	Hope	SE
McCay and Beanlands (2006)	42.3	27.0 (6.0)	3.5	100	X	*MES* 78.2 *Mild to moderately low*
McCay, Beanlands et al (2007)	31.0	25.1 (4.86)	2.53	100	*MHS* 137.05 *Moderate to very high*	*RSES* U/S *MES* 85.99 *Mildly high*
Yanos et al (2012)	33.3	47.14 (7.86)	>26.2	95.2	U/S	U/S
Roe et al (2014)	52.0	39.0 (12.1)	U/S	86 (estimate)	*SADHS* 46.64 *Moderate high*	*RSES* 29.8 *Moderately high*
Hansson and Yanos (2016)	51.6	37.0	13.0	100	X	*RSES* 25.3 *Neither low nor high*
Hansson et al (2017)	52.8	45.1 (11.5)	26.4	64.9	X	24.77 (25.57 follow-up group) *Neither low nor high*
Yanos et al (2019)	38.0	47.4 (11.8)	>24.2	100	*BHS* *OPD Group* 8.6 *Mildly high* Comp Group 8.2 *Mildly high*	*RSES* *OPD* Group 15.1 *Neither low nor high* Comp Group 17.7 *Mildly high*
Fung et al (2011)	47.1	43.91 (10.38)	U/S	100	X	RSCQ 82.82
Young (2018)	83.1	50.3 (10.2)	13.38	39.4	X	*CCMIS* 37.8 *RSES* 24.3

						Neither low nor high
MacInnes and Lewis (2008)	0	31.8 (7.2)	8.7	100 SMI	X	*RSES* 20.07 *Moderately low*
Morrison et al (2016)	20.0	39.0 (13.5)	47% FEP	100	*BHS* 13.57 *Moderate Low*	*SERS* 66.43 *Mildly high*
Wood et al (2018)	33.3	32.07 (12.21)	FEP (n=2)	100	X	*SERS* 99.07 *Moderate to very high*
Moritz et al (2018)	54.3	36.91 (12.5)	U/S	100	X	RSES 16.82 *Neither low nor high*
Best et al (2018)	40.0	22,4 (5.29)	1.4 FEP	100	X	*RSES* 12.78 *Neither low nor high*
Pijnenborg et al (2019)	30.0	40.82 (10.81)	14.06	100	X	*SERS* 15.13 *Mild to moderately high*

The HSC intervention (McCay and Beanlands, 2006; McCay Beanlands et al, 2007) addressed a similar aged cohort of participants, but these studies were progressed at a time when Early Psychosis was not so well considered or understood and the authors fail to make any reference to this aspect of their participants' needs. Several of the studies (McCay and Beanlands, 2006; Roe et al, 2014; Yanos et al, 2019; Wood et al, 2018; Pijnenborg et al, 2018) failed to use levels of hope or self-esteem as defining inclusion criteria and their results are likely to have been affected by mild to moderately high (moderate to very high in the case of Wood et al) scores at baseline. In effect, these researchers were exploring the utility of an intervention for self-stigma, with individuals whose levels of hopefulness and high self-esteem were inconsistent with the negativity of engulfment.

Table 4.20 – Cluster 3 – Interventions that Address Self-Stigma – Summary of Study Characteristics

Study	Country	N (Total)	Design	AAL
McCay and Beanlands (2006)	Canada	29 (52)	Quasi-experimental	Quasi-experimental design. Small sample numbers. High rate of drop-out.
McCay, Beanlands et al (2007)	Canada	41 (67)	RCT	Small sample numbers. Voluntary, self-selected involvement. Lack of intention to treat analysis strategy. Difference in baseline scores of completers / non-completers.
Yanos et al (2012)	USA	21 (39)	RCT	Small sample numbers and limited statistical power. High drop-out rates.
Roe et al (2014)	Israel	137 (222)	Non-controlled Trial	No random assignment. High drop-out rates. Poor level of attendance by completers. Lack of specificity of diagnosis in inclusion criteria. No follow-up.
Hansson and Yanos (2016)	Sweden	48 (48)	Cohort Study	No control-group. High drop-out rate.
Hansson et al (2017)	Sweden	53 (106)	RCT	No information available comparing those included in the study from wider pool of potential participants. No information regarding rates of refusal. Small sample numbers.
Yanos et al (2019)	USA	85 (170)	RCT	Differential attrition rates. Homogenous participant sample.
Fung et al (2011)	China / Hong Kong	34 (66)	RCT	Diagnoses not verified with reference to standardised measures. No external norm to effectively evaluate target need. Insensitivity of key measures. Lack of assessment of confounding variables. Attention to statistical significance not clinical significance.
Young (2018)	China / Hong Kong	33 (71)	Quasi-experimental	Small sample size. Non-randomized design. No targeted assessment of the relevance of the group factors postulated to be important.

MacInnes and Lewis (2008)	UK	20 (20)	Cohort Study	Small sample numbers. No comparison-group. No follow-up.
Morrison et al (2016)	UK	15 (29)	RCT	No correction for multiple comparisons. No active control-group. Not registered with a trial registry. Stretched resources. Inconsistency between different measures of the same construct. Exclusion criteria limit generalisability. Small sample size.
Wood et al (2018)	UK	15 (30)	RCT	Small sample size, underpowered to detect small or moderate outcome effects. Not blind, risking methodological bias. No detailed assessment of target problem prior to delivery of the intervention. Non-comparative control. Overlapping content in experimental and control interventions. Confounding effects of participant medication regimes. Use of self-report measures. Use of 'last observation carried forward' to account for missing data.
Moritz et al (2018)	Germany	46 (92)	RCT	Need for primary instrument to be complimented by more objective measures. Test-retest reliability of the measure is low. Need for longer term follow-up to allow changes to mature. Small sample size and limited diversity.
Best et al (2018)	Canada	15 (15)	Non-controlled naturalistic	Homogenous participant group. Small sample size. No control-condition.
Pijnenborg et al (2019)	Netherlands	58 (109)	RCT	Use of self-report measures. Other identified limitations relate to assessment of ancillary factors.

Cluster 4 - Interventions that Promote Recovery

The interventions included in Clusters 3, 4 and 5 are all concerned with evaluations of self in the context of a diagnosed mental illness. Cluster 3 was focused on attitudes to self, relating to the meaning of being ill. Self-stigma often involves critical perceptions of self as ‘other than’, of being different and of less worth. It is rooted in ideas of shame and lost value, particularly, though not exclusively, in the ‘now’. The literature relating to ‘recovery’, on the other hand, is more concerned with illness narratives as they relate to expectations or aspirations for the future. As such, recovery-focused-considerations of illness connect much more with the concept of hope. The penultimate section, Cluster 5, considers interventions that target hope or self-esteem in relation to employment and education. In those programmes, narratives of illness, now and for the future, are considered with regard to their roles in service-users’ expectations, aspirations or fears concerning their potential for a ‘meaningful existence’.

It was noted earlier in the chapter that there is a reciprocal relationship between individuals’ subjective sense of hopefulness and their investment in recovery-orientated activities. Hope is a significant factor in motivation and how hopeful a person might feel, strongly influences how motivated they might be to fight or work to achieve more. There is, also, a logical, though not necessarily direct, correlation between effort or investment expended and outcomes achieved, such that higher hopefulness encourages greater motivation, more effort and better outcomes, which, in turn, encourage more self-focused hopefulness. The pool of literature relating to recovery-focused psychological interventions is extensive. This review has included studies in which the relationship between hope and recovery has been a central consideration, where direct attention to aspects of hope have been included within the intervention, and where changes in hopefulness have been explicitly evaluated as a key outcome measure. Two studies were identified which met these criteria - Barbic, Krupa and Armstrong (2009) and Fukui, Starnino, Susana, Davidson, Cook et al (2011). Data relating to the relevant characteristics is presented in Tables 4.21, 4.22 and 4.23 below.

Table 4.21 – Cluster 4 – Interventions that Promote Recovery - Summary of Intervention Characteristics

Study	PT/T	I/G	N/D/F	RoA %	B(R) EoT	B(R) Fup1	B(R) Fup2
Barbic et al (2009)	Recovery Workbook Program	Group	12 sessions, 2.0 hours, 12 weeks	0	*HHS* 7.2 (5.0)	X	X
Fukui et al (2011)	WRAP	Group	8-12 Sessions, 1.5-2.0 hours, 12 weeks	0	*SSHS* 15.8 (8.8)	*SSHS* 10.4 (10.8)	X

As can be seen from the details presented in Table 4.21, the two interventions were similar in delivery mechanism (group-based) and resource investment (up to 12 sessions of 1.5 to 2.0 hours, weekly). Both are part of a wider research thread relating to recovery. Fukui et al, for instance, note that the Wellness Recovery and Action Plan (WRAP) is 'now offered in all 50 states [of the USA]' (2011, p221). Both, however, appear to represent the only papers in their respective threads that have placed hope central to their considerations. The intervention in the study by Barbic and colleagues (2009) is a 'Recovery Workbook'. This programme was adapted from a 30-session course of treatment (Spaniol, Koehler and Hutchinson, 1994). As with most of those in the previous section, this intervention was invariant, delivered consistently, irrespective of the individual needs or circumstances of the recipient and without recourse to a personalised formulation. The programme included a strong leaning towards psychoeducation, but with cognitive components consistent with Snyder's (2002) model of hope – goal-setting, personal agency ('acknowledge one's accomplishments and increase awareness of one's own recovery process' - p493) and behavioural strategies (pathways) for change. The WRAP Group Programme (Fukui et al, 2011) was delivered with slightly more variation with regard to the frequency or length of sessions, but was, nevertheless, group based and geared towards collective needs and understandings. The components of the course, as described in the paper, do not appear to directly address considerations of hope, but, rather, are concerned with more effective illness management. The authors' argument is that hope is directly affected by individual perceptions of control and predictability regarding their illness. Hope is compromised by fears of relapse and the imaginings of associated trauma, disability and loss. Greater confidence in one's ability to contain and / or move on from illness inspires and nurtures greater hopefulness, which, in turn, provides impetus for more invested and effective life management. They suggest that 'recovery, defined by them as 'fulfilling the potential to live a meaningful life beyond one's illness', is captured more by indicators such as perceived hope, empowerment and quality of life, than by measurements of relapse and hospitalisation rates (p495).

The two studies used different scales; Barbic et al - Herth's Hope Index (HHI – Herth, 1991), and Fukui et al – Snyder's State Hope Scale (SSHS- Snyder et al, 1996) as their outcome measure. Both scales are inverse-problem scored with ranges, respectively, of 12-48 and 6-48, giving cut-offs between low and high hope of 30 and 27.

Table 4.22 – Cluster 4 – Interventions that Promote Recovery - Summary of Participant Characteristics

Study	G	Age	DoI	Psych	Hope	SE
Barbic et al (2009)	31.0	44.69 (9.62)	U/S	100	*HHI* 37.1 *Moderate to very high*	X
Fukui et al (2011)	62.1	44.2 (11.2)	U/S	65.0	*SSHS* 32.52 *Moderately high*	X

Table 4.23 – Cluster 4 – Interventions that Promote Recovery – Summary of Study Characteristics

Study	Country	N (Total)	Design	AAL
Fukui et al (2001)	USA	58 (114)	Quasi-experimental, Non-controlled comparison	Generalisability – no control group and homogeneity of participants. Comparability of the two conditions. No fidelity protocol was available. Statistical power. Confounding variables. Potential response bias.
Barbic et al (2009)	Canada	16 (33)	RCT	Abridged intervention with restricted time for interaction. No follow-up. Homogeneity of participants. TAU involved significant levels of input. High rate of participation refusal.

Both studies neglected to use ‘level of hopefulness’ as an inclusion-exclusion criterion and, consequently, in each case baseline means for hope were moderately high. In spite of this fact both interventions were associated with reported small gains in hope. Neither paper presents follow-up data. Neither study identifies any drop-outs from the therapy program, implying that participants found the philosophy, content or style engaging. Finally, neither study considered the needs of FEP service users.

Cluster 5 - Interventions that Promote Employment or Education

As noted in the previous section, the fifth cluster of papers relates to those interventions that target employment or social recovery as the principal goal of therapy, but which regard hope or self-esteem as inextricably interlinked and central to that purpose. Vocational experiences, including, in particular, those associated with perceptions of success or failure, contribute to the construction of personal narratives about self, self in relation to others (particularly with reference to social status) and the future. These attitudes, in turn, shape the person's practical approaches to education, employment and social integration. Papers relating to vocation- or social recovery-focused interventions have been included in this review where practical strategies to promote social and vocational engagement were delivered in concert with cognitive interventions targeting attitudes to hope or self-esteem. This cluster includes five papers, relating to two intervention threads - The Indianapolis Vocational Intervention Program (IVIP – Lysaker, Bond, Davis, Bryson and Bell, 2005) and Social Recovery Cognitive Behavioural Therapy (SRT – Fowler, Hodgekins, Berry, Clarke, Palmier-Claus et al, 2019). IVIP has been evaluated through three intervention studies (Lysaker et al, 2005; Mervis, Lysaker, Fiszdon, Bell, Chue et al, 2016; Mervis, Fiszdon, Lysaker, Nienow, Mathews et al, 2017). Social Recovery Therapy, on the other hand, has, at this time, only been subject to one. That study, the ISREP Trial, has generated a number of papers, only two of which have been included in this review - Hodgekins and Fowler (2010) which presents the post-therapy outcome data in relation to hope and self-esteem and Fowler, Hodgekins and French (2019) which reports on longer-term outcomes (two-year follow-up).

IVIP allied individual work placements in a sheltered mental-health setting with cognitive - behavioural techniques designed to 'help participants identify and correct dysfunctional beliefs about work' (Lysaker et al, 2005, p676). The psychological therapy component of the course was organised in relation to four modules, covering - thinking and work, barriers to work, workplace relationships, and realistic self-appraisal. Target-dysfunctional beliefs were principally concerned with negativity in self-evaluation or expectation (hope). They included, for example, ‘I cannot succeed’ and ‘My supervisor criticizes my work and dislikes me’. (p674). The work placement was of low responsibility and low pay, intended to encourage whilst minimising risk of failure. The placement and course were offered conjointly with the expectation that participants completed 10-20 hours of employment per week as well as the programme of hope- and self-esteem-targeting CBT. Mervis and colleagues (Mervis et al, 2016; Mervis et al, 2017) adapted the programme with regard to the relative balance of individual and group therapy sessions, but otherwise followed the same approach. Lysaker was part of their research team, though concurrently elsewhere progressing his ideas regarding NECT (Yanos et al, 2019). There is, in fact, some considerable overlap in the descriptions of the two approaches.

Fowler’s Social Recovery Therapy (Fowler et al, 2019) is described as ‘an individual psychosocial therapy developed for people with psychosis .. [designed] .. to improve social recovery through increasing the amount of time individuals spend in meaningful structured activity’ (p261). Core components are listed as (i) ‘an assertive outreach approach to promote a positive therapeutic relationship’, (ii) with the focus of the intervention on using ‘active behavioural work conducted outside the clinical room’, and (iii) ‘promoting hope, values, meaning and positive schema’ (p261). The intervention is informed by the understanding that social and occupational withdrawal in the face of mental illness are maintained by, amongst other factors, a lack of hopefulness and self-agency. In this context self-agency might be regarded as occupying the intersection between hope (Snyder’s ‘Agency Thoughts’, 2002) and self-esteem (Fennell’s ‘bottom-line’, 1997). SRT is explicitly described as concerned with the ‘development of hopefulness and positive self’ (p261). As with most of the interventions discussed in this systematic review, the content of SRT overlaps considerably with other approaches – developed previously or subsequently. It includes a combination of behavioural interventions, behavioural experiments and activation, cognitive strategies, including thought records, positive data logs, and the identification and rehearsal of positive self-statements, similar to the interventions of Hall and Tarrier (2003) and Korrelboom (van der Gaag et al, 2012) and the cost-benefit of appraisals of alternative cognitions, similar to Morrison et al (2016).

Table 4.24 – Cluster 5 – Interventions that Promote Employment or Education – Summary of Intervention Characteristics

Study	**PT/T**	**I/G**	**N/D/F**	**RoA %**	**B(R) EoT**	**B(R) Fup1**	**B(R) Fup2**
Lysaker et al (2005)	IVIP	Group and Individual	Minimum 14 Group and 26 Individual plus Work placement. 1.0 hours, 6 months	8.0	*BHS* 35.6 (5.8) *RSES* 0.2 (0.1)	X	X
Mervis et al (2016)	IVIP	Group	17 sessions (approx.) 0.75 hours, 4/12	8.0	*RSES* 20.4 (7.8)	X	X
Mervis et al (2017)	IVIP	Group	24 group sessions plus 26 individual sessions, U/S, 6 months	U/S	U/S	U/S	X
Hodgekins and Fowler (2010)	Social Recovery Cognitive Behavioural Therapy (SRT / SRCBT)	Individual	12 sessions (mean), U/S, U/S	5.7	*BHS* 22.5 (12.5) *BCSS* *-ve Self* 8.1 (6.3) *+ve self* 41.7 (14.6)	X	X
Fowler et al (2019) 2-year Follow-up	Social Recovery Cognitive Behavioural Therapy (SRT / SRCBT)	Follow up	Follow up	17.1	Follow up	*BHS* 26.1 (14.5) *BCSS* *U/S* ***2 years***	X

Table 4.25 – Cluster 5 – Interventions that Promote Employment or Education – Summary of Participant Characteristics

Study	G	Age	DoI	Psych	Hope	SE
Lysaker et al (2005)	0	48.1 (5.7)	23.4	100	*BHS* 15.7 *Moderately low*	RSES 29.83 *Moderately high*
Mervis et al (2016)	34.0	38.54 (4.73)	9.02	100	X	*RSES* 21.42 *Moderately low*
Mervis et al (2017)	41.0	36.91 (6.31)	U/S	100	X	RSES U/S
Hodgekins and Fowler (2010)	28.6	29.0 (6.8)	4.9	100	*BHS* 8.9 *Mild high hope*	*BCSS* -ve Self 5.5 +ve self 8.4 *Very low negative beliefs about self* *Moderately low positive beliefs about self*
Fowler et al (2019) 2-year Follow-up	Follow-up	Follow-up	Follow-up	Follow-up	BHS 8.9 *See above*	*BCSS* -ve Self 5.5 +ve self 8.4 *See above*

The authors state that SRT differs from traditional CBT in its ‘foregrounding the promotion of hopefulness and positive sense of self’ (p266). It, also, shows variance from other individual group and CBT approaches in its attention to the role played by multi-systemic dynamics relating to family, friendship, vocational, educational and other social contexts. In contrast to IVIP, Fowler et al's SRT (2019) is delivered as an individual therapy and organised with reference to a detailed personal formulation for each service-user-recipient.

Lysaker and colleagues' initial evaluation of IVIP (2005) reported strong outcome gains in hope, but limited impact on self-esteem. It is, of note, however, that, whilst participants' mean baseline scores of hope were low, their baseline self-esteem scores were moderately high, suggesting, once again, that the benefits of any approach are likely to be informed by the degree of pre-therapy need reported by recipients. The first study by Mervis et al (2016) focused only on self-esteem and, with participants evidencing lower baseline means, the programme achieved good results. The group did not present data in their second study (Mervis et al, 2017) that could be used comparatively in this review. None of the three studies were subject to any follow-up and the authors did not speculate on the potential for gains to be sustained. The SRT study showed more substantial gains in both hope and self-esteem. The study employed Fowler's own outcome measure, the Brief Core Schemas Scale (BCSS – Fowler et al, 2006), which separately examines positive and negative attitudes to self. Whilst the approach was associated with only small reductions in negative evaluative schema, it achieved much more extensive changes with regard to the inspiration of positive self-evaluations. Fowler and colleagues, also, noted in their first evaluation paper that the 'changes in positive beliefs predicted improvements in levels of activity' - the primary purpose of the intervention (p323). Self-esteem was not evaluated at two-year follow-up, but hope was, evidencing sustained and improved gains. In fact, the 'two-year' follow-up reported by the authors was only approximately 15 months after the end of therapy. Nevertheless, a follow-up period of this length potentiates the introduction of numerous confounding variables through life-experience and changing circumstances. As such the authors are careful to avoid attributing too much causation exclusively to the therapeutic process, emphasising instead the benefits of sustained social and vocational integration. The results can, however, be confidently interpreted to indicate that gains achieved at the end of therapy had not been lost (or reduced) as reported by other hope- or self-esteem-targeting interventions.

Engagement of participants appears to have been very positive with both IVIP (Lysaker et al, 2005; Mervis et al, 2016) and SRT (Hodgekins and Fowler, 2010) showing single digit percentage rates of attrition during the course of treatment. Even at two-year follow-up (Fowler et al, 2019) there was only a 17.1% drop out from an initial sample number of 35 in the experimental condition.

Table 4.26 – Cluster 5 – Interventions that Promote Employment or Education – Summary of Study Characteristics

Study	Country	N (Total)	Design	AAL
Lysaker et al (2005)	USA	25 (50)	RCT	Homogenous participant group – age and gender. Employment setting very specific.
Mervis et al (2016)	USA	54 (54)	Cohort Study	Difficulty distinguishing between the benefits of the therapy vrs the employment placement – determining direction of causality. Small sample size. Absence of comparison group.
Mervis et al (2017)	USA	29 (64)	RCT	Unrepresentative sample (higher pre-morbid education levels). Inseparability of therapy and work programme. Small sample size. Reliance on self-report measures.
Hodgekins and Fowler (2010)	UK	35 (77)	RCT	Small sample size. The assumption of no hidden confounding variables undermines the credibility of the statistical methods used. Methods do not address risk of measurement errors.
Fowler et al (2019) Follow-up	UK	Follow-up	RCT	No satisfactory control-condition. 'SRT plus TAU' was compared with 'TAU alone'. There was, however, no consistency to TAU within the participant group and 'TAU alone' was not matched against 'SRT + TAU' for 'frequency of contacts and other non-specific factors' (p103). Inability to follow-up those who dropped-out.

Finally, SRT was delivered and evaluated within the ISREP MEC Trial, which was concerned with Improving Social Recovery in Early Psychosis' (Fowler, Hodgekins, Painter, Reilly, Crane et al, 2009). However, although the participant population was younger than in most of the studies considered in this review, mean age of 28.6, which is consistent with FEP demographics, the research was specifically shaped to address *persistent* social disability problems, which meant the exclusion of FEP service users. The mean duration of diagnosed and treated illness was 4.9 years, which was consistent with 'early in the course of the disorder ….. but not first episode' (Fowler et al, 2009, p1628).

Cluster 6 - Individual CBT and CBTp

The final cluster of four papers, reporting on four studies, represents those CBT-based interventions that were adjudged to not fit within any of the other clusters. Two of the papers describe the implementation of CBT in Psychosis – Wragg and Whitehead (2004) and Sonmez, Hagen, Andreassen, Lie Romme, Grande et al (2014). The first was written and published prior to the recent development of CBTp as a specialised subset of CBT. It was not written in relation to a research agenda. The second is described as part of a wider study to examine CBT for emotional dysregulation in early psychosis. The two papers present case studies of, respectively, one and two clients. In each paper, psychosis was the broad context of intervention, but self-esteem was a central target of the process, evaluated as a key outcome measure. Quantitative data is reported separately for each individual, with no summation of scores. Morrison (see above re cluster 3), already at that time a leading author in the field with regard to CBTp (e.g. Morrison and Barratt, 2009), was a contributor to the Sonmez et al study. The final two papers both report on RCT's in which CBT was targeted towards an aspect of the experience of psychosis. Jackson and colleagues (Jackson, Trower, Reid, Smith, Hall et al, 2009) report on their Cognitive Recovery Intervention (CRI) which is concerned with reducing the trauma, depression and low self-esteem that follows the onset of a psychotic illness, whilst Gumley and his colleagues (Gumley, Karatzias, Power, Reilly, McNay and O'Grady, 2006) discuss a CBT approach to preventing loss of self-esteem in the face of an incipient or emerging relapse. All four intervention strategies were progressed in individual, rather than group, therapy. Characteristics of the interventions, participants and studies are presented below in tables 4.27, 4.28 and 4.29.

Table 4.27 – Cluster 6 – Individual CBT or CBTp – Summary of Intervention Characteristics

Study	PT/T	I/G	N/D/F	RoA %	B(R) EoT	B(R) Fup1	B(R) Fup2
Wragg and Whitehead (2004)	CBT	Individual	16 sessions, U/S, 16 weeks	0	CFSEI -50.0 U/S	X	X
Jackson et al (2009)	CT to Reduce Trauma Symptoms	Individual	26 sessions (max), U/S, 6 months	11.1 and 27.8	*RSCQ* -1.9 (-0.5)	*RSCQ* 4.4 (1.2) ***6/12***	X
Sonmez et al (2014)	CBT	Individual	Case 1:- 24 sessions, U/S, 24 weeks Case 2:- 21 sessions, U/S, 21 weeks	0	*Case 1:- RSES* 50.0 (20.0) Case 2:- *RSES* 10.0 (6.7)	X	X
Gumley et al (2006)	CBT	Individual	5 sessions of 'engagement' and then up to 16 sessions of intensive (2-3 meetings per week) at the appearance of early signs of relapse.	U/S	*RSES* -13.6 (-6.7)	X	X

The paper by Wragg and Whitehead (2004) describes their implementation of CBT with a single FEP service user. They focus, in particular, on the feasibility of applying a CBT intervention for an adolescent FEP service user in an inpatient setting. The priority focus of the therapy was on the reduction of psychotic symptoms, anxiety and depression. Self-esteem was identified as a potentially significant factor both in the onset of the service user's psychotic crisis and in mediating their subsequent adjustment to their diagnosis. The authors' individually-tailored therapy-formulation emphasised the development of the client's beliefs regarding predictability, controllability and depression. These were linked, via helplessness and hopelessness, to low self-esteem, self-loathing and perceptions of personal failure. Fennell's model (1997) is referenced. The therapy was offered over 16 sessions, though frequency and duration are not reported. In spite of the significance given in the formulation to the client's negative self-evaluations with regard to both the development and maintenance of her difficulties, however, this consideration does not seem to have been a focus of the intervention, which prioritised attention to specific psychotic symptoms. The description of the therapeutic 'procedure' touches in places on issues pertinent to addressing low self-esteem (and, in fact, hopelessness), but the authors do not describe specific processes of cognitive or behavioural technique targeted towards those evaluative beliefs.

Although they do not reference the article above, Sonmez et al (2014) build their paper around the argument that the use of generic models of psychosis (e.g, Morrison 2001) are limiting when addressing the specific needs of depression, anxiety or low self-esteem in FEP clients. In their description of the implementation of CBT for FEP, strategies include socratic deconstruction of negative schematic beliefs about self, belief modification aimed at reducing certainties with which these beliefs might be held, psychoeducation regarding psychosis which offers narratives of normalisation and potential controllability, some attention to personally meaningful goal setting and behavioural strategies to encourage greater sense of control. The therapy programme is organised with reference to Morrison's (2001) normative model for the conceptualisation of psychosis, and, also, pays reference, with regard to one client, to the stress-vulnerability model (Zubin and Spring, 1977) and, to the other, Clark's model of panic (1986). The authors (including Morrison himself) overtly wonder, however, ‘whether more specific models targeting panic, social anxiety, and low self-esteem would be more fit for purpose than those more generic models of psychosis and early psychosis which focus more urgently on positive symptomology’ (p52). They suggest that such models / approaches ‘might be more effective for specific difficulties’ and recommend that ‘forthcoming studies should aim at specifically focusing on social anxiety, depression, or self-esteem’ (p52).

Table 4.28 – Cluster 6 – Individual CBT or CBTp – Summary of Participant Characteristics

Study	G	Age	DoI	Psych	Hope	SE
Wragg and Whitehead (2004)	100	15	3 months *FEP*	100	X	*CFSEI* 6 *Very low*
Jackson et al (2009)	13.9	24.1 (4.7)	U/S *FEP*	100	X	*RSCQ* 55.94 *Very low self-esteem*
Sonmez et al (2014)	50.0	Case 1:- 27 Case 2:- 23	Case 1:- 2.0 Case 2:- U/S *FEP*	100	X	*RSES* Case 1:- 22 *Mildly low* Case 2:- 30 *Mild to moderately high*
Gumley et al (2006)	25.0	35.8 (9.6)	9.4	100	X	*RSES* 24.7

The intervention reported by Jackson and colleagues (2009) is described as ‘a form of CBT’ (p454) designed to reduce post psychotic trauma symptoms following the first onset of a psychotic illness. The authors note, however, that the approach has benefit beyond those with an acknowledged trauma and is ‘intended to be helpful for all ….. patients adjusting to and recovering from a first episode of psychosis’ (p456). The challenges of adjustment are explored with respect to primary appraisals, regarding the symptoms and social context of the onset of psychosis, which, in turn, are linked to perceptions of diminished social rank. The intervention was delivered in a maximum of 26 sessions over 6 months and organised into three parts – engagement and formulation, trauma processing and appraisals of psychotic illness, which included attention to shame, loss and entrapment. Individualised therapy only included attention to those elements assessed to be pertinent to the person and involved the use of ‘standard cognitive therapy techniques’ (p456) to encourage change in their appraisals, particularly with regards to self.

The final study included in this cluster represents something of an anomaly. Gumley and colleagues (2006) explored the efficacy of CBT, delivered as a response to the appearance of early signs of relapse. The intervention was evaluated in this paper, however, with regard to its impact on a number of perceptions or attitudes (self and illness, entrapment, loss, humiliation, shame and self-esteem) rather than its efficacy in pre-empting or minimising the relapse itself. Participants in the experimental condition received five sessions of assessment and engagement at the beginning of the research programme. They were then observed for 12 months. If, during that time, early signs of relapse were identified, they received a more intense, 2-3 sessions per week, period of treatment, with a maximum course of 16 meetings. During the trial, however, only 28 of the 72 participants in the CBT cohort received this additional input and the median level of exposure to the specialised therapy was just 5 sessions (with a range of 2-16). The CBT delivered in response to signs of relapse included ‘identifying and targeting beliefs and behaviours, which increased risk to self or others, identifying and targeting beliefs and behaviours accelerating relapse and developing alternative beliefs and reinforcing those through behaviour change’ (p251). Although these considerations appear to be very general, not concerned with self-esteem, the authors insist that the approach ‘specifically targeted negative appraisals about psychosis .. [and] .. self-esteem’ (p257), alongside ineffective or problematic coping strategies.

Of these four papers, three report unpromising or confusing results with respect, specifically, to self-esteem. Only one, Sonmez et al (2014), offers any suggestion of significant efficacy in that area. Their approach was more targeted towards addressing self-esteem and, over the period of treatment, both individual FEP clients showed substantial gains with respect to that, as reported with the employed measures. The Wragg and Whitehead (2004) article, concerning the therapy of a single adolescent female on an inpatient unit, notes some benefits with regards to symptoms, but little in terms of self-esteem, which, in fact, deteriorated over the course of therapy. The study by Jackson and colleagues showed evidence of significant improvement in evaluations regarding a number of areas of adjustment - depression, intrusions and avoidance behaviours - using the Impact of Events Scale (IES – Sundin and Horowitz, 2002). The measure of self-esteem, however, reduced very slightly (-1.9% from baseline, -0.5% across the range) to the end of the therapy, although it did pick up to an improvement of 4.4% (1.2%) at 6 months follow-up. It should be noted that mean self-esteem measured at baseline was extraordinarily low - 55.94 on the RSCQ (Robson, 1999) which is more than 2 standard deviations below the mean of any of the clinical populations for which Robson offers norms. On the other hand, the cohort that received Treatment-as-Usual started from an even lower point (mean of 51.10) and achieved gains over the period of the study and to follow-up that were consistent and greater than those achieved by the treatment group (16.6% from baseline and 4.0% across the range at follow-up). The authors' conclusions were that the approach offered significant benefits, but not in relation to self-esteem. The final report, Gumley et al (2006), is the most confusing in terms of interpretation. Within the study, the timing of the proactive intervention, where required, was variable and the detail is not included in the paper. In addition, outcome scores, reported at 3 monthly intervals over the period of observation, are presented as means across the whole CBT treatment group, irrespective of whether participants actually received the targeted intervention. The interpretation of reported scores is, also, made complicated by an apparent inconsistency regarding the instrument employed. The study utilised Rosenberg's Self-Esteem Scale (1965), which, the author's note, was scored, on this occasion, with a range of 10-40. Rosenberg, himself, has been clear that the measure is inverse-problem scored, such that higher scores represent higher self-esteem. The author's note, however, that 'a higher total score is indicative of lower self-esteem' (p251). It is possible that they intentionally inverted the scoring process, but, if so, that it not acknowledged or explained within the paper. Over the course of the 12 months, mean RSES scores for this group reduced progressively from 24.7 to 22.7 – a loss of 13.6% from baseline and 6.7% across the range. At the same time, the mean scores of the group that received only Treatment-as-Usual increased marginally – 3.9% from baseline and 1.7% across the range. The authors interpret those changes to indicate that ‘participants who received CBT showed greater improvement in …Rosenberg self-esteem’ (p257). If the scoring system was not intentionally adjusted, the outcomes actually show the opposite. Furthermore, the paper does not provide comparative figures concerning rates of relapse, and, with regard, specifically, to the treatment group, no analysis is offered concerning the relationship of outcomes to degree of exposure to the CBT programme, to the appearance of early signs of relapse, or, even to relapse itself. As a consequence, no meaningful conclusions can be drawn regarding the efficacy of the approach in addressing the potentially diminishing self-esteem associated with an emerging experience (and fear) of relapse.

Table 4.29 – Cluster 6 – Individual CBT or CBTp – Summary of Study Characteristics

Study	Country	N (Total)	Design	AAL
Wragg and Whitehead (2004)	UK	2 (2)	Single case design	U/S
Jackson et al (2009)	UK	36 (66)	RCT	Lack of an active control group. High rates of reluctance to take part. Non-representative participant sample. High attrition rates. Failure to record details of potentially confounding variables.
Sonmez et al (2014)	Norway	2 (2)	Single case design	Uncontrolled case studies.
Gumley et al (2006)	UK	72 (144)	Non-randomised CT	Study design did not allow for measurement of negative self- and illness-appraisals before during or after relapse. Assessors were not

				blind to treatment allocation. A factor-structure of a key measure employed had not been confirmed. Important confounding variables were not assessed.

The question of engagement was, by definition, not addressed by the two papers that reported on individual case studies (Wragg and Whitehead, 2004; Sonmez et al, 2014). Neither was it discussed by Gumley and colleagues (2006), although their protocol, of only offering the additional, targeted therapy to those participants who reported signs of relapse and only providing as much sessional investment as each individual required, effectively limited the opportunity for any participant to consciously elect to leave the process. Jackson et al (2009) did report rates of attrition – with 11.1% dropping out prior to the commencement of therapy and a further 27.8% by the end of the course of treatment. The Wragg and Whitehead, Sonmez et al, and Jackson et al studies were all concerned with an FEP client population. Although there might have been some overlap regarding age in the Gumley et al participant group (35.8 years with a standard deviation of 9.6), their mean duration of illness (113 months or 9.4 years) meant that they were significantly further along in the course of their illness.

Limitations of the studies examined

In each of the clusters reported above, the table that considered Study Characteristics (4.14, 4.17, 4.20, 4.23, 4.26 and 4.29) included reference to the limitations of the studies as acknowledged in the papers by the authors themselves. With few exceptions, the papers might be divided into three groups – case descriptions, exploratory or pilot investigations and RCT's. The case descriptions and pilot studies, of necessity, were limited to small sample sizes and most of the authors involved emphasised the consequent limitations with regard to their capacity to generate statistically meaningful outcome data or the generalisability of conclusions to other service user groups. Even the authors of some of the RCT's, with slightly larger numbers of participants (e.g. Hansson et al, 2017; Hodgekins and Fowler, 2010; Mervis et al, 2017; Morrison et al, 2016) moderate their conclusions with reference to the limitations of the numbers involved. Most of the RCT's utilised TAU as the control arm of the investigation (e.g. Hall and Tarrier, 2003; Lecomte et al, 1999; Schrank et al, 2015; Van der Gaag et al, 2012) and, even, where there was a more active comparator (e.g. Wood et al, 2018) concerns were expressed as to whether the comparison was truly balanced. For the RCT's observations were, also, made about the lack of sufficient blinding in either the randomisation of allocation or the assessment and interpretation of results (e.g. Laithwaite et al, 2007; Schrank et al, 2015; Wood et al, 2018). Participant groups were defined, alternately, as too homogeneous (e.g. Barbic et al, 2009, Fukui et al, 2001) and too heterogeneous or unrepresentative (e.g, Mervis et al, 2017). Instruments were criticised for being inappropriate to need, too insensitive to detect change or not validated for the group under investigation (Laithwaite et al, 2007; Lecomte, Leclerc et al, 2015). The failure of a study to adequately determine and monitor potentially confounding variables was a regular concern (e.g. Barbic et al, 2009; Hodgekins and Fowler, 2010; Wood et al, 2018), particularly amongst those few studies that endeavoured to follow-up participants, as were the rates of reluctance of those approached to take part (e.g. Hall and Tarrier, 2003) or of attrition from the study once commenced (e.g. Jackson et al, 2009; Lecomte, Leclerc et al, 2015). Additional comments related to the impossibility of separating programme effects and therapist factors when delivered by a single therapist (e.g. Hall and Tarrier, 2003), missing data (e.g. Lecomte, Leclerc et al, 2015), lack of standardisation of diagnosis with reference to inclusion criteria (e.g. Fung et al, 2011) and failure to follow-up those who completed the intervention programme (e.g. Barbic et al, 2009) and those who did not (e.g. Fowler et al, 2019).

Conclusions

Taken separately, these various limitations have been cited as reasons for the authors to be tentative in their statements and the reader to be cautious in their evaluations or interpretations. One value of a systematic literature review, however, is that it has the capacity to collate the outcomes and offer a collective view regarding the generalisability of the various findings. This review has not sought to combine the various quantitative outcomes in a formula of statistical significance. It is not unreasonable, nevertheless, to draw attention to patterns relating to the data elicited from the papers and reported above. Part 4.7 (below) presents the learning points arising from the combination of the different reviews of the literature as reported in relation to all sections of the chapter. Those arguments will not be rehearsed here in detail. The following observations are worthy of note specifically with regard to the focus on addressing hopelessness and low self-esteem in the context of early psychosis.

This systematic literature review was organised, in the first instance, by the questions – 'how and to what degree might the experiences of hopelessness and / or low self-esteem in those recently diagnosed with a psychotic illness be being met by existing CBT-based intervention programmes?' Based on the outcomes of the review documented and examined above, it is possible to say that there are a number of approaches already available and, at least partially, tested-out with regards to their accessibility, capacity to engage and potential efficacy. These programmes include strategies to address low self-esteem, and, to a lesser extent, hopelessness, as considerations in their own right (the explicitly identified therapy goal of the individual) and as factors whose resolution might improve adjustment to the diagnosis and recovery from the mental illness-associated disabilities, prevention of relapse, engagement with vocational and educational opportunities and social integration. There is some evidence of hope and self-esteem being addressed in concert, but primarily as linked consequences of the same aetiological processes, rather than as a complex of mutually influential evaluative appraisals. The efficacy of the existing interventions has been very variable, with very little evidence of high levels of improvements sustained over time in relation of any approach. There is, it might be argued, space to consider alternative ideas and approaches, but with the intention of adding to, rather than competing with, the existing menu of options.

The content and delivery of the different existing interventions have varied along a continuum from the largely invariant, where a set, structured programme was facilitated with, usually, a group of service users, with little reference or adaptation to each individual's unique circumstances, to the uniquely tailored, where each programme was specific to the recipient and significantly diverse from those offered to others. Most of the interventions reviewed were delivered to groups and erred towards the invariant. There is a strong argument within the culture of mental health services, particularly within the UK, that group therapy programmes are more efficient than individual therapy – when comparing the net gain per person per unit of resource supplied. Very few studies provided adequate detail with regards to the resource implications of an offered programme, so a comparative analysis of the efficiency question is beyond the capacity, or purpose, of this review. It does appear that, of these studies reviewed, the greatest sustained gains were achieved where there was, in addition to the principal intervention, attention to 'relapse prevention' and 'staying well' and an extensive period of assessment and collaborative formulation-development prior to commencement of the 'research-approach'. It seems likely that these three components would each have contributed to a more successful embedding of any strategy and more effective management of subsequent factors that might otherwise have served to challenge the person's new self-view.

The majority of the studies reviewed offered an intervention that was specifically tailored to the head-line problem – e.g. low self-esteem, self-stigma, recovery, adjustment following the first onset, employment. These approaches appear to be universally rooted in a belief, referenced above with regard to Sonmez et al (2014), that efficacy is likely to be increased when there is a direct fit between conceptual understandings of the nodal determinants of evaluative appraisals of self and the future and the specific techniques or strategies employed. Allied to that position is the approach to define a menu of such strategies or techniques by which to guide the therapy-provider. Finally, in the context of psychosis, and particularly early psychosis, almost every programme or intervention discussed included specific attention to the role and detail of the person's illness narratives with regard to self, their capacities, potentials and aspirations, in social positioning and endeavours, in vocation and education. This position has emphasised in each case, both, the importance of cognitive evaluation and remediation of these perspectives and comprehensive attention to action – in relation to the immediacy of coping strategies and more significant life choices.

4.6 Hope and Self-Esteem Interventions – Delivered in Contexts other than Psychosis

4.6.1 Content, Structure and Delivery

It was noted earlier in the chapter (Section 4.2) that the constructs of, both, hope and self-esteem were transdiagnostic. The discussion of conceptualizations (Section 4.4) identified interventions or programmes designed to ameliorate hopelessness and / or low self-esteem in a variety of wider contexts and in relation to, both, physical and mental health as the underlying concern. This section presents a brief review of those approaches whose value has not yet been considered with regard to psychosis. It addresses the question – '***To what extent could those experiences (needs) be met by existing CBT-based psychological interventions that are not currently being considered within the field of psychosis?'***

The identified intervention research papers were associated with a small number of collectives, presenting as 'threads' of linked articles, usually lead by a principle author. The categorisation of these threads has been organised in relation, either, to a basis in a shared intervention strategy explored by different teams, or to a specific team writing progressively about the journey towards and through a programme of intervention research. The research threads showed different degrees of mutuality or insularity, with some in particular making very little reference to others working in the field and progressing comparative ideas. Appendix 2 includes a series of 'wiring' diagrams detailing examples of the citational relationships between articles in different threads identified in the self-esteem literature.

The following sections explore the interventions examined in each of the identified threads of hope- and self-esteem-intervention research. Each intervention is described with reference to the breadth and depth of research-articles and associated published material, the mode of delivery, resource investment and primary content. These studies were primarily identified in the first reviews of the literature (prior to the undertaking of the research). It is important to acknowledge that the construction of the novel Therapy Programme was directly informed by the detailed consideration of these existing approaches, with particular reference to questions of what worked and what did not. Where strategies or techniques had received especially positive evaluation and were deemed consistent with the conceptualisation of the hope-self-esteem complex being constructed, they were imported into the menu of options available within the framework of the new Therapy Programme. For that reason, the content of interventions relating to each research thread is described with some detail.

Hope-Intervention Research

The analysis of the hope-targeted intervention research, not relating to psychosis, identified 4 clear and significant ‘threads’. The three threads associated with Herth, Rustoen and Duggleby as the lead authors have been exclusively concerned with the amelioration of hopelessness and the inspiration of hope in the field of acute, physical health care and, specifically, the context of terminal illness. The principle focus of these threads was on the experiences of palliative care patients. Some attention has, also, been given to the experiences of the informal caregivers, mostly family, who support them. In contrast, the Snyder-Cheavens thread, which has been the most prolific in terms of research articles, as well as the wider body of academic writing, has spanned the physical-mental health divide, and extended into fields of academia and athletics.

Of the three threads associated with cancer-care, the most developed ideas are associated with Herth. She has written extensively on the subject of Hope (1990, 1991, 1993a, 1993b, 2000, 2001, 2005; Buckley and Herth, 2004; Cutcliffe and Herth, 2002), contributed to the evolution of a comprehensive thematic framework (Farran, Herth and Popovich,1995), constructed a highly regarded outcome measure (the Herth Hope Index, Herth 1991), and developed a therapeutic model (the 'Hope Intervention Program'). The literature review, however, was only able to identify one study (Herth 2000, 2001) in which the efficacy and accessibility of the approach was investigated. Her intervention was delivered as a course of 8 one-hour group-therapy sessions. Organised in relation to the 'Hope Process Framework' (Farran et al, 1990) it addressed 4 dimensions of hope – experiential, spiritual / transcendent, relational and rational thought. Content included attention to the search for hope (both within oneself and in the wider social and physical environment), the importance of connecting with others, reflections upon the meaning and purpose of life, death and suffering, the identification of personal strengths, and the building of a hopeful, rational mentality. Cognitive-behavioural elements encompassed strategies and techniques aimed at cognitive reframing, reality surveillance, energy saving and energising, and goal refinement.

Rustoen and colleagues' 'HOPE-IN' programme (Rustoen, Wiklund, Hanestad and Mourm, 1998; Rustoen, Cooper and Miaskowski, 2011) was also group-based and delivered in eight sessions (though two-hours each, rather than one). Their programme structure reflected Nowotny's (1986) definition of hope as a 'a six-dimensional, dynamic attribute of the person which orients to the future, includes active involvement by the individual, comes from within, is possible, relates to or involves others or a higher being, and relates to meaningful outcomes to the individual' (p89). As with Herth (2001), and consistent with the recommendations of Cutcliffe (2004; Cutcliffe and Herth, 2002), significant attention was paid to the tone of the meetings and the manner or attitude of the group facilitators. Sessions encouraged participants to be pro-active in their own wellbeing, which included engagement and motivation in their health care, but also investment in their lives, greater connections with the spiritual and with those family and friends whose approaches were adjudged to be nurturing and affirming.

The Duggleby thread is the least consistent with the Cognitive-Behavioural paradigm (a key search criteria) of all those reviewed. The thread includes a number of articles exploring participants' experiences of hope (Duggleby, Cooper and Penz, 2009; Duggleby, Holtslander, Kylma, Duncan, Hammond and Williams, 2010; Duggleby and Swindle, 2011; Duggleby and Wright, 2005; Holtslander and Duggleby, 2009; Williams, Duggleby, Eby, Cooper, Hallstrom, Holtslander and Thomas, 2013), along with three intervention-studies (Duggleby, Degner, Williams, Wright, Cooper, Popkin and Holstlander, 2007; Duggleby, Williams, Holtslander, Cooper, Ghosh, Hallstrom, McLean and Hampton, 2013; Duggleby, Wright, Williams, Degner, Cammer and Holtslander, 2007). The group's research intervention (the 'Living With Hope Program') was described as being based upon an integration of elements arising from the Farran, Wilken and Popovich (1990) 'Hope Process Framework' together with those associated with Holtslander, Duggleby, Williams and Wright's (2005) own 'Hanging on to Hope'. 'Hanging on to Hope' included 'doing what you have to do', 'living in the moment', 'staying positive' and writing your own story'. Given the predicted fragility of the target recipients, the intervention was designed to be simple, delivered flexibly and with minimal invasiveness. It consisted of watching an 'international award-winning film' (Duggleby, Degner et al, 2007, p249), which presented interviews with patients, family members and others reflecting upon their experiences of hope in the face of terminal illness, along-with the strategies that they employed to sustain that hopefulness and, then, completing a hope-inspiring exercise. Finally, participants were asked to undertake one only of a series of options intended to promote reflection upon, and the internalisation and assimilation of, the points raised. The intervention was believed to impact upon the hope of participants, both, directly and indirectly. Indirect elements included the encouragement of self-efficacy and amelioration of loss and grief (Holtslander and Duggleby, 2009). The authors argued that the approach promoted cognitive reframing, a greater sense of psychological balance, new perspectives on illness and self, and new meaning and purpose in life.

The Snyder-Cheavens research thread includes numerous articles concerned with the prevalence, relevance, conceptualization and measurement of the construct of hope, two texts detailing a 'Hope Therapy' (McDermott and Snyder, 1999; Lopez, S.J., Ciarelli, R., Coffman, L., Stone, M. and Wyatt, L., 2000) and 9 published intervention studies (Cheavens, Feldman, Gum, Michael and Snyder, 2006; Feldman and Dreher, 2012; Irving, Snyder, Cheavens, Gravel, Hanke et al, 2004; Klausner, Clarkin, Spielman, Pupo, Abrams and Alexopoulos, 1998; Klausner, Snyder and Cheavens, 2000; Redlich, Hados-Lidor, Weiss and Amirav, 2010; Shekarabi-Ahari, Younesi, Borjali and Ansari-Damavandi, 2012; Thornton, Cheavens, Heotzmann, Dorfman, Wu and Anderssen, 2014; Wilbur and Parente, 2008). The studies were all organized with respect to Snyder's Hope Theory (1994) and, mostly, with reference to his specific Hope Therapy (McDermott and Snyder, 1999). They focused on Goals, Pathway Thoughts and Agency Thoughts. Different studies varied the content, clinical investment, target populations, and outcome measures employed. The majority examined a group-based intervention, although Thornton et al facilitated the intervention with both groups and individuals. Clinical investment ranged from 90 minutes (a single group session) to 45 hours (15 three-hour group meetings). Hope Therapy appears to have been delivered in its most pure and complete form by Cheavens et al (2006). Their intervention incorporated aspects of psycho-education and skills training, allied to a therapeutic utilisation of the group process. Session content included the explicit and transparent discussion of hope theory, detailed exploration and setting of goals, attention to the nurturing of motivation and pragmatic considerations of pathways. Other studies in the thread delivered component parts of the therapy (Feldman and Dreher, 2012) or included additional elements of intervention - e.g. CBT and problem-solving (Klausner et al, 1998; Klausner, Snyder and Cheavens, 2000) and Mindfulness (Thornton, et al, 2014). Irving et al (2004) employed a 5-session course of Hope Therapy as a 'pre-treatment' approach designed to enhance the quality of the individual therapy to follow. Most interventions targeted those experiencing issues of hopelessness with respect to their own ill-health. Shekarabi-Ahari et al (2012) and Redlich et al (2010), however, were more concerned with the feelings of hopelessness experienced by parents in the face of traumatic and disempowering challenges to those that they loved (mothers of children with diagnoses of cancer). Feldman and Dreher focused on a non-clinical population. Given the established relationship between Snyder's (1994, 2000a) model of hope and that of the researcher-therapist (Pearson, 2010) and, in the absence of any intervention-research to date with regard to the Pearson model, Snyder's hope-therapy was adopted as a beginning point for the development of the novel Therapy Programme.

Self-Esteem Intervention Research

The majority of articles relating to the evaluation of a self-esteem targeting intervention identified in the various searches of literature either considered the approach specifically in relation to psychosis (e.g. Hall and Tarrier, 2003, 2005) or included a consideration of psychosis along-with other targets of intervention (e.g. Korrelboom, van der Weele et al, 2009). Articles concerned with self-esteem-targeting interventions which have not been examined with reference to psychosis are limited exclusively to the work of Melanie Fennell. Research associated with this thread has been the most prolific of all those that have paid specific attention to self-esteem – in any context. Her ideas have been developed through 3 articles (1997, 1998b, 2004), 2 book chapters, (1998a, Fennell and Jenkins, 2004), a self-help guide (1st ed - 1999; 2nd ed - 2016) and self-help course (2006). Although she has not, herself, published research in relation to this approach, her ideas have been used widely in clinical practice and have been subject to research by others (Rigby and Waite, 2006; Whelan, Haywood and Galloway, 2007; McManus, Waite and Shafran, 2009; Morton, Roach, Reid and Hallam Stewart, 2011; Waite, McManus and Shafran, 2012). Fennell's approach is collaborative and formulation-driven. It is concerned with weakening negative core beliefs about self, inspiring or nurturing more positive self-beliefs and encouraging self-acceptance. Both cognitive and behavioural interventions have been detailed, with particular stress placed upon processes of guided discovery (1997, 1998a) and behavioural experiments (Fennell and Jenkins, 2004). The structure of delivery of the intervention is organized with regard to three stages - (i) Providing a context for change, (ii) Breaking the self-perpetuating cycle, and (iii) Re-evaluating dysfunctional assumptions. Fennell's approach has evolved over time, in particular becoming more engaged with metacognitive, mindful and compassionate processes (2004). Recent contributors to the thread, however, have tended to base their practice on her original (1999) self-help guide, although sometimes incorporating new elements (Rigby and Waite, 2006) or additional frameworks of support (Morton et al, 2011). The model has been delivered in both individual (Whelan, Haywood and Galloway, 2007; McManus, Waite and Shafran, 2009; Waite, McManus and Shafran, 2012) and group therapy (Rigby and Waite, 2006; Morton et al, 2011).

There is a sub-thread to this body of research involving the delivery of 1-day Self-confidence workshops. It consists of 5 articles, presenting three intervention studies (Brown, Boardman, Elliot, Howay and Morrison, 2005; Brown, Elliot, Boardman, Ferns and Morrison, 2004; Brown, Elliot, Boardman, Andiappan, Landau and Howey, 2008; Horrell, Goldsmith, Tylee, Schmidt, Murphy et al, 2014; Prytys, Harman, Lee and Brown, 2009). The Self-confidence Workshops were initially entitled 'Coping with Depression', but were renamed to increase recruitment. They were delivered in a single day, facilitated in a non-health-related community setting and targeted non-clinical populations. The workshops were delivered in 4 parts - (i) Understanding the development of low self-esteem and its emotional components, (ii) Identifying and challenging negative cognitions, (iii) Teaching behavioural methods for improving low confidence (problem-solving and assertiveness training), and (iv) Action-planning through the use of personal homework tasks. Following recommendations from a previous study (Brown et al, 2008), Horrell et al (2014) included a short (2 hour) booster session after approximately 1 month.

4.6.2 Hope and Self-Esteem Interventions – Outcome Data

The previous section considered the content of different interventions. This examines their relative efficacy. Attention to the outcome data arising from these hope and self-esteem targeting intervention studies has been examined with reference to three purposes –

1. To contribute to a broad consideration of the worth of specific interventions and their composite techniques.
2. To address questions regarding the worth of the agenda to develop a novel Therapy Programme (including attention to both need and the potential for improvements)
3. To provide comparison data against which to evaluate the efficacy of the novel Therapy Programme.

The evaluation of efficacy is, of course, influenced by the research design as much as by the shape of the programme under investigation. Different therapeutic approaches have been evaluated with different groups of target participants, different protocols of evaluation and different outcome measures, including multiple variables, different measures for the same variables and alternate interpretations of the same measure. There has been no consistency or standardization in reporting ‘effect size’. It is of note that many of the studies considered did not include any measure of hope or self-esteem within their inclusion criteria. In consequence baseline mean scores were, on occasion, in the moderate or high range and the interventions were effectively being delivered to those who might be regarded as not in need (Duggleby, Degner et al, 2007; Duggleby et al, 2013; Herth, 2000; Lecomte et al, 1999; Rustoen, Wiklund et al, 1998; Rustoen, Cooper and Miaskowski, 2011). This circumstance appears to have impacted upon the potential for gains in the employed outcome-measures, and undermined reflections with respect to value or efficacy. To reduce the confusion of extraneous ‘noise’, and in consideration of the primary purposes of the review, in the discussion of outcomes (below) only the data relating to ‘mean’ changes in hope and self-esteem in the intervention groups has been considered. Consistent with the analyses presented in 4.5, to allow comparison between studies employing different outcome measures, two different indices of changes in hope or self-esteem have been reported – (i) Percentage change from baseline scores, and (ii) Percentage change across the total range of the scale. Also, as with the articles reviewed in Section 4.5. for the calculation of the ‘percentage change from baseline’ raw scores have been adjusted ‘as if’ the measure was inverse-problem scored with a range beginning at zero. Selected summary outcome data from the most successful intervention-studies is presented in Tables 4.30 (Hope) and 4.31 (Self-esteem) below. More comprehensive data tables are included in Appendix 2.

Hope-Intervention Research

Table 4.30 – Summary of Most Successful Hope-Targeting Intervention-Studies

Study	**Intervention Cost (Clinical Hours)**	**Outcome Measure**	**Evaluation Point**	**Percentage Change from Baseline**	**Percentage Change across the Range of the Measure**
Herth et al (2000, 2001)	16hrs (group)	HHI	End of Therapy	***39.5***	***26.7***
			3-Month Follow-Up	***34.1***	***23.0***
			6-Month Follow-Up	***29.1***	***19.7***
			9-Month Follow-Up	***24.2***	***16.4***
Klausner et al (2000)	11hrs (group)	SSHS	End of Therapy	***53.0***	***24.7***
Cheavens et al (2006)	16hrs (group)	SSHS	End of Therapy		
		Immediate Start		***49.7***	***25.6***
		Delayed Start		***17.8***	***10.3***

Of the 9 articles relating to the Snyder-Cheavens thread which were reviewed, only 5 presented outcome data in sufficient detail to allow comparisons, according to the criteria described above. The Irving et al (2004) paper included no data relating to the hope therapy as pre-treatment. The Redlich et al (2010), Shekarabi-Ahari et al (2012) and Wilbur and Parente (2008) articles presented processed change scores rather than raw pre and post means. In addition to their primary concern with hope, Cheavens et al (2006), also, evaluated self-esteem and life-meaning. The authors stated that the treatment programme was associated with significant improvements in both self-esteem and in 'life- meaning', but those assertions were contradicted by the tabled data. Self-esteem scores, measured using a problem-scored index, increased, and life-meaning scores, measured using an inverse-problem-scored test decreased. Both changes would indicate a deterioration, not improvement, in experience. The baseline scores for the two measures were similar and the conflict between the numerical data and narrative prose might represent an inputting error in the publication of the results. Some uncertainty has, however, attached itself and so those results have been excluded from the table of combined data for this research thread. Although the outcome data for these studies is quite varied, two (Cheavens et al, 2006; Klausner et al, 2000) showed very consistent gains of the total score of both percentage change from baseline (49.7% and 53.0% respectively) and across the range (25.6% and 24.7% respectively). These represented the greatest efficacy achieved of the hope interventions studied. Unfortunately, only one study in this thread presented any follow-up data (Feldman and Dreher, 2012). That study utilised a very truncated version of Hope Therapy and achieved only modest gains over the course of therapy, all of which were lost at follow-up. Given the level of adaptation of the principle model, those disappointing results cannot be meaningfully generalised to the approach as a whole.

The two studies by Rustoen and colleagues, exploring the ‘HOPE-IN’ Programme (Rustoen, Wiklund et al, 1998; Rustoen, Cooper and Miaskowski, 2011), used different measures, but neither achieved any substantial therapeutic gains - 2.0% and 2.1% respectively on percentage change from baseline and 1.4% and 1.4% respectively on percentage change across the range. Very little of these small gains was retained at 3- or 12-month follow-up. In addition to the problem with high baseline scores already noted, these studies focused on patients diagnosed with terminal illness and suffered from high rates of participant drop-out due to issues of failing physical health. The Herth study (2000, 2001) was, also, concerned with oncology patients. Results achieved compared very favourably with Rustoen and colleagues - 39.5% change from baseline and 26.7% across the range. These results showed progressive reduction in gains when followed-up at 3, 6 and 9 months, but did still indicate an improvement of 24.2% change from baseline / 16.4% change across the range at the end of that period. Herth noted that there had been particular gains in hope in the subscales of the relevant measure (the Herth Hope Index - Herth, 1991) relating to (i) ‘interconnectedness with self and colleagues’ and (ii) ‘positive inner readiness’. She suggested that this might be regarded as validating the argument for a multi-modal hope intervention.

The three Duggleby studies (Duggleby, Degner et al, 2007; Duggleby, Wright et al, 2007; Duggleby et al, 2013) achieved only modest gains in hope (change from baseline / change across the range) at the end of therapy (i) 6.09% / 4.2%, (ii) 10.5% / 8.2% and (iii) 4.9% / 3.5%. The third of these studies, focusing on the experiences of care-givers, identified a variable, but generally improving picture over the course of 3-, 6- and 12-month follow-up, with final gains of 10.6% / 7.6%. The authors did not, however, include significant detail regarding the circumstances of the care-givers at follow-up. There are, consequently, unanswered questions as to how hopeful attitudes towards cancer in a loved one might naturally change over 12 months, either in response to processed grief or the continued survival of the diagnosed individual. It is of note that over repeated follow-up evaluations the number of respondents reduced and the standard deviation narrowed. It is possible that the data simply showed that there was a loss of outlier reporters over time – resulting in a self-selection of respondents skewed towards those who felt more positive.

Self-Esteem Intervention Research

Table 4.31 – Summary of Most Successful Self-Esteem-Targeting Intervention-Studies

Study	**Intervention Cost (Clinical Hours)**	**Outcome Measure**	**Evaluation Point**	**% Change from Baseline**	**% Change across the Range**
Rigby and Waite (2006)	20hrs (group)	RSES	End of Therapy 3-Month Follow-Up	***46.0*** ***78.36***	***17.0*** ***28.3***

Whelan, Haywood and Galloway (2007)	10hrs (individual)	RSES All Low SE	End of Therapy	 ***13.7*** ***49.5***	 ***7.3*** ***17.3***
McManus, Waite and Shafran (2009)	12hrs (individual)	RSCQ	End of Therapy 12Month Follow-Up	***28.7*** ***40.4***	***12.9*** ***18.1***
Morton, Roach, Reid and Stewart (2011)	16hrs (group) plus individual sessions	RSCQ	End of Therapy	***35.8***	***13.2***
Waite, McManus and Shafran (2012)	10hrs (individual)	RSCQ	End of Therapy Follow-up	***33.3*** ***38.9***	***13.7*** ***16.0***
Brown et al (2008)	7hrs (group)	RSES Depressed Group Non-depressed Group	 3Month Follow-up 12Month Follow-up 24Month Follow-up 3Month Follow-up 12Month Follow-up 24Month Follow-up	 ***37.2*** ***38.3*** ***39.4*** ***2.3*** ***16.8*** ***11.5***	 ***17.5*** ***18.1*** ***18.6*** ***1.8*** ***13.0*** ***8.9***
Horrell et al (2014)	1-day (plus booster) (group)	RSES	3-Month Follow-Up	***22.7***	***9.0***

The Fennell research thread described in the previous section included two sub-groups - one concerned with the facilitation of Fennel's therapy, as defined by her self-help guide (Fennell, 1999), in a group therapy programme or course of individual therapy and the other with the 1-day 'Self-confidence' workshops. In general, all of the studies in both sub-threads were associated with improvements into the 'normal' range of self-esteem, except for Morton et al (2011), which achieved statistically significant gains (35.82% from baseline / 13.2% across the range), but the baseline mean was so low that the end of therapy mean was still closer to the norms of the clinical population than the non-clinical. The Waite, McManus and Shafran (2012) study achieved, both, statistically- and clinically-significant gains in self-esteem. Of the investigations into the 1-day workshops, the Prytys et al (2009) study did not explore self-esteem as an outcome measure, but the other two (Brown et al, 2004, 2008; Horrell et al, 2014) both showed moderate to good gains over the course of therapy, which, in the case of the former were, not just sustained, but built upon over the 24 months to final follow-up. That research, also, considered differential benefits according to the needs (depression and self-esteem) of the person at baseline. There was a clear split, with those recording a baseline of greater depression and lower self-esteem showing a substantially greater improvement than those with less depression and higher self-esteem.

4.7 Conclusions and Learning Points

The primary purposes of this review have been to –

1. Develop an argument to justify the attention to hope and self-esteem in Early Psychosis and the endeavour of developing a psychological therapy programme to address those considerations.
2. Examine conceptual understandings of the two constructs and associated targeted, CBT-informed interventions, to develop a paradigmatically coherent, structured novel Therapy Programme to address the hope-self-esteem complex.
3. Identify comparative data against which to evaluate the efficacy of the novel Therapy Programme.

This literature review has attempted to encompass a very broad remit of responsibility. That has included exploration of the wider prevalence of compromised hope and self-esteem, primarily in matters of physical and mental ill-health, the centrality of experiences of hopelessness and low self-esteem in those diagnosed with First Episode Psychosis (including both pre and post-morbid considerations), conceptualisations of Hope and Self-Esteem (in particular those which had been operationalised into targeted psychological interventions), and intervention research (including both the content and structure of hope- and self-esteem targeting interventions and the available evidence regarding their efficacy).

4.7.1 Conceptualisation of Hope and Self-Esteem

The concepts of Hope and Self-esteem have been explored with very limited cross-reference or cross-fertilization of ideas and so explications have tended to use different frames, images and language. On deeper comparison, however, it might be argued that the essential agreed elements of each are quite similar. Definitions, frameworks and models of hope frequently implicate aspects of self-judgement (Miller, 1983; Morse and Doberneck, 1995; Pearson, 2010; Scioli and Biller, 2009; Snyder, 2000a) and those of self-esteem frequently implicate aspects of future anticipation (James, 1890; Fennell, 1999, 2016). Both have been discussed in terms of global and specific interpretations (generalised and particularised). This dichotomy has been articulated more clearly with respect to self-esteem (Rosenberg, 1965, 1979). It has, however, also been addressed by Snyder (1994, 2000a) in relation to the particularised nature of goals, as well as proposed by others as an explanation for how a person might appear both hopeful and despairing at the same time – a tension between oppositely viewed specific hopes or between a specific hope / despair and a global, balanced position (Farran, Herth and Popovich, 1995; Dufault and Martocchio, 1985). Both have been considered in relation to personality traits and states of mind. Conceptual formulations of each include reference to, both, developmental considerations and maintenance or moderating factors (Farran and Popovich, 1990; Fennell, 1997, 1999, 2004; Miller, 1983; Pearson, 2010; Rosenberg, 1965; Snyder,1994). Both have been explored with respect to different dimensions – such as strength, direction, importance, consistency and salience (Rosenberg, 1965, 1979; Farran, Herth and Popovich, 1995; Snyder, 2000a). Both suggest that there is a reciprocity between evaluations and action, mediated through cognitive biases and rules for living – with a tendency to self-maintaining patterns of thoughts and behaviour. Finally, for both constructs, relational processes have been identified as significant with regard to development and maintenance. In addition, in some areas where reflections have been confined only to one concept it is possible that the learning might be reasonably extrapolated to the other. In particular, it is likely that observations with regard to evaluative compartmentalisation and integration, conscious and unconscious awareness and stability, all explored with regard to self-esteem (Ditzfeld and Showers, 2013; Franck and De Raedt, 2007; Kernis and Goldman 2005; Lewandowski, Nardone and Raines, 2010; McElwee and Haugh, 2010), might be productively examined with respect to hope.

4.7.2 Structure and Content of Hope- and Self-Esteem-Targeting Interventions

Most, though not quite all, interventions examined were organised within a framework of positive psychology, giving primary attention to the inspiration and nurturing of positive evaluations towards self and the future. Most, though again not all, also, considered the amelioration of negative evaluations – such that the approaches might be described in terms of the ‘re-balancing’ of positive and negative perspectives. Most of the programmes explored prioritised attention to processes of problem-maintenance, with only a few (e.g. McDermott and Snyder, 1999; Fennell, 1999) actively encouraging attention to facets of problem-development and restructuring of core-schema. Interventions were constructed with varying levels of complexity, tackling single or multiple aspects of the evaluative experience, employing simple or multi-modal techniques, and single or multiple cognitive and behavioural strategies. Hope-targeted interventions tended to prioritise attention to goal-identification and goal-achievement strategies. All self-esteem targeting interventions included aspects of positive self-storying, including positive data-logging and the expression of positive self-statements. For those interventions delivered within the field of psychosis, that ‘story-telling’ was particularly concerned with narratives of illness and issues of self-stigma. In those interventions that were delivered individually, stories of self in relation to psychosis were connected to wider narratives regarding, in particular, competence and capacity and social integration. Self-evaluations concerning agency were present in most interventions targeting both hope and self-esteem. Many interventions relating to both concepts included some measure of attention to the person’s familial, social and spiritual relationships. For hope that focus prioritised relationships as resources. For self-esteem they were considered more with regard to received- or interpreted-judgement. There was a strong suggestion of a premium attached to intervention strategies that encouraged greater investment in relationships that offered moral and practical support. Some interventions were developed to be delivered exclusively in a group therapy format. Others were created for more flexible facilitation. The overwhelming majority of studies elected to use the group context – either as a 'traditional' group therapy or a classroom-based course. A small number made reference to group process, but no study examined provided a rational for the individual-group decision.

4.7.3 Efficacy of Hope- and Self-Esteem Targeting Interventions – The Value of Specific Strategies and Techniques, Proof of Need and Potential for Improvement

Collectively the studies provide a significant level of evidentiary support for the argument that the direct targeting of negative evaluations about self and the future can improve the person's perspectives. Although the data is not presented or discussed above, the studies also support the position that the direct targeting of hopelessness and low self-esteem can result in improvements in wider mental and physical health symptomology, can improve engagement and prognosis. There has been little attention to, and no clarity regarding, the question of directionality in concomitant gains to symptoms and to self and future evaluations. There is, in general, consistent evidence that interventions targeting negative evaluations are of greatest benefit to those for whom that consideration is more relevant – i.e. those evaluated at baseline to have lower hope and / or self-esteem. There is, however, also, some suggestion that hope and self-esteem can be so compromised (so low) as to make the person less reachable by the intervention offered. Therapeutic gains were very variable, with no clear pattern as to whether more complex, multi-modal interventions achieved greater benefits. There was no data provided with reference to wider and longitudinal gains that might have allowed for a calculation of efficiency – with regard to efficacy per unit of resource-intervention. There was some suggestion that simpler, unidirectional interventions might achieve more rapid change, but that that change was less likely to be sustained over time. More specifically, sustained gains seemed to be associated with the incorporation of a unique, client-centred formulation and attention to relapse prevention, including the use of booster sessions. There did appear to be a tendency amongst some authors to over-state the significance or gains of their intervention.

Chapter 5 – A Novel Therapy Programme

5.1 Introduction to the chapter

This chapter presents the novel, complex Therapy Programme, the piloting, evaluation and fine-tuning of which is the focus of this thesis. It was noted in Chapter 2 that the Medical Research Council (Craig et al, 2008) recommend four stages to be followed in the development of any complex treatment programme – identifying an initial structure based on theory and prior evidence, consultation, examination of acceptability and fine-tuning through piloting and, finally, more extensive and controlled intervention research. The development of the novel Therapy Programme has been progressed in line with these recommendations, with preliminary ideas, representing an integration of many of the learning points discussed in the preceding two chapters, evolving in response to feedback from consultations with mental health professionals, service users and carers involved in the field of Early Psychosis. That iterative process of discussion and revisioning was described in an earlier, unpublished, academic, developmental paper (Pearson, 2013) and will not be covered in this thesis. The programme described in this chapter is the product of those first two stages. The thesis reports on the third stage of development - the initial piloting of the intervention. It has been noted that the Therapy Programme was organised within the therapeutic paradigm of Cognitive-Behavioural Therapy (CBT). In order to orient the reader, this chapter is, therefore, presented in two parts –

1. An introduction to the central theoretical tenets and clinical practices of CBT.
2. A description of the new intervention.

5.2 Introduction to CBT as the Organising Therapeutic Paradigm

Cognitive-Behavioural Therapy (CBT) was selected as the core organising paradigm for the intervention for three reasons.

1. There is extensive evidence to support its efficacy in the treatment of a number of mental health conditions, including, in particular, Early Psychosis (e.g. Chadwick, Birchwood and Trower, 1996; French and Morrison, 2004; Gumley and Park, 2010; Henry, 2004; Newton and Coates, 2010; Siddle and Haddock, 2004).
2. As a consequence of the above it has been identified by NICE (National Institute for Health and Care Excellence) as the psychological therapy of choice in the provision of services to those struggling with conditions of Generalised Anxiety and Panic Disorder for Adults (2011), Social Anxiety Disorder (2013), Depression for Adults (2004, 2009) and Post-Traumatic Stress Disorder (2005), as well as, in particular, Schizophrenia and the Psychoses, including Early Psychosis (2002, 2009, 2014).
3. It was the principle treatment modality of the researcher-therapist.

The therapeutic paradigm of CBT encompasses a broad range of intersecting, but also diverse approaches. These approaches share common theoretical foundations and practice elements. CBT is rooted in the presumption of human beings as scientists - logical and empirical. There is an expectation that practice should always be informed by explicitly acknowledged understandings, and that those understandings, from theory to service-user story, should be the subject of robust investigation and evaluation (Beck, 1967, 1979). Facts, it is argued, should be examined, not assumed, and should be based, where-ever possible, on consensually agreed evidence (Kennedy, 2009; Kennerley, Kirk and Westbrook, 2017). The approach has historically been associated with the philosophical paradigm of modernism and a bias towards positivist research methodologies. That relationship has, however, been subject to challenge in recent years and a post-modernist cognitive-behavioural perspective consistent with critical realism is now widely accepted (Safran and Segal, 1996). As a therapeutic approach CBT is structured, within and across sessions and goal-directed. As its name suggests it promotes attention to both cognitive and behavioural change. Both are deemed equally necessary in order to achieve clinically significant and sustainable improvements (Beck, 1967, 1979; Persons, 2005).

> ‘CBT requires formulation, the application of that formulation to a collaborative treatment schedule, an emphasis on changing thought as well as behaviour patterns, goal-setting and homework between sessions, and consensus on generally focused problem areas identified, clarified and optimally resolved in a time-limited frame’ (Hanna, 2009, P12).

5.2.1 Defining the Structure of CBT and CBTp

This commonality of core of components in the delivery of CBT are encapsulated in the CTS-R audit tool (Cognitive Therapy Scale-Revised – Blackburn, James, Milne and Reichelt, 2000; Blackburn, James, Milne, Baker, Stanart et al, 2001). The CTS-R is used to evaluate the practice of Cognitive Behaviour Therapists (trained and in training) with regard to, both, fidelity to the CBT paradigm and quality of the therapy delivered. The tool covers 12 elements of practice - five general items that might be regarded as appropriate to any therapeutic paradigm and eight that are identified as particularly specific or pertinent to the delivery of CBT. One of those, agenda setting and adherence, is listed as, both, general and specific. It is suggested that this feature might be present in some form in all therapies, but is considered to be an essential core ingredient in the structuring of the CBT therapy. The 12 components are presented in Table 5.1 below.

Table 5.1 – Components of the Revised Cognitive Therapy Scale (Blackburn et al, 2000, 2001) – subdivided into General Items and CBT-specific Items

General Items	CBT-specific Items
1. Agenda setting and Adherence	1. Agenda setting and Adherence
2. Feedback	6. Eliciting appropriate emotional expression
3. Collaboration	7. Eliciting Key Cognitions
4. Pacing and the efficient use of time	8. Eliciting behaviours
5. Interpersonal effectiveness	9. Guided Discovery
	10. Conceptual Integration
	11. Application of change methods
	12. Homework setting

In recent years, a focused form of CBT has been developed to address the needs of those diagnosed with psychotic illness. This approach is referred to as Cognitive Behaviour Therapy for Psychosis (CBTp). Some interpretations of this broad, formulation-driven and problem-focused approach were explored in section 4.5. In 2010, Morrison and Barratt published the results of a Delphi Study - a conversation between leading clinicians and theorists in the field, regarding the defining features of a CBT specifically for psychosis. That process identified 77 items that were rated as essential components of CBTp by more than 80% of those involved in the discussions. The consensually agreed elements included attention to engagement, structure and principles, formulation, assessment and model, homework, change strategies and therapist assumptions. Table 5.2 presents example elements relating to each of these areas.

Table 5.2 – Component elements of CBT for Psychosis identified in Morrison and Barratt’s (2010) Delphi Study – Example elements in each key area (p139-140)

Area	Examples
Engagement	Interventions should be informed by client feedback. The client should be engaged in the therapeutic relationship. The rationale of CBT should be explained and demonstrated to the client.
Structure and Principles	CBT should aim to reduce distress and prevent future distress. The client should be given a chance to explain his or her own model first. CBT should assist the maintenance of the client’s capacity to make informed decisions about their lives.
Formulation	A good collaborative relationship must be formed to help develop a comprehensive formulation. A balanced conceptualization should highlight the client’s strengths. A formulation should be developed and used to outline a treatment plan.
Assessment and Model	CBT should be idiosyncratic to the individual client. CBT should help the client to elicit those thoughts, images, and beliefs that are fundamental to their distress (i.e. the key cognitions). CBT should identify emotional issues that interfere with effective change (e.g. hostility, anxiety, excessive anger).
Homework	‘Homework’ should be a ‘standing’ item on the agenda. Homework assignments ought to act as a bridge between therapy and the real world. Practice assignments (‘homework’) should be planned and reviewed.
Change Strategies	Therapists should use elements of self-disclosure to help normalize clients’ psychotic symptoms. CBT should help a client modify core beliefs / schemas and associated behaviour. Self-report measures and self-monitoring ought to guide therapy and monitor outcome.
Therapist Assumptions	Therapists should have a good understanding of recovery from psychosis. Therapists ought to believe that delusions can be quite understandable. Therapists ought to view most symptoms of psychosis as quite common in the normal population.

5.2.2 CBT, CBTp and Unique Therapy Programmes

Within the broad field of CBT (and CBTp) there are strong traditions of valuing the importance of both (i) a unique, person-centred, collaboratively-developed treatment plan (e.g. Morrison and Barratt, 2010; Persons, 2005) and (ii) fidelity to the specifics of evidence-based interventions, developed in relation to, and generalised from, 'comparative' difficulties experienced by others. The tension between these two perspectives supports a spectrum of approaches to CBT. One end of that continuum might be represented by the provision of a course of 'generic' CBT (or CBTp) delivered flexibly and uniquely to each client (e.g. Wragg and Whitehead, 2004). The other end might be reflected in the facilitation of a largely invariant intervention (e.g. IVIP - Lysaker et al, 2005; NECT - Yanos et al, 2015; SSRP - Fung et al, 2011; COMET - van der Gaag et al, 2012; WELLFOCUS PPT - Schrank et al, 2015). The systematic review of intervention research presented in Section 4.5 suggests that the former approach is associated primarily (though not exclusively) with individual, one-to-one therapy and the latter more with group therapies. Between those two extremes there are interventions (e.g. Social Recovery Therapy - Fowler et al, 2019; Cognitive Therapy for Self-Stigma - Morrison et al, 2016, Wood et al, 2018) which seek to offer a positive balance between the relative risks and benefits of service-user-focused flexibility and evidence-based invariance. These approaches are characterised by a degree of fidelity to specific programmes alongside a collaborative negotiation of particular techniques and strategies. Treatment plans tend to be organised with reference to both individual formulations and normative conceptualisations.

Whilst emphasising that these interventions or programmes are unique, it is, also, important to recognise that they sit within the wider definitions of, both, CBT and CBTp. In that context, it is to be noted, that very little of the content (technique or strategy) of any of the approaches explored in Section 4.5 was actually unique to that intervention. Most composite strategies identified were common to CBT and CBTp and many were shared by multiple 'different' intervention-programmes, but collected together in different combinations or formats. It is suggested that these interventions were able to be defined as specific and targeted for the following five reasons.

1. Focus - they were invested with the intent of the developer to target a particular focus.
2. Conceptualisation - they tended to be organised with reference to a specific (novel) normative conceptualisation of the target problem.
3. Structure - they were delivered within a specific structure, including separate modules (e.g. The 'Positive Living Group of Meyer et al, 2012; and the NECT of Yanos et al, 2012), the ordering of attention in terms of chronology (e.g. Lecomte et al, 1999) and the style of the delivery of the programme (e.g. McDermot and Snyder's Hope Therapy, 1999).
4. Content - they included a specific menu of techniques and strategies.
5. Resources - they involved the provision of, or access to, specific adjunctive resources. These, variously, included bespoke-developed reading material (e.g. Fennel's Self-esteem, 1999), videos (e.g. Duggleby et al's 'Living with Hope', 2007) or vocational opportunities (e.g. Lysaker et al's IVIP, 2005).

It is argued that the novel Therapy Programme is consistent with, both, CBT and CBTp, but, also, meets all of these five conditions and might, therefore, be defined as a unique and specific, complex intervention.

5.3 The Therapy Programme

This section presents the new programme. It begins with an acknowledgement of the principles, questions and recommendations that organised the preliminary development of the intervention. The approach is then described with respect to the five criteria defined in section 5.2.2 (above) – Focus, Conceptualisation, Structure, Content and Resources.

5.3.1 Introducing the Therapy Programme

The development of the Therapy Programme was organised by a number of core principles, questions relating to the selection of programme-structure and recommendations regarding content. The principles were identified at the outset by the researcher-therapist based on personal experience. The questions and recommendations regarding programme structure and content emerged from the extensive first review of the intersecting intervention-outcome literature. Guiding principles, questions and recommendations are presented in Table 5.3 (below).

Table 5.3 – Developing a Novel Therapy Programme - Guiding Principles, Questions and Recommendations arising from the Review of Literature regarding Programme Structure and Content

Guiding Principles	*The novel Therapy Programme should be ..*
	Organised within the framework of Cognitive-Behavioural Therapy.
	Conceptually and pragmatically consistent.
	Deliverable within a ‘reasonable’ time-frame.
	Clear and structured enough to allow evaluation of ‘fidelity’, but flexible to the unique needs of each individual client.
	Aspirational with regard to long-term, sustainable change.
Questions regarding Structure	*In considering the structure of the programme ..*
	Should the therapy approach employ a single technique or multiple strategies?
	Will the intervention seek to limit its focus of ‘attack’ to a single nodal point in the conceptual model of the target problem or seek to address multiple points of change?
	If a more complex, multi-focal approach is adopted, which aspects or elements of intervention are included?
	Where the intervention represents a composite or aggregation of different strategies how are those elements organized in relation to each other?

	What format of delivery is preferred – individual or group?
	What level of clinical investment is deemed optimal?
Recommendations regarding Structure and Content	*Learning from other interventions suggests that ..*
	All Interventions should be organised according to the unique formulations of the person's difficulties.
	Formulations should be developed collaboratively with the client.
	Selection or targeting of an intervention should take account of the degree of embeddedness or chronicity of the person's views of self and the future, as well as stability or fragility.
	Therapy should be embedded within a commitment towards increased hopefulness
	Interventions would need to be organized with regard to clear goals – including both problem-focused and life-goals.
	Interventions aimed at inspiring or nurturing self-confidence might equally consider increasing the weighted value of the person's positive self-views or decreasing the strength of their negative self-views, and that changes in that balance might be achieved through improved performance or the cognitive restructuring of self-judgements.
	Cognitive restructuring might include attention to biased processes of perception and interpretation and improved access to more functional memories, as well as to a clearer and more engaging projected future identity.
	If self-esteem can be improved it can, equally, be re-lost and that improvements in self-esteem are likely to be better sustained if they have been assimilated at a schematic level.
	Treatment packages need to include specific strategies for the nurturance of improved self-esteem – through the provision of bibliographic resources, access to follow-up contacts and the development of targeted 'staying-well' plans.
	Different clients benefit from different strategies, such that, in selecting interventions with any client, it would be important to weigh-up the relative merits of different approaches, and to deliver the Therapy Programme flexibly, though within the structure of a clear menu of 'approved' elements.

There is a strong argument at the core of the MRC guidelines on the development of complex interventions (Craig et al, 2008) that they should strive for the simplest, or least complex, strategy. Given the clear overlaps between those recommendations described in Chapter 4 relating to the therapeutic inspiration of self-esteem and those relating to the nurturing of hope it would not have been unreasonable to construct a simple, single-dimensional intervention aimed at the intersection between the two. The review of literature, however, suggested that more sustained gains were associated with more complex interventions – in particular those which invested in establishing detailed personal formulations, addressed multiple loci of change, or set aside time to consider relapse prevention (see Chapter 4). More complex approaches, therefore, might be regarded as less efficient in the short-term with reference to the detail of what is covered (in that some elements are likely to be more redundant than others) and in the length of the delivered programme. They might, however, offer the potential for greater efficacy and efficiency over time, with regard to the sustaining of gains. Given the pre-requisite core principles described, the decision was made to develop a complex intervention, using multiple strategies and targeting multiple nodes in the conceptual model of the hope-self-esteem complex. Decisions with regard to the specific content and structure of the Therapy Programme were informed by the commitment to offer a 'formulation-driven' therapy.

5.3.2 The novel Therapy Programme – A unique focus on the integrated-complex of hope and self-esteem

The focus of the new intervention is the amelioration of hopelessness and low self-esteem (and the inspiration of hopefulness and improved self-esteem) in those recently diagnosed with a psychotic illness. When considering the unique conceptualisation of the integrated hope-self-esteem construct and the associated menu of strategies and techniques, it is important to note that these have been influenced by – (i) ideas and strategies relating to the amelioration of hopelessness (or the inspiration of hope), developed and explored with regards to FEP or elsewhere, (ii) ideas and strategies relating to the amelioration of low self-esteem (or the inspiration of higher self-esteem), developed and explored with regards to

FEP or elsewhere and (iii) the specific issues and needs of the FEP service user population. It is significant that very few of those strategies designed to specifically address hope have been developed or facilitated within FEP, and that, neither the most extensively considered hope and self-esteem interventions (Fennell, 1997, 1999; McDermot and Snyder, 1999), nor the hope and self-esteem frameworks that have most-informed the author's ideas (Rosenberg, 1965, 1979; Snyder, 1991), have been considered with respect to FEP. The descriptions of the conjoint conceptualisation and the new intervention, therefore, include reference, both, to elements of hope- and self-esteem-targeting interventions that are generically applicable within multiple contexts and those which are more specific to the experience of FEP.

5.3.3 A coherent normative conceptualisation of the Hope and Self-esteem conjoint complex

The understandings of the person and their problems are referred to as formulations or conceptualisations (Adams, 1996). Meyer and Turkat defined 'formulation' as 'an hypothesis which (1) relates all the client's complaints to one another, (2) explains why the individual developed these difficulties, and (3) provides predictions concerning the client's behaviour given any stimulus conditions' (1979, p261-262). Bruch has suggested (1998) that any formulation, or clinical theory, regarding the individual needs to accommodate both those aspects of experience that are unique to the history and circumstances of the person and those aspects of commonality that attach to particular diagnoses or problems. The terms 'formulation' and 'conceptualisation' are often used synonymously. In this chapter 'formulation' will be used to describe the unique understanding of a specific client's particular experiences and difficulties, whereas 'conceptualisation' will be used to refer to normative or 'template' models of understanding particular problems, such as low self-esteem, hopelessness and psychosis. Bruch argues that the development of normative conceptualisations can allow a CBT Therapist and client to learn from the experience of others, whilst simultaneously shaping their formulation towards the person as a unique individual. A number of well-tested and highly validated template conceptualisations exist currently; e.g. Salkovskis on Obsessive-Compulsive Disorder (1985), Beck on Depression (1979), Clark (1986) on Panic Disorder, Fennell (1997, 1999) on low self-esteem (see Section 4.5), Snyder et al (1994) on Hope (see, also, 4.5), Siddle and Haddock (2004) and Morrison (2001) on Psychosis. The unique service-user formulation, it is proposed, is organised with reference to the normative conceptualisation for the problem or need under consideration. Collectively they allow for the selection and design of informed and tailored programmes of treatment (Adams).

Sonmez and colleagues (2014) have argued that that there appears to be a direct relationship between the specificity of the normative conceptualisation employed and its benefit within the therapy process and, consequently, that the development and effective delivery of any new intervention requires the creation or importation of an appropriate, targeted normative conceptualisation (see Section 4.5). In line with that position, it is proposed that attention to the experience of hopelessness and low self-esteem in the face of the first onset of psychosis might reasonably be expected to be helped by reference to any of the existing models of psychosis (e.g. Morrison, 2001), self-esteem (e.g. Fennell, 1997, 1999) and hope (e.g. Snyder et al, 1994, 2000a), but that the specific complex of issues identified might be likely to benefit more from the employment of a normative conceptualisation that integrated all three components.

Cognitive-Behavioural theory (and therapy) can be described in relation to four principal structures of formulation or conceptualisation, relating to the development of a difficulty, it’s maintenance within intrapsychic or interpersonal processes and its manifestation within the context of therapy (e.g. Bond, 1998; Bruch, 1998; Kennedy, 2009; Turkat, 1985, 1990). The conceptual model constructed to organise the new Therapy Programme is presented below in five parts.

1. A description of the dimensions or characteristics of the hope-self-esteem complex.

2. A developmental conceptualisation that considers the processes by which the person might have arrived at their current traits or tendencies in their evaluations of self and the future.
3. An intrapsychic maintenance conceptualisation that focusses on the reciprocal cycles through / by which states of attitude toward hope and self-esteem are sustained.
4. A relational maintenance conceptualisation that explores the interactional processes of received judgement and action which, in turn, serve to reinforce or challenge prevailing attitudes and behaviours with regard to hopefulness and self-esteem.
5. A conceptualisation of the therapy relationship that considers the manifestation of hope and self-esteem as active elements in the dynamics of the therapy itself.

The development of this comprehensive and complex conceptualisation is organised with respect to the following two positions – (i) that there is likely to be a reciprocity between evaluations of oneself in the present and predictions of achievements or experiences in the future, and (ii) that, notwithstanding the historical, predominantly unconnected approaches to theory development with regard to hope and self-esteem, and the consequent inconsistencies of terminology and presentation, a great many of the ways in which each has been considered might apply to the other. The combined hope-self-esteem conceptual model is multi-dimensional in nature. It captures both global and specific considerations. It does not, consequently, lend itself to presentation as a neat flow-chart.

Characteristics of Hope and Self-Esteem

The discussion of models, frameworks and conceptualisations of hope and self-esteem (Chapter 4) observed that both constructs are regarded as composite perspectives, which incorporate both specific, targeted evaluations (of self or the future) alongside more generalised or global aggregates. Both components are experienced in relation to a number of dimensions, the most significant of which include strength and direction, stability and coherence (Rosenberg, 1965, 1979). With regard to self-esteem this conceptual model has adopted the categorisation proposed by Rosenberg; physicality, competence and achievement, social position and status, and moral character. With regard to hope categorisation might apply both to the three key elements suggested by Snyder (1994, 2000a), agency and pathway thoughts and goals, and the specific and distinct goal-directed concerns. It is argued that, for both hope and self-esteem, the global perspective reflects a balancing of weighted positive and negative evaluations. It is acknowledged that different individuals will allocate different priorities to the composite judgements in their experience of the generalised whole. In addition, it is likely that, for each, there will be a degree of shift and change in these prioritisations over time - as the person matures, their circumstances change and they have different experiences. It is, also, accepted that some individuals will tend more towards evaluative integration and others compartmentalisation for aspects of, both, hope and self-esteem. This is likely to result in very different levels of awareness of specific judgements, and different capacities for contagious infection from one area of judgement to another.

Problem-Development Formulations and Conceptualisations

CBT ‘problem development’ formulations describe the way in which traits (tendencies towards particular clusters of attitudinal, affective and behavioural response) are learnt. They propose, in general, that early experiences give rise to understandings about self, others, the wider world and the future, which, over time become crystalized as core schema (e.g. Beck, 1967; Kennerley, Kirk and Westbrook, 2017). Beck termed these core beliefs ‘dysfunctional assumptions’. Fennell (1999) has referred to them, when concerned with self, as the ‘bottom line’. She suggested that, where the bottom-line beliefs or judgements are unpleasant or aversive, the person develops conditional assumptions about ‘how to live’ in order to moderate or elsewise reduce the experience of these judgements. These include, both, standards of achievement and rules of engagement. In turn, these underlying assumptions organise the person to respond with specific thought processes leading into the individual maintenance cycles described. An understanding of developmental experiences and processes is often regarded as essential to a comprehensive assessment, as well as being central to some more specialised ‘schema-based’ interventions (e.g. Linehan, 1993a, 1993b).

It is proposed, following both Fennell (1997, 1999) with regard to self-esteem and Snyder (1994) and Pearson (2006, 2010) in relation to hope, that evaluative attitudes to self and the future are learnt, developing in response to significant experiences. As with all attitudes, evaluative or otherwise, early experiences are considered to be more influential than later ones in shaping personal traits towards self and future perspectives. It is postulated that there is a tendency for, both, global and targeted judgements to progress towards greater consistency over time. In this process immediate context has a decreasing influence and the person’s states of hope and self-esteem become increasingly reflective of their underlying traits. It is, however, also acknowledged that these perspectives might shift dramatically later on in life in response to a strong precipitant. Hope and self-esteem traits, whether developing progressively from early age or arising suddenly in response to a later event, will reflect core schema or beliefs about self, conditional underlying assumptions about standards to achieve and strategies (rules for living) to follow to ameliorate more aversive elements. Where early experiences are particularly challenging, resulting in an ‘implicit’ negativity towards self or the future, the person’s degree of success in following their ‘rules for living’ and achieving their subjective standards will determine whether or not their explicit experiences of hope or self-esteem are able to rise above their innate tendencies towards negativity. When, therefore, in the face of a major crisis, such as the onset of a psychotic illness, a person presents with hopelessness and / or low self-esteem, one of three conceptual scenarios would be implicated - that the crisis had – (i) reinforced an existing and consistent pre-morbid negativity, (ii) shattered an existing and consistent pre-morbid positivity, or (iii) stripped away a pre-morbid surface positivity, to expose a previously hidden underlying negativity.

Problem-Maintenance Formulations and Conceptualisations

The first and main focus of intervention in CBT tends to be on what is happening in the present – the dynamics of problem-maintenance. Within CBT, individual problem-maintenance formulations propose that, in the experience of any event, emotional and behavioural responses are informed by cognitions. These might include 'assumptions, schemata, memories, beliefs, goals, attributions, expectations, wishes, plans, inferences and perceptual biases, thoughts and mental images' (Reinecke, Washburn and Becker-Weidman, 2010, p27). Different cognitions give rise to different emotions and actions. There is, in addition, a reciprocity of mutual influence (a transactionality of relationships) between these thoughts, feelings and actions, such that the person's emotional and behavioural responses feed back into their cognitions. This is generally referred to as the Cognitive-Behavioural triad (e.g. Beck, 1967, 1976; Freeman, Freeman and Garety; 2006; Kennedy, 2009). The relationship between thoughts, feelings and actions can be presented with causal directionality or in terms of multi-directional associations (e.g. the five-systems model of Padesky and Greenberger, 1995). In the context of mental health (or other) problems, this mutuality of relationship is considered to promote a self-maintaining circularity of influence, in which the person's thoughts, feelings and behavioural responses become stuck in a vicious cycle. The explication of this cycle has been termed the 'problem-maintenance' conceptualisation.

Consistent with that CBT maintenance conceptualisation, it is postulated that there is an iterative relationship between attitudes towards hope and self-esteem and the resulting feelings and actions. As noted in Chapter 4, unavoidable exposure to hopelessness and low self-esteem is associated predominantly with feelings of anxiety, sadness or, occasionally, anger. These are linked with a reduction in motivation, energy and investment. Reduced motivation, in turn, has been implicated in compromised goal-seeking activity, withdrawal, avoidance and discouragement of expended effort, resulting in further experiences of failure and diminished social standing. Cognitive biases towards perception, interpretation and memory mean that the person's negativity of mind-set in the moment is likely to shape their experiences in ways which promote a vicious cycle of negativity. Where a person experiences greater positivity towards themselves and the future, increased engagement, motivation and effort, with correspondingly higher rates of success and achievement, a more virtuous cycle of reciprocity is likely to eventuate. Although hope and self-esteem can both be experienced on a continuum from low to high, over time these tendencies towards self-maintaining cycles of thought, feeling and action are likely to result in a measure of perspectival-polarisation. In the context of recent-onset psychosis, conceptualisation of the traumatic challenges to a person’s hope and self-esteem should include, as a priority, their experience of the psychotic crisis, the process of revised meaning-making arising in response to it and the maintenance factors in which those perspectives might be becoming unhelpfully stuck. Beliefs about self and the future can be influenced by numerous factors, but in the context of a psychotic crisis, the person’s illness-narratives are likely to have especial significance. In those situations, in which the psychotic crisis is adjudged to have reinforced existing and known, pre-morbid negativities about self, or exposed previously ‘hidden’, self- and future-critical schemas, conceptual attention would, also, need to urgently consider those historical and developmental processes.

Relational Formulations and Conceptualisations

Although primarily ‘individual’ in delivery, and intrapsychic in focus, CBT also recognises that all human beings are social animals, and that no-one exists in a ‘social vacuum’ (Dattilio and Freeman, 2007, p8). Processes of learning are understood, therefore, to take place within the context of relationships, interpersonal dynamics and communication (e.g. Dattilio and Freeman; Epstein, Schlesinger and Dryden, 1988; Barrowclough and Tarrier, 1992). Developing beliefs and coping strategies are subject to operant influence through the reinforcement or challenge of the attitudes and behaviours of others. In the same way, therefore, that problems might be regarded as being maintained within a vicious intrapsychic cycle of stuck thoughts, feelings and actions, they might equally be viewed as maintained within a relational vicious cycle, wherein the responses of others serve to reinforce these patterns. Within the broad field of psychosis, there is extensive evidence to suggest that the emotional tenor of a person’s social living circumstances can have an immense influence on their wellbeing, including considerations with regard to, both, relapse and recovery (Hogarty, Anderson and Reiss, 1986; Leff and Vaughn, 1981; Oksuz, Karaca, Ozaltin and Ates, 2017; Vaughn and Leff, 1976; Vaughn, Snyder and Jones, 1984; Wang, Yang and Chen, 2017).

A number of the conceptual models of both hope and self-esteem discussed in Chapter 4 considered a relational or affiliative dimension to be of significance. Human beings exist in social contexts. Their experiences of themselves and their hopes for the future are shaped through dialogue with others. The actions that result from hopelessness or low self-esteem will be noticed, judged and responded to by those who are around. Some of those other individuals will be regarded as being more important and having a correspondingly greater capacity to influence the person’s self and future orientated evaluations. In addition, there is a recognised tendency amongst those diagnosed with a psychotic illness towards increasing social withdrawal. Compromised hope and self-esteem have been clearly identified as proximal mediators in this process. Furthermore, the unpredictable, bizarre and sometimes dangerous nature of the psychotic presentation has been associated with strained familial and friendship relationships (Barrowclough et al, 2003), a situation not helped by the appearance of selfishness and egocentricity arising in response to the person’s sense of psychological trauma. Esteem and support received from others can be powerfully interventive in the person’s recovery. Unfortunately, in the face of hopelessness and low self-esteem, received negativity and the withdrawal of support can be more common. In situations where the love and care of others are sustained, family burden and distress are common, and hopelessness and low self-esteem can be further compromised by feelings of guilt and / or powerlessness. In these contexts, ‘interactional vicious cycles’ are also not uncommon.

Formulation of the Therapy Relationship and Process

Kennerley, Kirk and Westbrook (2017) have argued that the position that ‘everything takes place in the context of dynamic relationships’ might be equally applied to the therapy itself (see also Kennedy, 2009). The therapy process is organised around and through a ‘working alliance’, in which the client and therapist engage meaningfully and collaboratively in the pursuit of negotiated outcomes. The effective construction of targeted interventions, therefore, requires some level of consideration of the ways in which the interpersonal dynamics of therapy might shape what is and is not explored, said or done.

Developing this idea, Snyder and Taylor (2000) have suggested that engaging in therapy is an act of hope, in that it represents an investment in a new pathway towards change. Greater proactive engagement, they have pointed out, reflects more committed ‘pathway thinking’. In addition, the ‘goal-directed’ nature of CBT defines it as ‘hope-inspiring’ in its fundamental structure. Finally, for those struggling with issues of self-confidence, psychological therapy involves exposure to the judgement of another person and, as such, requires considerable courage. These observations suggest that for those struggling with hopelessness and / or low self-esteem the therapy is both a place in which these issues can be explored and addressed, and a context in which they are likely to be enacted. These factors are likely to be a particular challenge in the context of psychosis where disorders of perception and thought are inclined to leave the diagnosed-individual insecure in their confidence in their own judgements and in their trust of others. Illness-related tendencies to suspiciousness, misinterpretation, scanning for hidden meanings and jumping to conclusions (Freeman, 2007) might all impede the development of a trusting and collaborative therapeutic relationship, defined as central to both CBT (Blackburn et al, 2000, 2001) and CBTp (Morrison and Barratt, 2010).

5.3.4 The Structure and Process of delivery of the Therapy Programme

A detailed description of the Therapy Programme is available in the Participant Handbook which has been provided as an attachment to this thesis, and which is discussed in Section 5.3.6 below. Figure 5.1 provides a brief overview. In the analysis of targeted interventions reported in Chapter 4, the majority of programmes used Group Therapy as the treatment modality. A small sample of approaches delivered therapy in a 1:1 format (e.g. Hall and Tarrier, 2003, 2005; Hodgekins and Fowler, 2010; Gumley et al, 2006; Jackson et al, 2009; Morrison et al, 2016; Moritz et al, 2018, Sonmez et al, 2014) and two (Fung et al, 2011; Lysaker et al, 2005) as a combination of both individual and group formats. The outcome evidence does not support an argument of greater efficacy for either form of facilitation, although there has been some suggestion that group therapy, by reason of the sharing of resources, might have been more efficient. For this new intervention the decision was made to construct a therapy programme that might lend itself to adaptation into multiple different formats, including individual, group and classroom processes. It was, however, to be delivered and evaluated in the first instance as an individual therapy.

The hope- and self-esteem-targeting interventions examined in Chapter 4 involved an extremely wide and varied range of resource investment, from a single 90-minute session with 1 therapist to a 30-hour group programme led by two co-therapists. There was no obvious pattern or suggestion of an optimal level. Apart from the 1-day self-confidence workshops (Brown et al, 2004, 2008; Horrell et al, 2014) none of the papers reviewed explained the decision made regarding the level of investment of a course of therapy or even the length of time of each meeting. NICE Guidance for the provision of CBT for Psychosis (2002, 2009, 2014) recommends a minimum of 16 sessions or 6 months intervention. In the absence of any other more concrete guidance this framework of 16 sessions was adopted, although with the clear understanding that the length of therapy would be reviewed as part of the research agenda. Each meeting was scheduled for 60 minutes, but 90 minutes were allocated in the therapist’s diary. This arrangement was intended primarily to accommodate any delays with regard to travel or the accessing of a meeting room, but with an additional understanding that an extension to the appointment duration might be negotiated on occasion. The first four appointments were planned to be scheduled on a weekly-basis, with the frequency of subsequent meetings to be negotiated with each client, taking into account their personal needs and circumstances. There was an expectation that no course of therapy would last longer than 8 months.

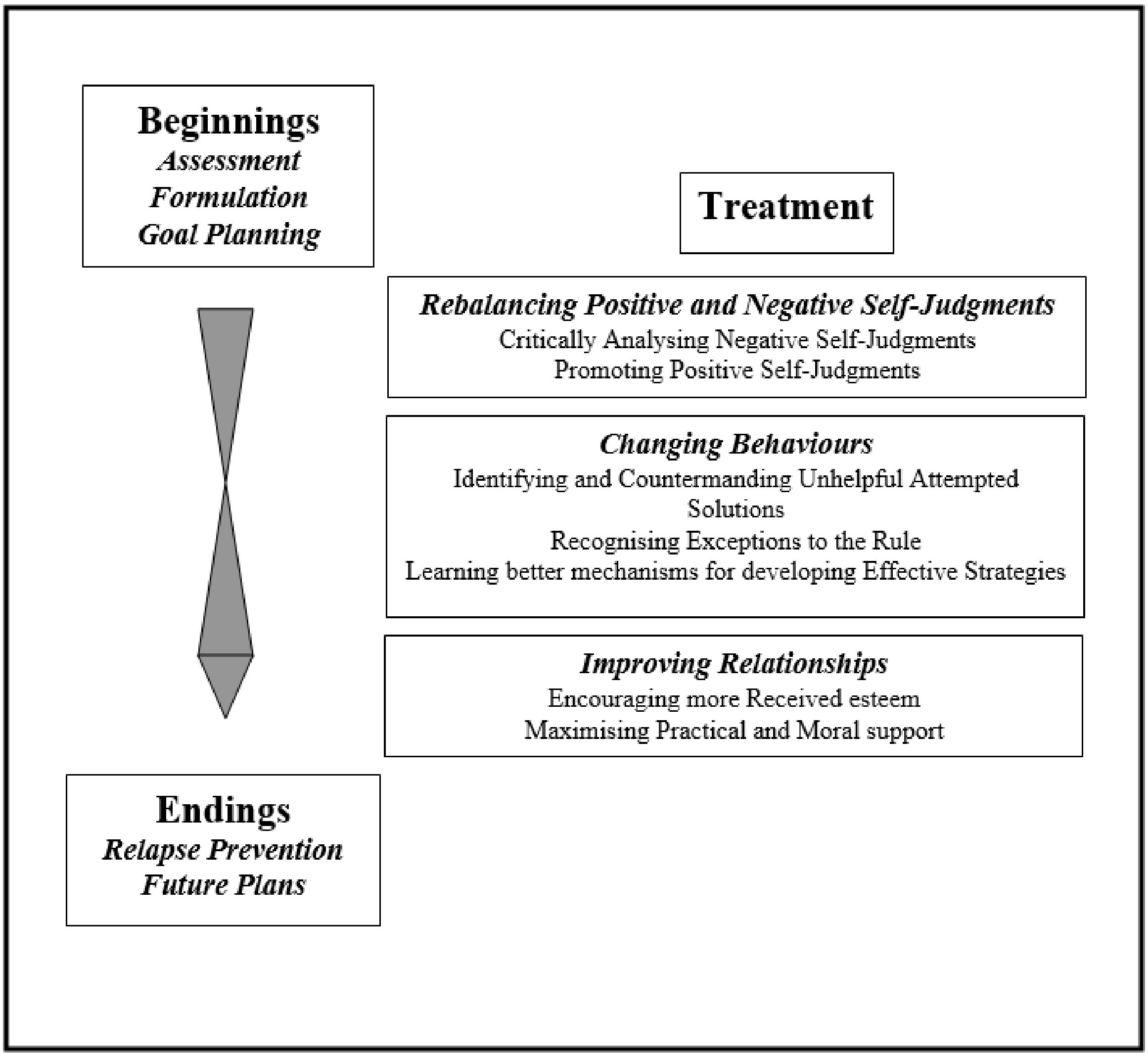


Figure 5.1 Schematic Overview of the Hope-Self-Esteem Therapy Programme

Following the example of several of the interventions examined in the systematic review of literature (Section 4.5 above), e.g. Social Recovery Therapy (Fowler et al, 2009, 2019), Early Intervention for Relapse (Gumley et al, 2006), Cognitive Recovery Intervention (Jackson et al, 2009), Cognitive Therapy for Internalised Stigma (Morrison et al, 2013, 2016), COMET (Korrelboom, 2007; Korrelboom, Marissen et al, 2011; van der Gaag et al, 2012), and NECT (Yanos et al, 2011), the novel Therapy Programme was constructed to be delivered in three stages (or phases) - 'Beginnings', 'Treatment' and 'Endings' (see diagram 5.5 above). 'Beginnings' included the processes of engagement, assessment of problems and goals, and formulation. 'Endings' included the 'handing over of responsibility for ongoing therapy to the client', development of a plan for 'staying well' and the 'bringing to an end' of the therapy relationship.

5.3.5 Content of the Therapy Programme – the menu of available / recommended composite strategies and techniques

The Therapy Programme was designed to be delivered flexibly, responding to the unique formulation of need of the client. It is, however, important to note that, in all cases, particular attention was given to –

1. Engaging the person with comprehensive, personally-meaningful goals, including - (i) the resolution of specific cognitive, affective and behavioural problems, (ii) improving wider occupational and social functioning, and (iii) aspirations for the future with regard to life-choices.
2. Working proactively towards the attainment of life goals (an 'applied' element of therapy) alongside attention to issues specifically pertaining to the experience of hope and self-esteem (a 'pure' element of therapy).
3. The rebalancing of attention to self – including the amelioration of specific aspects of negativity and the inspiration or nurturing of more positive self-evaluations with

reference to, both, the particular and global. This included, where relevant, acknowledgement of justified negativities and approaches to restitution.

4. The sustaining of achieved gains through the encouragement of greater confidence with regard to self-determination, the development of planned strategies for pre-empting future hope- and self-esteem-compromising setbacks, and the provision of a resource (the Participant Handbook) to help guide the service user-participant to become their own therapist.

Beginnings

As noted, the 'Beginnings' stage included attention to processes of engagement, assessment of problems and goals and formulations. In large part these followed the standard practices of CBT or CBTp, but with the following specific considerations.

Regarding engagement - Given the heightened levels of self-stigma associated with the diagnosis of psychosis and the frequency of insecurity and suspiciousness implicated in the primary symptomology of the condition, the process of engagement was designed to include extensive and transparent reflections on the client's expectations and anticipations of therapy. This included particular attention to fears or anxieties relating to the process of the therapy, the person of the therapist, and the inter-personal dynamic being enacted in the room.

Regarding problems and goals - Almost invariable a course of CBT either starts with, or is preceded by, a detailed exploration of the client's principal problems and goals (e.g. Jackson et al, 2009; Morrison and Barratt, 2010; Sonmez et al, 2014; Wragg and Whitehead, 2004). Problems and goals are formulated with regard to the service user's history and current circumstances and are negotiated collaboratively, primarily with regard to the person's purposes for entering therapy. The new intervention has been developed to target hopelessness (amongst other factors) and, as noted in Chapter 4, a common element of hopelessness-cognitions is an inability or difficulty in goal-directed thinking (Snyder et al, 1999). That part of the ‘beginnings’ stage of the therapy that concerned the identification of goals needed, therefore, to include identification of any cognitions that might impede goal-directed thought or behaviour. Furthermore, in CBT and CBTp it is strongly suggested that goals should be SMART (Doran, 1981; Wade, 2009) - Specific (simple, sensible and significant), Measurable (meaningful and motivating), Achievable (agreed and attainable), Relevant (reasonable, realistic, resourced and results-based) and Time-bound (timely and time-sensitive). This tends to focus goal-setting onto what might be achievable during the course of therapy. A number of specific CBT interventions (e.g. Social Recovery Therapy - Fowler, Hodgekins and French, 2019; Lysaker et al, 2009) consider both short term and aspirational goals. The focus of this programme on evaluations of self, now and extrapolated into the future, was deemed to require more extensive consideration of participants’ wider life-goals.

Given the requirements for more in-depth attention to the implications of hopelessness and low-self-esteem with regard to engagement and goal-setting, the ‘Beginnings’ stage of the Therapy Programme was specifically extended to a minimum of 3 sessions.

Treatment

The core structure of the Therapy Programme to be delivered to each service user-participant is presented in Figure 5.1 (above). It was anticipated that the specificity of strategies utilised in each participant’s treatment would vary from person to person. The menu of recommended strategies and techniques is detailed in the Participant Handbook (see attached) and listed in the audit tool developed bespoke for the purpose of evaluating fidelity in the delivery of the Therapy Programme (see Appendix 4D). Alongside the therapeutic processes already described regarding goal-directed thoughts and actions, and plans for staying well in the future, content strategies were concerned with three areas of intervention –

1. Rebalancing positive and negative judgements.
2. Changing behaviours.
3. Improving relationships.

Table 5.4 (below) presents examples from the menu of strategies offered to address each of these three considerations. Once again, it is important to stress that none of the identified strategies or techniques was, in itself, completely unique to this programme. They can all be found elsewhere as component parts of other programmes. Many are present in the various interventions considered in Section 4.5. Their 'novelty' in this context arises from the unique combination or menu of what is offered – targeted as they are to the collective focus of hopelessness *and* low self-esteem *and* Early Psychosis.

Table 5.4 –Targeting the 3 Key Areas of Intervention - Example Strategies from the Recommended Menu of Options

Treatment Targets	**Example Strategies**
Rebalancing Positive and Negative Self-Judgements	• Examining Standards. • Examining Evidence – current events and the past. • Positive Data Logging. • Promoting positive self-statements.
Changing Behaviours	• Identifying and countermanding unhelpful coping strategies. • Recognising and promoting exceptions. • Problem-solving training.
Improving Relationships	• Encouraging more positive 'reflected appraisals'. • Encouraging more effective support.

Endings

Attention to the ending of the therapy process and relationship is an established aspect of good CBT and CBTp (Blackburn et al, 2001, 2002; Morrison and Barratt, 2010). In the context of a therapy to address compromised confidence in self and negativity about the future, a focus, at the end of the treatment, on the person's future extrapolations with regard to self has particular significance. In addition, attention to future wellbeing, with reference to 'Staying Well' or 'Preventing Relapse', is an established component of many psycho-social interventions for psychosis (e.g. Barbic et al, 2009; Fukui et al, 2011; Jackson et al, 2009). In addition to sessions on 'staying well' with regards to psychosis, as a key component of the 'Endings' stage of the therapy, this novel Therapy Programme, also, addressed the 'prevention of relapse' with regard to hopelessness and low self-esteem. Given the additional challenges regarding the ending of therapy associated with, each of, Early Psychosis, hopelessness and low self-esteem, the 'Endings' stage was, also, extended to a minimum of 3 sessions.

5.3.6 Adjunctive Resources – the Participant Handbook

As noted in Chapter 1, a preliminary articulation of the new intervention was written in the form of a Participant Handbook. A number of the hope and self-esteem-targeted intervention strategies reviewed in the previous chapter included the provision of a detailed protocol. In some instances, this was developed and provided as a resource for service-user-participants (Fennell, 1999; McDermot and Snyder, 1999). In others it was produced as a guide for professionals, to allow training, replication and evaluation of fidelity (Lecomte, Leclerc and Wykes, 2016; Korrelboom, 2007). An analysis was undertaken of a selection of available self-help guides and clinical manuals, not merely those concerned with hope or self-esteem, with particular attention to questions of structure, style and language (Pearson, 2013). Aspects of consistency across those texts examined included – (i) a clear rationale as to the value of the approach, (ii) an explanation of the overarching therapeutic model, (iii) a description (with rationales) of the specific elements of intervention involved, and (iv) the use of diagrams, questionnaires, worksheets and illustrative examples. The most striking differences between the various manuals examined were linked to the question of 'target audience'. Those written for the service user showed less jargonistic, more idiomatic language, a lower reading age, and a more chatty and personal style. They were mostly written in the 2nd person and included more images, metaphors, examples of service user stories, exercises and worksheets.

The decision was made to produce a handbook principally as a resource for participants and as an 'aide to structured therapy' rather than as a 'self-help guide'. The primary significance of this distinction was in relation to the intended 'reading age' of the language employed. Self-help guides, developed as a primary intervention in their own right and to be utilised without ready access to a therapist, tend to be written for the average reading age of the country. According to Martinez, Whitfield, Dafters and Williams (2008) that is 11-13 years. Given that this resource was written to be used within a collaborative process, and to avoid the need for it to be supplemented with additional notes, articles or other materials, the language of the handbook was targeted at a higher reading-age - of 17-19 years. This was calculated using the Flesch-Kincaid Grade Level formula (see Table 5.5).

Table 5.5 Calculations of Reading Age (Cited in Martinez et al, 2008)

Key:- ASL – Average Sentence Length; ASW – Average Number of Syllables per Word

	Calculations of reading age
Flesch-Kincaid Grade Level	(0.39 X ASL) + (11.8 X ASW) – 15.59 + 5 Ideal is 12 to 13 years of age; higher scores reflect more complex language.
Flesch Reading Ease Scale	206.835 – (1.015 X ASL) – (84.6 X ASW) Ideal is 60–70; higher scores reflect simpler language.

The choice of format was not intended to be conducive for use as a manualised-intervention. In order to enhance participant engagement with the handbook and with the material there-in contained, a commercial design company (CreateActivate Ltd. www.createactivate.co.uk) was employed to address issues of design and production.

As a secondary consideration, certain aspects of the format and style of the handbook were selected to allow the handbook to be used as a template against which the research-delivered Therapy Programme might be audited for fidelity. As such, the Participant Handbook was produced, both, to represent a central part of the Therapy Programme and to be a description of it. It was hoped that the research feedback would provide guidance for the fine-tuning of the handbook alongside the betterment of the Therapy Programme itself. The Participant Handbook included a number of bespoke work-sheets; designed to be completed with the therapist, or by the service-user-participant as homework. Images of some of those worksheets are included in Appendix 3.

5.4 Summary

A novel Therapy Programme lies at the heart of the research. The content and structure of the programme have been developed through a combination of the logical extrapolations of a conceptualisation of the hope-self-esteem complex and learning from what therapists, service users and researchers consider to be ‘what works’?’ Two core criteria in the development of the Therapy Programme have been that it should be organised within the researcher-therapist’s therapeutic paradigm of choice (Cognitive Behavioural Therapy) and that it should be coherent, consistent and formulation-driven. There is a detailed description available in the form of the handbook developed as a resource for participants in the study. Although the Participant Handbook has been provided as an attachment to the thesis, this chapter has sought to provide the reader with an accessible introduction to the approach.

The novelty, or uniqueness of this programme lies in –

1. The new, never previously presented, conceptualisation of the conjoined complex of hope and self-esteem.
2. The overarching structure of the intervention, which, although delivered with considerable flexibility and responsiveness to individual need, nevertheless, also, includes a clear commonality of balanced attention to 'self-' and 'future-related' interventions. This structure begins with an enhanced consideration of the client's capacity for goal-identification and planning, and ends with attention to personal responsibility for staying well, preventing relapse, and continuing to work on the pursuit of negotiated life goals.
3. The unique content of the menu of strategies recommended and the specific nodal points of the conceptualisation identified as their target / trigger.
4. The Participant Handbook – written bespoke as a reference and resource for the client.

Finally, it is worth emphasising that, in the context of early psychosis, there are likely to be multiple intersecting needs or challenges. In those circumstances hopelessness or low self-esteem might be formulated as a secondary consequence of other significant difficulties or as a factor peripheral to the person's primary concerns. The two aspects of experience might benefit from direct attention, but might not. There is no expectation that this novel Therapy Programme should be capable of addressing the needs of every service user. Neither is it the position of this research or thesis that hope and self-esteem should always be addressed as a priority. It might be that, even when hope or self-esteem is compromised, the spotlight is better directed to other issues. Attention elsewhere might secondarily impact on negativities with regard to self and the future. It is, however, the contention of this research that, for some FEP service users, direct and primary attention to hope and self-esteem will have significance both, directly, to those specific aspects of experience and, indirectly, through them, to other elements of resilience and recovery. It is, also, not suggested that this novel programme be capable of meeting every need of those service users to whom it is offered. It is important to remember that the intervention has been developed to be delivered in addition to TAU. Where, therefore, there are other difficulties in a client’s primary or secondary psychotic experiences that are not addressed by this programme, it is not unreasonable to suggest that their amelioration might be negotiated previously, concurrently or subsequently within the context of that wider package of support.

Chapter 6 – The Design and Undertaking of the Research

6.1 Introduction

The research that is reported and examined in this thesis has been concerned with the development of a novel psychological intervention, organised within the framework of CBT, and designed explicitly to target experiences of negativity with regard to self and the future, in the context of the recent diagnosis of a psychotic illness. It was noted in Chapter 2 that the Medical Research Council (Craig et al, 2008) has recommended a series of steps or stages through which such a constructive process might proceed. The previous chapter presented the form and content of the Therapy Programme that emerged following the first two of those stages – the preliminary identification of the parameters of the intervention, and its early amendment in response to feedback from professionals and service users. This chapter describes the research process that was followed with regard to Step 3 of the MRC guidance – the first piloting of the programme and its finetuning in response to participant feedback.

A central tenet in the design of the research was that it should evidence conceptual and pragmatic consistency – across the research questions, underpinning philosophical paradigm, chosen methodology, the selection of data form, and the undertaking of the research process itself. Cresswell (2003) and Mcleod (2001), amongst others, have argued that such an explicit positioning is essential, a 'vital' requisite, and that 'failing to [*address this clearly*]….can result in work that lacks wider credibility, is inadequately justified, or even lacks internal coherence' (Clark, Lissel, and Davis, 2008, pE67).

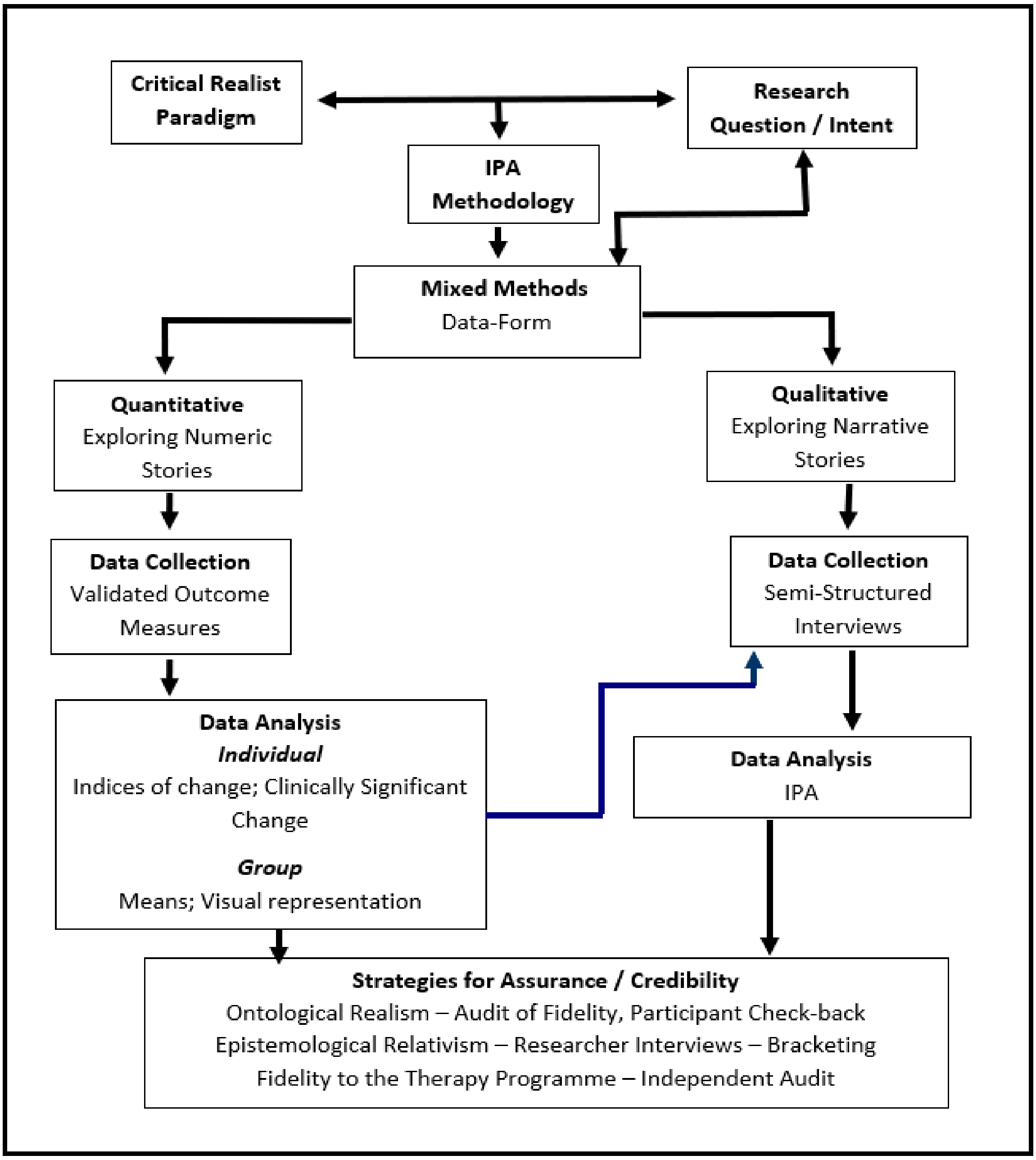


Figure 6.1 – Research Design – Central Architecture

The chapter is presented in two parts. The first part is concerned with establishing a considered and coherent framework for the research, an articulation of the relationship between the first four of these elements - research questions, paradigm (critical realism – Bhaskar, 1975, 1998), methodology (Interpretative Phenomenological Analysis – Smith, Flowers and Larkin, 2009) and data form (mixed methods – Cresswell and Plano Clark, 2007; Tashakkori and Teddlie, 1998, 2003). The second part of the chapter reports on what was actually done. It is important to stress that this chapter is only concerned with explaining and describing the process that was followed. The critical evaluation of the decisions made and actions taken are addressed in the discussion (Chapter 8) and considerations as to how that learning might be imported into the progression of the Therapy Programme are picked up in the conclusions (Chapter 9). The overarching plan for the research is presented in Figure 6.1 (above).

6.2 Central Architecture – Research Questions, Philosophy, Methodology and Data

6.2.1 Research Questions

The fundamental purpose of the research has been to progress the development of the Therapy Programme. Following the MRC guidelines (Craig et al, 2008) the principal intent has been to achieve that goal by piloting the programme and seeking feedback from participating service-users. That agenda has been articulated in the form of two primary research questions (see Chapter 2).

1. ***How is the Therapy Programme experienced by participant-clients as it is currently constructed and delivered?***
2. ***What thoughts or recommendations might be offered by participant-clients for the improvement of the Therapy Programme?***

The priority of the research was the exploration of participant-service-users' experiences of the process of therapy. It was, however, predicted that (i) the specific nature of those experiences would be likely to have had an influence on participants' attitudes to engagement in therapy and perceptions of the benefits accruing from that engagement, and (ii) in any retrospective discussion of experiences, the narratives presented by participant-service-users would be influenced by their judgements with regard to personal efficacy. In exploring participants' experiences of the therapy, therefore, in addition to questions regarding the content of the programme and the associated style of delivery, the research has, also, been interested in considerations of accessibility, engagement and efficacy. These concerns have been expressed in relation to five secondary questions.

1. ***With regard to accessibility, what patterns might emerge from an analysis of the demographic characteristics of those individuals who participated in the research in comparison with those who were invited to take part, but declined?***
2. ***With regard to engagement, what patterns might emerge from an analysis of participant demographics, the trajectory of outcome measures and other available information in a comparison of those participants who completed the therapy and those who did not?***
3. ***With regard to the goals of therapy, what individual and collective changes in reported hopefulness, self-esteem and wellbeing might be identified over the period during which participants received the Therapy Programme?***
4. ***To what extent might any changes in hopefulness, self-esteem or wellbeing be sustained over time following the completion of the Therapy Programme?***
5. ***To what extent, and in what ways, might any recorded changes be said to be clinically significant?***

It should be noted that these secondary questions address issues pertaining to, both, individual and collective data. In this study the questions of 'collective' engagement and efficacy have been deemed to be relevant exclusively with regard to a consideration of 'proof of concept'.

6.2.2 Research Paradigm

The research was organised with reference to the philosophical paradigm of critical realism (Bhaskar, 1975, 1998), which has been defined as a position of 'weak constructivism' (Bhaskar and Danermark, 2006; Schwandt, 2000) and which presents a paradigmatic complex of 'ontological realism and epistemological relativism' (Denzin and Lincoln, 2000c; Korzybski, 1948, cited in Strate, 2010; Schwandt, 2000). These terms are explained below with reference to the reasoning for their utilisation.

Ontology and epistemology

In the context of research-design the term 'paradigm' refers to the philosophical perspective of the researcher with regard to the fundamental natures of reality and knowledge. It encompasses two primary dimensions, relating to (i) ontology, which concerns the nature of 'what is', and (ii) epistemology, which concerns the nature of knowledge, truth and knowing. Both ontology and epistemology might be considered in terms of realism or relativism. Realism refers to the position that 'things are' or that they exist in an absolute sense. Relativism posits the idea that something is only 'real' in the way that it has been 'constructed' - given shape through processes of witnessing and storying. This research has been organised by the philosophical complex of ontological realism and epistemological relativism. This combination proposes that - 'the world and the universe exist without any human awareness of this existence as being necessary' (Connelly, 2000, p263), but that awareness, understanding or knowledge of something is only 'real' in the way that it has been 'constructed' - given shape through processes of witnessing and storying (Denzin and Lincoln, 2000c; Wittgenstein, 1953). It is 'not disinterested, apolitical and exclusive of affective and embodied aspects of human experience', but rather is 'ideological, political and permeated with values' (Schwandt, 2000, p198). This paradigmatic complex has been exemplified by Korzybski (1948) in his metaphor of a territory (ontological realism) and the various maps (epistemological relativism) constructed in order to define, navigate or constrain it. The map, he has argued, is not the same as the territory.

Strong verses Weak Constructivism

The complex of territory and map includes two interconnected, similar, but nevertheless discreet positions – strong and weak constructivism. Both accept that there is a reality 'out there'. Both, also, accept that that reality is experienced subjectively as a map or series of maps - situated, context-bound, shaped by the culture and history both of the experiencing context and of the observer. The difference between the two positions concerns the degree to which it is believed that the maps can ever truly describe the underlying territory. Strong constructivism considers the real to be unknowable and regards fit and creditability to be consensual or storied. This perspective has been described by Schwandt (2000) as a 'radically sceptical and … nihilistic stance' (p198). Bhaskar and Danermark point out, however, that 'most constructionists are willing to agree that there are understandings …. which are more reliable than others' (2006, p285). This perspective, termed weak constructivism, accepts the ultimate unknowability of the territory, but takes the view that it is possible to aspire towards ideas or understandings that might have a better fit, greater likelihood or wider credibility. Coherence within research requires a close, iterative relationship between the research question and the organising paradigm. The study described in this thesis was concerned with participants' stories in terms of their usefulness in shaping a therapy programme to positive effect. To achieve that, those stories needed to be imbued with qualities of fit and likelihood with regard to truths about accessibility, utility and efficacy. That focus indicated that a weak constructivist paradigm might be of greater value.

Weak Constructivist Perspectives – Choosing between Post-positivism, Weak Social Constructionism and Critical Realism

Weak constructivism has been articulated in relation to three different paradigmatic research positions – post-positivism, weak social constructionism and critical realism. These paradigms differ, both, in the relative importance that is accorded the two parts of the complex, and in their pragmatic consequences with regard to the doing of research.

In terms of philosophical perspective, post-positivism gives primacy to the question of ontology, but offers a tentative acceptance of an epistemological relativism. It reflects an evolution from a positivist interest in 'verified hypotheses established as facts or laws' towards a more accommodating focus on 'non-falsified hypotheses that are probable facts or laws' (Denzin and Lincoln, 2000c, p170). In contrast, weak social constructionism is primarily concerned with questions of how realities are mapped - experienced through biological, cognitive and other individual human biases or storied through language and in interaction with others. Critical realism developed in reaction, both, to a concern with what was perceived to be excessive reductionism within positivism, over-valuing ontological considerations, and at the same time a rejection of what were regarded as the logical errors of post-modernism, reifying the constructed processes above the 'thing itself' (Archer, Bhaskar, Collier, Lawson and Norrie, 1998; Bhaskar, 1975, 1998; Clark, Lissel and Davis, 2008). As a consequence, it seeks to show equal interest towards the complexities of reality and the processes of construction.

In relation to the pragmatics of research, the three paradigms offer particular differences in their stance with regard to the principle data form, attitudes and approaches to the concept of researcher bias and preferred research setting. Post-positivism has tended to be associated with quantitative data more than qualitative. Weak social-constructionism and critical realism, in contrast, have been more commonly associated with the collection and examination of qualitative data, although, critical realism, in particular, takes the view that any study which seeks to move from analysis at the level of ‘case’ to the level of ‘group’ is likely to, also, employ limited quantitative strategies for clustering and comparison. When mixed methods are pursued in post-positivist studies, they tend to be framed in terms of triangulation – an attempt to ‘catch as much reality as possible’ (Denzin and Lincoln, 2000a, p9). Where mixed data is considered in research organised within a weak social-constructionist or critical realist perspective, on the other hand, the two forms tend to be seen as providing depth and texture to an emerging narrative, more than intersecting levels of proof (Sayer, 1992, 2000; Bergin, Wells and Owen, 2008). With regard to the question of researcher bias, post-positivist research has tended to approach the issue through rigorous attention to objectivity and / or ‘bracketing off’. In weak social constructionism, on the other-hand, researcher biases, rather than being regarded as a hindrance to understanding, are embraced as key elements in the construction process. Sitting, philosophically, somewhat between the two, as it does, critical realism respects both possible approaches, as alternatives, or in concert. Finally, post-positivist methodologies have an established good fit with research in experimental settings, whereas weak social constructionist and critical realist paradigms are deemed to have greater value in naturalistic contexts of study (Clark et al, 2008). Given the central concerns of the study, as described, the paradigm that was adjudged to have most ‘fit’, and which was, therefore, adopted, was critical realism.

Critical Realism as the Paradigm of Choice

The description above implies a clarity and homogeneity of ideas with regard to critical realism. As noted in Chapter 1, however, the construct might better be regarded as an umbrella term (McEvoy and Richards, 2003), including a broad church of understandings and approaches (Lopez and Potter, 2001). There are, never-the-less, certain commonalities which link these disparate perspectives.

1. Although critical realism developed, in the first instance, out of a criticism of ‘positivist accounts’ of phenomena and of human experience (Clark, Lissel and Davis

2008), the central paradigmatic claims remain ontologically realist (Walters and Young, 2010) - 'things exist and act independently of our descriptions' (Outhwaite, 1998, p283).

2. Critical realism, both, actively embraces a critical stance towards the concept of factual or objective truth - 'Human social processes and perceptions … , as with physical phenomena, are fallible and perspectival' - Clark et al, 2008, pE69) and is 'critical of radical forms of relativism that accentuate the socially constructed nature of scientific practice and detach scientific discourse from what is real' (McEvoy and Richards, 2003, p412).

Bhaskar (1975, 1993, 1998) and colleagues (Archer et al, 1998), have suggested three key features of critical realism – intransitivity, stratification and transfactuality. 'Intransitivity' suggests that things exist independently of their witnessing or naming. 'Stratification' presents the perspective that reality has depth. It is not limited by or to what is observed on the surface, but extends below, encompassing a complex of influencing or causal factors (Walters and Young, 2010). Bhaskar and Danermark (2006) have described this as a 'necessarily laminated system' reflecting a 'conjunctive multiplicity of causes' (p289). Some aspects of influence, 'generative mechanisms', Bhaskar suggests (1998), can only be identified through their effects. Within the complex stratification of experience three particular domains have been identified (Clark et al 2008) – (i) the empirical (a surface world of experience, reflecting fallible human perceptions and interpretations), (ii) the actual (a world of observable events and actions) and (iii) the real (a non-actual world of underlying powers, mechanisms and generative structures, which cause the events in the actual domain, and might remain latent until triggered). Finally, 'transfactuality' posits that there is a capacity for positions to shift as understandings about the world change and there is a frequent, if not routine, misalignment of the three dimensions described, such that the actual and real can often not be deduced from experiences at the level of the empirical.

These elements might be reframed as offering two distinct dimensional challenges in the exercise of understanding social phenomena, relating to, respectively, the *complexity of* *human experience and interaction*, and the *subjective construction of understanding*. The first dimension (the complexity of human experience) proposes a continuum from the actual to the real. It stresses that the world is informed by the dynamic fluxes of innumerable factors. Some of these influences, it is suggested, might be more obvious or visible to immediate identification at a surface level (the actual), whereas others might only be construed from their perceived or extrapolated effects, and yet more might be completely invisible and unpredictable (the real). The second dimension, the subjective construction of human understanding, proposes an axis from the actual to the empirical. It takes the position that, even if it were possible to uncover all factors of influence to the smallest element, the experience of those 'realities' would still only be possible through subjective, contextualised processes of construction. In the context of an investigation into the human experience of engaging with a therapy programme, these two perspectives would posit, respectively, that it would not be possible, either, to identify or control for all influencing factors or to avoid the interaction of protagonists' intersecting cognitive biases, irrespective of any strategies employed in the pursuit of objectivity. These understandings have profound implications for research design, both, in relation to the 'doing' of data capture and analysis, and the 'thinking' in terms of the outcomes of the research process.

6.2.3 Methodology

The Relationship between Paradigm and Methodology

In the introduction to this chapter it was argued that there needs to be a philosophical and organisational consistency across the depth and breadth of research design and delivery. Within that perspective, the intimacy between paradigm and methodology, the operational implementation of that philosophy, is of particular importance. Bhaskar and Danermark (2006) have stated that critical realism can be both a 'metatheory' (paradigm) and a methodology. They have designed a bespoke strategy, 'retroduction' (or 'abduction'), to allow the direct exploration of 'generative mechanisms' and to mediate the translation of their philosophical first principles into action. However, although the critical realism paradigm has been applied to research across a breadth of human sciences, including health (Bergin, Wells and Owen, 2008; Clark, Lissel and Davis, 2008), education (Nash, 2005), economics (Lawson, 1997), ethnography (Porter, 1993), and Sociology (Archer, 1995), articles have tended to prioritise theoretical considerations over pragmatic guidance. As a consequence, available explication of the 'retroduction' approach is very limited. Bhaskar and Danermark (2006) have, however, noted that coherence might, equally, be achieved through the importation of an appropriately established and validated methodological tradition - so long as there is sufficient fit across the complete skeleton of the research design. For the research under discussion, given the identified agenda and questions, the over-arching framework of critical realism and the pragmatics of access to both qualitative and quantitative data sets, an 'appropriate' methodology would need to exhibit seven qualities (see Table 6.1 below).

Table 6.1 – Qualities Necessary to the selected Research Methodology

	Qualities
1	Reflect a complex stance of ontological realism and epistemological relativism
2	Be concerned with the depth and complexity of the ontological world – Real, Actual and Empirical
3	Show interest in exploring, rather than 'bracketing off' to one side, the constructed nature of data, and the processes of that construction
4	Have the capacity to bring forth perspectives of 'possibility' and 'likelihood' with regard to the abstraction of recommendations for the betterment of the Therapy Programme
5	Allow the possibility of the 'outcomes' being able to speak tentatively to questions of efficacy or 'proof of concept'
6	Accommodate the use of both quantitative and qualitative data
7	Engage with both idiographic exploration and cautious nomothetic generalisation

The methodological approach deemed to be most appropriate was Interpretative Phenomenological Analysis (IPA - Smith, Flowers and Larkin, 2009).

Interpretative Phenomenological Analysis

Smith and colleagues (2009) have described IPA as a 'qualitative research approach committed to the examination of how people make sense of their major life experiences' (p1). At its heart, they report, IPA reflects a desire to get to an 'enduring and certain knowledge of an inner, conscious, and cognitive domain' (p109) - an enduring truth (rather than a transient story) about the perspectival experience of the person. This might be regarded as a position of ontological reality. On the other hand, they, also, state that it is only ever possible to understand the subject-in-context, and acknowledge that access to the experience of the person can only ever be partial and complex (Smith, 1996, 2004, 2007). With regard to methodology, Smith and his colleagues have suggested (2009) that IPA represents a unique marriage of the traditions of phenomenology, hermeneutics and idiography. These three dimensions are discussed below, separately and in combination, in relation to their relevance, or fit, with the guiding paradigm (critical realism) and research agenda.

The broad methodology of phenomenology has been described as being concerned with exploring 'the structures of consciousness in human experiences' (Polkinghorne, 1989) or the 'humanness of being in the world' (McLeod, 2001, p38). It tends to be associated with description more than interpretation (Bergum 1991). Its central concern has been 'to produce an exhaustive description of the phenomena of everyday experience, thus arriving at an understanding of the essential structures of the 'thing itself' (Bergum, p55) and 'to reduce the thing to its essence or 'essential qualities'' (McLeod, 2001, p39). Its unifying theme, consequently, is a privileging of ontological realism. Creswell (1998) notes that these goals are generally pursued through careful and exhaustive description at both the level of 'texture' (what is experienced) and 'structure' (how it is experienced). Phenomenology is, therefore, concerned with both the manifest outcomes that are visible on the surface (the *actual*) and the generative mechanisms that lie beneath (the *real*). Epistemologically, however, phenomenology has a much broader tradition, reflecting a multiplicity of distinct perspectives, which cross the real-relativist divide. All phenomenology recognises that experience is subjective and context-bound (the *empirical*), and advocates ‘bracketing-off’ strategies to create distance between the subject of consideration and the personhood of the researcher. However, whilst epistemologically-realist phenomenologists regard this ‘bracketing-off’ as a route to the direct accessing of the ‘experience’, relativist phenomenologists use the process to lay a discussion of the process of construction alongside the postulated description of the thing. An epistemologically-relativistic phenomenological methodology might, therefore, be regarded as fitting very closely with both the ‘construction’ dimension of the paradigmatic assumptions of critical realism and the research focus of exploring and improving the therapeutic approach.

In contrast to phenomenology, which is defined as the study of human experience, hermeneutics is concerned with studying ‘the objectifications of human cultural activity’ (Radnitzky, 1970, p22, cited in McLeod, 2001). Hermeneutic theory stresses that social phenomena are intrinsically meaningful. Hermeneutic inquiry is concerned with understanding those phenomena through the creative interpretation of that which is outside of the field of vision and a curiosity about the constructional forces involved. Whereas, therefore, phenomenology gives primacy to the critical realist dimension of the complexity of human experience, hermeneutics engages much more with the second dimension - the subjectivity of human perception and interpretation. Hermeneutics has been traditionally concerned with the study of language-based materials, though texts more than conversations (Gadamar 1975, cited in McLeod, 2001). It seeks to interpret those texts in relation to understandings about their authorship and the wider context of their production. Taylor has extended the idea of a data-focus to include ‘text-analogue (s)’ (1971, p3, cited in McLeod, 2001), which Smith et al (2009) have suggested might include transcribed conversations. It seems not unreasonable, therefore, to suggest that a transcript of a semi-structured research interview, with an individual reflecting upon their experiences of self-confidence, hopefulness and a treatment programme, might be a suitable focus for Hermeneutic inquiry.

The third question regarding the ‘fit’ of IPA to the research agenda concerns the relative value of data arising in relation to the individual case or collective group. McLeod has said of both phenomenology and hermeneutics that they are principally concerned with a detailed understanding of the ‘case’ and do not naturally embrace hypotheses regarding the potential generalisation of experience from the one to the many (2001). Smith, Flowers and Larkin (2009) have, in fact, stated that the third key pillar of IPA is a commitment to idiography, where that is defined as being ‘concerned with the particular’ (p29). They have noted, however, that an approach that begins with a deep immersion in the individual case might move, with caution, to questions of comparison within a small homogenous group, and possibly even to a tentative or hesitant generalisation to a wider caucus. Although they are robustly against the use of IPA to try to capture the experiences of a large group, they do not stipulate a single case study approach. IPA, consequently, offers an ideal approach for exploring the experiences of the individual, but with the capacity to elucidate collective experiences and outcomes within a small, homogenous group, for the purpose of considering ‘proof of concept’. It does not, however, present a strong approach for more extensive examination of collective efficacy or generalisability.

With regard to the question of ‘fit’, although IPA doesn’t acknowledge critical realism as an organising paradigm, there is a clear and extensive overlap in the explication of the two perspectives. Furthermore, Smith and colleagues’ (2009) description would suggest that IPA might be an ideal approach to exploring the central concern of the current study – ‘how service user-participants make sense of their experiences of involvement in a therapy programme?’ In relation to this agenda, it might be argued that IPA could offer a stratified, though fully integrated, view of the subject – a detailed description of what was visible, combined with a creative interpretation of those factors, including generative-mechanisms, which might exist or operate beneath that surface. In seeking to make sense of the person’s (or group’s) experiences, IPA would clearly connect with the idea of ‘demi-regularity’. This proposes that any pattern identified can merely be offered as an idea of regularity within a particular case or small group, and only tentatively extended in relevance towards a wider group. Such a position would allow a hesitant consideration of questions of ‘possibility’ and ‘likelihood’ with regard, both, to the utility of observations being capable of shaping improvements in the programme and of the programme being capable of offering therapeutic benefit.

6.2.4 Data Form – Mixed Methodology

The central purpose of this study, within the wider intention of developing a 'complex intervention' (Craig et al, 2008), has been to explore the Therapy Programme in a way that allows for its meaningful improvement. In this context, 'meaningful' improvement was considered to require direct observations and recommendations from service user-participants who had experienced the therapy within a 'naturalistic setting'. A key assumption from the beginning of the design process was that these experiences, observations and recommendations would be best gathered through an interview process. The principle data-form anticipated from such a process would be qualitative. The research was, however, concerned with the implementation and evaluation of a CBT-based Therapy Programme. It is routine within the practice of CBT to use validated and idiographic outcome measures, pre, mid and post-treatment, in order to track the direction and progress of the therapy. These outcome measures, which produce data primarily in numeric form, can be generic or specific to conditions, problems or attitudes. Selection tends to be determined by client need and the goals of therapy.

A key challenge at the design stage for the research was the question of whether both sets of available data might be usefully and effectively incorporated. The integration of narrative and numeric data within a single research design has been referred to as a 'mixed methods' approach. When first employed this integration of forms was considered to present something of a philosophic dilemma. Qualitative methodologies, concerned primarily with narrative or language data, have been increasingly associated with interpretative, post-modern or relativist perspectives. Numeric data has tended to be associated with quantitative research methodologies, and, in turn, with positivist, post-positivist, modernist and realist philosophies (Yardley and Bishop, 2015). Gelo, Braakmann and Benetka (2008) observed that some theoreticians had believed that the ‘meta-theoretical paradigms underlying the two approaches [were] so different that any reconciliation between them would destroy the philosophical foundations of each.’ (p268). This perspective has shifted in recent years, with, amongst some researchers at least, a move towards a position of reconciliation or integration of these data-forms (Creswell and Plano Clark, 2007; Tashakkori and Teddlie, 1998, 2003; Teddlie and Tashakkori, 2009).

The ‘mixing of methods’ began as a pragmatic approach to the enrichment of evidence, with the triangulation of different data being used to strengthen claims of legitimacy (Dunning, Williams, Abonyi and Crooks, 2008). ‘Pragmatic’, in this instance, referred to the prioritising of ‘making use of all available data’ above the need for philosophical or methodological consistency. More latterly a move towards greater paradigmatic consistency has been evoked through the perspective of seeing numbers and words as different forms of storying or ‘knowledge product’ (Yardley and Bishop, 2015, p2). The argument follows that, in any situation in which numbers are employed, they have no significant worth or meaning unless or until they are translated into a language of words. As such there is a natural flow between these different story forms within human experience and language. The completion of an outcome measure produces a numeric picture. It is essential, however, to remember that those numbers are a representation of an extended inner dialogue that might encompass a complex reflection on multiple influences. In this framework of thinking about numbers and words as different storying strategies, those alternative representations might be competing or collaborative. They might be used to triangulate for a likelihood of truth or merged to create depth and texture (Yardley and Bishop; Johnson, Crosby, Engel, Mitchell, Powers, Wittrock and Wonderlich, 2004). In this research their combination has been designed to do both. That part of the research concerned with the question of ‘proof of concept’ makes use of the different data to triangulate towards a position of truth. That part of the research outcome that is concerned with improving the quality of the approach makes use of the different data to add richness and depth to questions about what might be changed.

Whilst it has been argued that the methodological processes of IPA lend themselves more to qualitative than quantitative inquiry, there have been a number of recent studies in which IPA has been used to organise a mixed methods approach (Kapur, Hayes, Waddingham, Hillman, Deighton and Midgley, 2014; Pantelidi, 2015; Passa and Giovazolias, 2015). Smith and colleagues (2009) have, themselves, observed that IPA can 'offer insights into experiences of events and processes, and the personal meaning of various "outcomes", which can help researchers to interpret their quantitative findings and to illustrate them for a diverse audience.' (p193). In this research (i) both sets of data have been considered to fit within one overarching framework of paradigm-methodology (critical realism and IPA), (ii) both sets of data have been adjudged to be important, but the qualitative data has been given primacy and a key element of design has been the translation of the numerical maps into a verbally articulated narrative (Bishop, 2015; Bradbury, Dennison, Little and Yardley, 2015), and (iii) with regard to the ordering of analyses (the 'point of interface' between the two forms of data – Yardley and Bishop, 2015, p2), the reconstituted numeric data has been incorporated into the qualitative data prior to analysis. This process ensured that the analysis of that qualitative data included exploration of each participant's reactions to the numeric data.

As noted previously, the principle focus of consideration in progressing the research was the gathering of qualitative data relating to participants' experiences. Quantitative data, where collected, was primarily of interest with regard to the context of participant feedback – on the basis that how a person remembered and reported upon their experiences of engaging with a therapy programme would be likely to be strongly influenced by their judgements as to whether, and in what ways, it had been of benefit to them. Any other use of the data, for instance, with regard to questions of 'proof of concept' were secondary. The small sample numbers and absence of any comparison group meant that no attempt would be made to draw meaningful conclusions with regard to collective or comparative efficacy beyond those relating to 'proof of concept'.

6.3 Pragmatics of Undertaking the Research

6.3.1 Introduction

The previous section presented the central architectural structure of the research design – research questions, paradigm, methodology and data-form. This section describes the processes followed in the research, with specific and detailed reference to the logic behind the decisions made. Critique of the research design, with regard to the possible consequences of those decisions, is presented in Chapter 8. In essence, the study design involved the piloting of the new Therapy Programme with a small, representative sample of service users. Specific elements of research process included – (i) participant selection and recruitment, (ii) the collection and analysis of quantitative data, (iii) the collection and analysis of qualitative data, and (iv) attention to questions of credibility, assurance and authenticity. The following section considers each of these elements. Ethical issues present a significant challenge to research design, and are central to any applications for approval to progress. In this chapter such considerations are discussed, as appropriate, in relation to those four defined areas.

6.3.2 Participant Selection and Recruitment

The selection and recruitment of participants was governed by the joint ethical requirements to treat service users respectfully and to ‘do no harm’, and involved three distinct considerations – sample size, the identification of a pool of potential participants, with regard to inclusion and exclusion criteria (in which the researcher determined who might be approached and who *should not*) and the process by which potential participants were approached (in which the researcher ensured that recruitment was based on the informed, un-coerced choice of the person).

Sample Size

The primary strategy of the research was to improve the Therapy Programme through detailed consideration of the experiences and recommendations of service-user participants. Consequently, the primary consideration with regard to data capture and, therefore, sample size, was the qualitative feedback of participants' experiences. Smith and colleagues (2009) have said that 'given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small number of cases' (p51) and, with regard to specific sample size, that there should be 'sufficient cases for the development of meaningful points of similarity, but not so many that one is in danger of being overwhelmed by the amount of data generated' (p51). They suggest that a study of the kind under discussion might be usefully progressed with three to six participants and a maximum of ten. The systematic literature review presented in 4.5 highlighted that there is, in most intervention research, a degree of attrition of participants from the process, both during the delivery of the intervention under consideration and, subsequently, during those elements of the contract specific to the research strategy. The studies examined in relation to the systematic review reported attrition rates (from the intervention) ranging from 0 to 53.0%, with a mean of 13.1%. Intervention studies that focussed specifically on an FEP participant population reported the same range of drop-out, but with a slightly higher mean of 17.2%. It should be noted, however, that very few of the studies reviewed included low baseline scores of hope or self-esteem as inclusion criteria and the higher rates of attrition were associated with those studies in which baseline hope and self-esteem scores were moderate-to-high. As noted above, the research was to be conducted in the naturalistic setting of a specialised Early Psychosis Service. In respectful acknowledgement of other clinical demands experienced by the service, a treatment window of 12 months for this study was negotiated with key stakeholders. Given the above, the decision was made to recruit 8 participants to the study, with the understanding that once the Therapy Programme had commenced with any individual, their subsequent drop-out would not lead to the recruitment of a replacement. Even with a greater-than-average predicted attrition rate, it was anticipated that this strategy would result in 4 to 6 completers of the combined therapy and research process.

Identifying potential service user-participants

Recruitment of participants to any research will be subject to defined inclusion and exclusion criteria. Such inclusion and exclusion criteria might be categorised in terms of whether they represent – (i) the best interests of the participants – balancing the potential benefits to the person with any anticipated risks or costs to them (including, distress, confusion, or exacerbation of psychological difficulty), (ii) the best interests of the research agenda – balancing the potential benefits of greater heterogeneity (improved generalisability) with those of greater homogeneity (approximating more closely to the 'essence' of experience), or (iii) restrictions imposed by the research context.

In this study such criteria were developed with reference to seven areas of consideration - context, level of wellness, age, race / culture, language, previous contact with the researcher-therapist, and baseline level of self-esteem and hope. The inclusion and exclusion criteria employed by the study are presented in Table 6.2 (below). The reasoning behind each of these determinations follows.

Table 6.2 – Participant Recruitment - Inclusion and Exclusion Criteria

Criterion	**Inclusion**	**Exclusion**
Service	Receiving support within the Specialist EIPS	Receiving support from an alternative service
Geography	Within the geographic terminus of the researcher's EIPS	Outside of the geographic terminus of the researcher's EIPS
Diagnosis	Broad diagnosis of Psychosis or differential diagnosis of Schizophrenia, Schizotypal or Delusional Disorder or Bipolar Disorder. ICD 10 coding – F20 to F29, plus F31	Non-Psychosis Organic Psychosis

Stage of 'Illness'	Within the first 3 years following first referral for treatment	Prodromal or 'At Risk Mental State'. Greater than 3 years since first treatment
Level of illness / Wellness	Remission. Acute but stable psychosis	Acute, unstable psychotic crisis
Current or previous compulsory treatment	No current compulsory treatment in inpatient or community.	Current compulsory treatment
Age	18 - 38	No clients below the age of 18 No clients above the age of 38
Language	Service Users capable of conversing in and reading the English language	Service Users who would require an interpreter and / or written information to be provided in a language other than English
Prior contact with the Researcher-Therapist	No prior contact with researcher-therapist	Previous therapy with researcher-therapist
Level of Hope / Hopelessness	Score of 36 or below using Snyder's Adult Dispositional Hope Scale (SADHS)	Score of 37 or greater using SADHS
Level of Self-Esteem	Score of 106 or below using Robson's Self Concept Questionnaire (RSCQ)	Score of 107 or higher using RSCQ

Context

The Therapy Programme has been developed specifically to address the experiences of young people recently diagnosed with the onset of a psychotic illness. The research took place in the naturalistic setting of an Early Intervention in Psychosis (EIP) Service, in which the researcher was employed and from which all participants were in receipt of support. That context dictated that all those approached would be diagnosed with a Psychotic Illness or Episode (ICD 10, WHO, 1992), between the ages of 14 and 38, within the first 3 years following diagnosis of the psychotic illness and living within the geographic terminus of the EIP Service (see also Chapter 3).

Level of Wellness / Illness

It was noted in Chapter 3 that, in the early stages of the development of a psychotic illness, the experience of positive symptomology tends, in the majority of cases, to be episodic, with level of wellness subject to change. At their most unwell, some service users might be required to accept compulsory treatment under a section of the Mental Health Act (Parliament of the UK, 1983, 2007), either with detention in a psychiatric hospital setting or on a 'Treatment Order' in the community. Psychotic symptomology, also, generally includes aspects of distorted and inconsistent thinking and is frequently correlated with poor insight (Amador and Kronengold, 2004). In circumstances where an individual is adjudged to be more acutely psychotic these associations undermine the researcher's ability to determine and show that the individual has capacity to make an 'informed choice'. It, also, increases the risk of an individual retracting or amending consent as their world views change, as well as the potential for perceptions of pressure or, even, coercion in any invitation to take part in research. In addition, whilst there is some evidence to suggest that CBT can be of value to persons who are acutely unwell (Drury, Birchwood, Cochrane and MacMillan, 1996; Freemantle and Clarke, 2009; Hanna, 2009), such circumstances are likely to result in greater heterogeneity with regard to participant experiences of the therapy process. In light of those concerns, it was decided that no service user would be actively approached to take part in the research if (i) they were assessed to be acutely unwell, with evidence of significant levels of positive psychotic symptoms, or (ii) were being treated under a section of the Mental Health Act as an inpatient or in the community. Prior compulsory mental health treatment was not defined as an exclusion criterion. In order to minimise the risk of inappropriately or inadvertently engaging an individual whose mental health was more in-question, it was a requirement that inclusion in the research be agreed by all members of the mental health team actively involved in the care of the service user.

Age

At the time that the research was progressed the host EIP Service worked with individuals aged from 14 to 38. This broad age range introduces the probability of substantial heterogeneity of life experience across the service user population. In addition, and more significantly, there are ethical, legal and pragmatic questions regarding recruitment into research for the younger service users. Between the ages of 14 and 18 there are three clearly defined legal groupings (NIMHE, 2009) - 14 and 15-year-olds (referred to as 'children'), 16 and 17-year-olds (referred to as 'young people') and 18-years and older (referred to as 'adults'). These three groups differ from each other with regard to service provision, legal and ethical considerations concerning capacity to make informed-choice, and reading age. The design of the research was to deliver the trial Therapy Programme in addition to Treatment as Usual (TAU), but, within the host service, TAU (service provision) was different for children and young people, in comparison with adults. 'Informed choice' requires that an individual has the capacity to 'understand the information about the decision to be made … retain the information in their mind … use or weigh that information as part of the decision-making process; [and] … communicate their decision (by talking, using sign language or any other means) (NIMHE, 2009, p25). 'Capacity', however, can be compromised by issues of psychological maturity. Adults are assumed to have capacity to make mature decisions on their own behalf, unless there is clear evidence to the contrary. Decisions as to whether Children and Young People are deemed to have capacity have to be clearly evidenced and those processes are governed by different legislation for the two groups – for children, the Mental Health Act (DOH, 1983), and for young people, the Mental Capacity Act (DOH, 2005). Finally, a significant component of the Therapy Programme was the provision of a Participant Handbook – developed specifically as a resource for service user-participants. The projected reading age was a key consideration in the development of this resource. The Handbook was designed as an adjunct to a 'therapist-lead' process and was written to the reading age of 18 (see Chapter 5). Based on these three concerns, specialist professional skillsets, capacity and reading age, it was decided that, at this stage in the development of the intervention, it would not have been in the best interests of the research agenda to involve service-users under the age of 18.

Race, Culture and Language

The geographic area in which the research was undertaken might be described as 'multi-cultural', with the population demographics, across city and county combined, approaching less than 50% 'White-British', and over 70 languages actively read and spoken (Regional Census Data for 2011, LSR, 2018). It has been suggested within the CBT literature that the development of the therapeutic paradigm has been primarily organised with reference to a culturally homogenous 'white' and western population and that the approach might need to be adapted to equitably accommodate the ways of thinking and being of different cultural groups (Muroff, 2007; Rathod and Kingdom, 2009; Rathod, Kingdon, Phiri and Gobbi, 2010; Rathod, Phiri, Harris, Underwood, Thagadur, Padmanabi and Kingdon, 2013). Furthermore, where language is an issue, services are encouraged to provide alternative-language reading material and / or interpreters. There is, however, evidence to suggest that the use of an interpreter in the context of the delivery of a therapy might affect the therapeutic relationship and process and that it can be associated with reduced benefits (d'Ardenne, Ruaro, Cestari, Fakhoury and Priebe, 2007; d'Ardenne, Farmer, Ruaro, and Priebe, 2007; d'Ardenne and Farmer, 2009; Mofrad and Webster, 2012). Both factors, the cultural resonance of the therapy and the need for interpreters, introduce significant additional variables into a research exercise designed to engage with an homogenous group. Given the early stage of the development of the Therapy Programme, the decision was made not to define inclusion or exclusion criteria with respect to ethnicity, culture or religion, but to pay particular attention to these considerations in relation to questions of accessibility and engagement. It was felt that including those who were non-English speaking would significantly add to the pragmatic demands of the study and it was, consequently, made a requirement of the study that participants be able to understand, read and speak English. It should be emphasised that this 'rule' did not exclude those for whom English was not their first language, but who were confident in reading and speaking it.

Previous Contact with the Researcher-Therapist

It is not uncommon for individuals referred to an EIP Services to have received psychological therapy prior to that referral. It is much less common, but not unheard of for service users within an EIP Service to receive more than one course of psychological therapy, from different practitioners, targeting different key difficulties. The research policy of providing the experimental Therapy Programme in addition to TAU required that prior experience of psychological therapy was not considered grounds for exclusion from the research. On the other hand, it was felt that prior contact with the researcher-therapist personally might risk the possibility of a perceived obligation to agree to involvement. Previous contact with the researcher-therapist was, therefore, identified as an exclusion criterion, whilst access to other therapies or therapists was not.

Level of Hope and Self-Esteem

The central purpose of the novel Therapy Programme is to reduce compromised self-confidence and despair and to inspire hope and self-belief. To test out the value of the programme, in terms of participant experience and reported efficacy, it was essential that it be considered personally meaningful to service-user participants. Learning from the problems identified in the review of previous intervention-research (Chapter 4) it was a requirement that participants should be clearly evidenced to be struggling with hopelessness and compromised self-esteem at the commencement of the Therapy. In order to ensure relevance, this study employed Robson's Self-Concept Questionnaire (RSCQ – Robson, 1989) and Snyder's Adult Dispositional Hope Scale (SADHS - Snyder, Harris, Anderson, Holleran, Irving et al, 1991) to evaluate, respectively, self-esteem and hope, prior to acceptance of the service user into the Therapy Programme. The RSCQ has a range of 0 to 210. Normative data suggest a clinical population mean of 106 (for service users diagnosed with Generalised Anxiety Disorder). This score was used as the upper cut-off for inclusion in the research. The SADHS has a range of 8 to 64. Normative data suggests a clinical population (low hope) mean of 46.22. There is, however, a substantial overlap between high- and low-hope populations, with a comparatively small difference between population means. This study, therefore, elected to take the midpoint of the scale (36) as the cut-off for inclusion.

Recruitment Process

It was an ethical requirement of the study that any consent to take part be informed and not coerced. Achieving informed consent necessitated that potential participants were judged capable of giving consent, provided with sufficient information and time for a judgement to be made, not made to feel under pressure to take part and given adequate exit opportunities. In discussing the process of identifying potential participants for an IPA study Smith et al (2009) have noted that ‘participants are selected on the basis that they can grant us access to a particular perspective or phenomenon under study’ (p49). With regards to this study those perspectives related to being of a certain age, having recently experienced the onset of a psychotic illness, being supported within a specialised Early Intervention in Psychosis (EIP) Service and experiencing both hopelessness and low self-esteem. Given the service context for the study, the process of recruitment was largely based on convenience, but, the methodological requirement to promote homogeneity, also, required a purposive approach to sampling (Gelo, Braakmann and Benetka, 2008; Smith et al). Potential participants were considered for involvement in the research on a ‘first-come-first-served’ basis, with service users being approached one-at-a-time until 8 had been recruited. All referrals to the research were made by the relevant EIP Service Key-Worker. The offer of involvement in the research was raised where a service user directly reported strong feelings of negativity about themselves and the future, or indicated, through the content of their speech or their actions, that they might hold those views. Once an individual had been identified as potentially appropriate, recruitment was progressed through a series of steps (see Figure 6.2 - below).

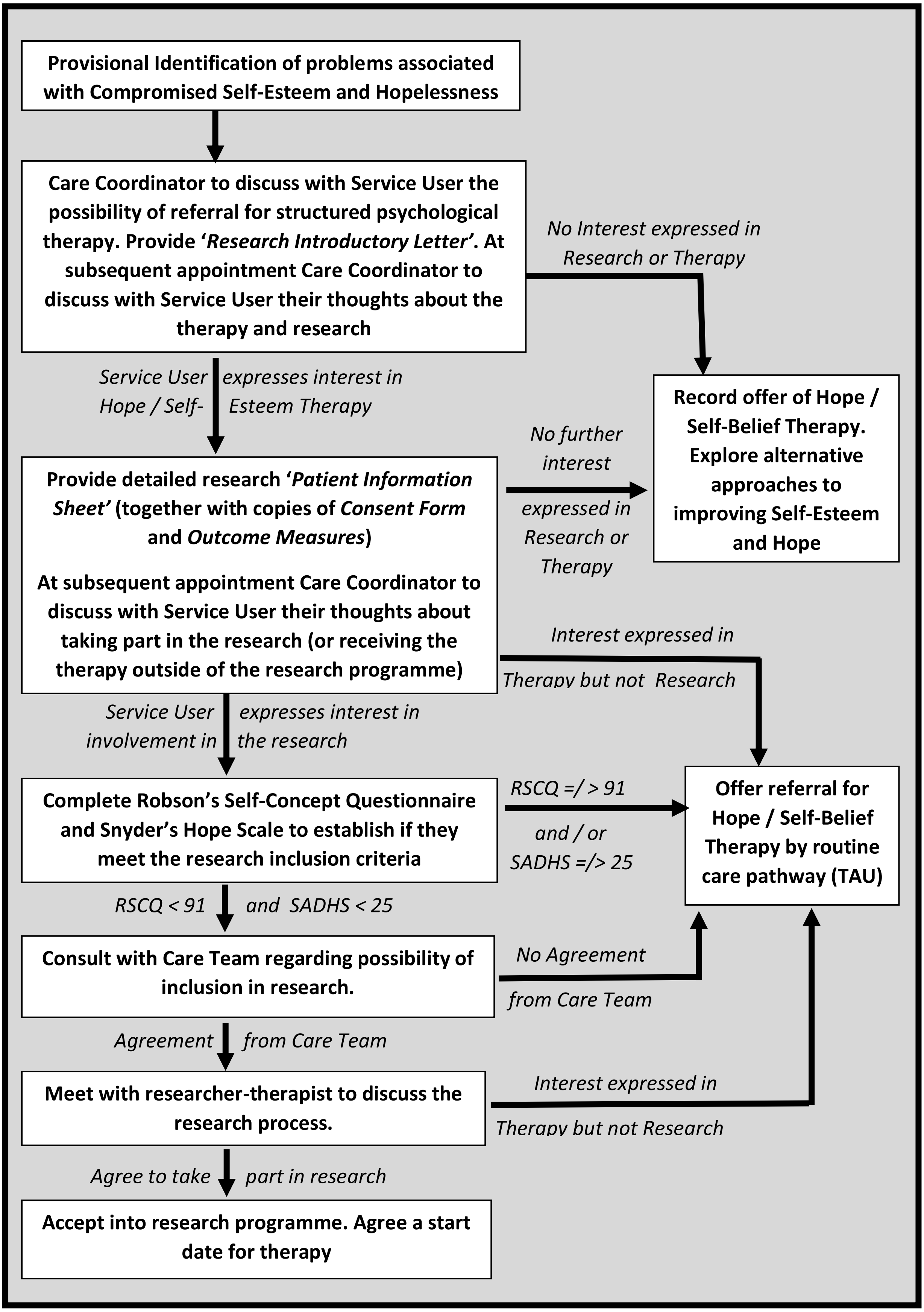


Figure 6.2 – Algorithm of the Recruitment Process

The stepped process was designed to ensure that (i) subject to the qualification that they retained the right to withdraw from the process at any point, service users' participation was informed by a detailed understanding of the research process and an agreement to meet all of the requirements specified (this included the video-recording of the therapy sessions for the purposes of clinical supervision and the audit of fidelity – see section 6.3.5 below), and (ii) recruited participants met all of the inclusion criteria detailed below.

Step 1 - Introducing the idea of involvement. The service user was informed about the research, provided with a copy of the 'Research Introductory Letter' (Appendix 4A) and invited to consider being involved. At this point Key-Workers were asked to make the following observations – (i) there would only be a few 'places' available in the research at this stage, and (ii) there would be no obligation to take part. The service-user was invited to take time to read the letter and to let the Key-Worker know if they would like more information.

Step 2 – More detailed discussions. If a service-user returned with an expression of interest, they were provided with a copy of the more detailed 'Patient Information Sheet' (Appendix 4A). The following points were emphasised – (i) the Therapy Programme might not be 'right' for the person, (ii) declining the invitation to take part in the research would not compromise the person's care, (iii) the person might not meet the research inclusion criteria, (iv) there was an option to receive the Therapy Programme without having to take part in the research, and (v) there would be no financial compensation for involvement in the research, but, due to ring-fenced clinical time for the research, there would be a more rapid access to the Therapy Programme than with TAU.

Step 3 – Meeting the Inclusion Criteria. If a service-user continued to express interest in the research they were asked to complete the SADHS (Snyder et al, 1991) and RSCQ (Robson, 1989). Completed outcome measures were scored by the researcher-therapist. Where the scores met the inclusion criteria for the research other members of the care team were consulted.

Step 4 – Meeting the Researcher. If the service user met all of the inclusion criteria, and there were no adverse concerns raised by the care team, they were, then, offered an opportunity to meet with the researcher-therapist. That conversation included clarification of outstanding questions, completion of consent forms (Appendix 4A) and negotiation of the practicalities of therapy - start date, location, weekly time-slot.

6.3.3 Collection and Analysis of Quantitative Data

Quantitative Data Collection

The primary concern of the Therapy Programme under development was the direct, targeted inspiration of hope and self-belief. The two primary outcome measures needed, therefore, to address those constructs directly. A number of validated measures are available with regard to each. Robson's Self- Concept Questionnaire (Robson, 1989) and Snyder's Adult Dispositional Hope Scale (1991) were employed. It has been argued, furthermore, that improvement in both hope and self-esteem are likely to show strong correlation with improvements in experiences of wellbeing, functioning (social, vocational and educational) and the prevalence of (and disability associated with) various primary and secondary symptoms of the psychosis (Irving, Snyder, Cheavens, Gravel, Hanke, Hilberg and Nelson, 2004). It was decided, therefore, to, also, evaluate the possibility of change with regard to wellness. Within the host service, the CORE Outcome Measure (Core Systems Group, 1998; Barkham, Evans, Margison, McGrath, Mellor-Clark, Milne and Connell, 1998; Evans, Connell, Barkham, Margison, McGrath, Mellor-Clark and Audin, 2002) is used routinely as a generic rating scale, so was adopted for the study. Finally, in addition to the use of validated outcome measures, snapshot evaluations of hope and self-esteem were ascertained using SUDs Ratings (Subjective Units of Distress). Copies of the three outcome measures, together with relevant normative data and a schedule of data collection are included in Appendix 4B.

Schedule of Data Collection

The RSCQ (Robson, 1989), SADHS (Snyder et al, 1991) and CORE-OM (Barkham et al, 1998) were all completed at baseline; the RSCQ and SADHS as part of the recruitment process (see 6.3.2 above) and the CORE-OM following the 'Sign-off' meeting with the researcher. They were repeated at 4-session intervals (4, 8, 12 and 16), the last representing a post-therapy score. The SUDs evaluated Hope and Self-Esteem using a -10 to +10 scale, which clearly illustrated negativity or positivity towards self and the future. These scores were recorded at the beginning of each session. The principal purpose of the use of these outcome measures was clinical. As noted previously, such instruments are employed routinely within CBT to support the processes of assessment and formulation, to evaluate progress in therapy and to inform decisions about changes to the direction or delivery of the treatment plan. In the context of this research such outcome data was perceived to have utility in underscoring and illuminating participant-service-users' experiences of the Therapy Programme. It has been postulated that how a person views their involvement in therapy is likely to be strongly informed by their judgement as to the extent to which it is perceived to have met their needs. That is likely, in turn, to be reflected in the scores arising from periodic completion of the identified outcome measures. Through careful triangulation with participants' verbal narratives (see qualitative data collection – below), the numeric data arising from the employment of these instruments offered the possibility of greater depth perception and more texture to the interpretative analysis of participants' presented experiences.

Due to the extremely small sample size necessitated by the primary focus on qualitative evaluation of experience, the research goals did not include plans regarding questions or statements of the generalisability of results to others. It was hoped, however, that the collective numerical data from completer-participants might be employed, secondarily, to address ‘proof of concept’, with regard to questions of whether, and in what ways, the outcomes of the research could support an argument for investment in further development of the intervention.

One of the principal aspirations in the construction of the specific Therapy Programme under review was that benefits accrued during the period of engagement with the programme should, as much as possible, be sustained over time, irrespective of subsequent challenges faced by the individual. With a small sample size and in the absence of any control condition it was, of course, never going to be possible to make any statements of certainty (or even strong likelihood) with regards to the direct relevance of the intervention to any changes in hope, self-esteem or wellbeing reported over the time in which the therapy was delivered. This is particularly the case in the context of a specialist EIP Service, in which therapy-research participants would be continuing to receive an extensive, broad-based package of support (TAU) from the wider team and with regard to which, there would always be an expectation that some service-users, at least, would improve in their wellbeing and concomitant hopefulness and self-esteem. Benefits of receiving the therapy could not, therefore, be proven with the research design employed. The same observations of multiple contributory factors, also, apply to discussions as to why any possible improvements might, or might not, be sustained over time. In the process of developing the research protocol, it was argued, however, that, even though any sustained gains might not be proven to be attributable to the provision of the therapy, any substantial loss of those gains, irrespective of the factors implicated in the undermining of accrued-gains, could be defined as evidence of the failure of the intervention to achieve one of its primary aims. In relation, therefore, to the question of proof of concept, it was deemed important to follow-up participants to evaluate their progress over time.

It was decided to undertake a follow-up, for each participant, after 24 months from the point at which their therapy was commenced, primarily to gather further qualitative reflections and to assess for evidence of the failure of the programme to achieve this goal. The follow-up process was organised primarily with reference to the gathering of further qualitative data through the pursuance of a second interview. That process was supported by the completion of the three outcome measures identified above, together with SUDs evaluations. The time to follow-up was chosen to allow a reasonable period for each person to be expected to experience some challenges in the wider progression of their recovery, in particular in relation to increased social, educational or vocational engagement, whilst avoiding the very unique psychological stresses associated with the drawing to a close of the person's relationship with their wider care team, as their time with the specialist EIP service (maximum of 36 months) came to an end. The design decision to leave such an extended period to follow-up was a design error. It contributed to very significant limitations in the research methodology, with the direct consequence that no relevance or utility can be accorded to the quantitative data that was collected. Those limitations are further highlighted and discussed in detail in Chapter 8.

Quantitative Data Analysis

The captured and analysed quantitative data was employed to address both the primary (participant experience) and secondary (proof of concept) research questions. Participant experience was considered with respect to an idiographic analysis of each person's scores. Proof of concept was addressed through the aggregation and collective analysis of those scores.

Quantitative data analysis at the level of the 'case'

The idiographic analysis of the quantitative data took two forms –

1. Evaluation of changes over time, which allowed examination of the question of the findings from the outcome measures regarding the programme for each individual.
2. Consideration of the trajectory of scores across the course of the therapy, which allowed reflection on possible connections with specific components of the Therapy Programme, as well as extraneous events or pressures.

Each level of analysis, comparison or form of presentation (see below) offers a different perspective on the impact of the Therapy Programme for the individual. It was anticipated that bringing together those different perspectives would allow both a degree of triangulation, and therefore, mutual confirmation and, also, a sense of texture and depth, thus connecting with the critical realist agenda of ontological complexity.

Evaluation of Changes to Scores over Time

Consistent with the analysis of prior intervention research (Chapter 4), for each participant scores post-therapy and at follow-up were considered with regard to – (i) the numerical change in score over the course of treatment, (ii) the percentage increase based on the base-line score, and (iii) the percentage change across the scale. In addition, scores were considered with regard to the question of clinical significance.

Clinically significant change

Jacobson and Truax (1991) have argued that it is more meaningful in considering the efficacy of psychotherapeutic practice to examine clinically significant change than statistically significant change. They have suggested that therapeutic benefits, such as ‘potency, .. impact on clients, or … ability to make a difference in peoples’ lives’ (p12) are missed by ‘conventional statistical comparisons’. Their ideas are introduced here, and elaborated upon in detail in Appendix 4B. In brief, Jacobson, Truax and colleagues

(Jacobson, 2001; Jacobson, Dobson, Truax, Addis, Koerner, Gollan, Gormer and Prince, 1996; Jacobson, Schmaling, Holtzworth-Munroe, Katt, Wood and Follette, 1989; Jacobson and Truax, 1991) have suggested that, for many outcome measures, the scores of clinical populations (those defined as experiencing a specific problem) and non-clinical populations (those defined as not experiencing that problem) might present as two 'normal' curves, with more or less overlap (see Figure 6.3). They have noted that, in the trajectory of improvement from a beginning point within a clinical population towards a position within the non-clinical population, there were three points (or cut-offs) whose achievement might represent a meaningful level of clinical change – (i) When the scores passed the outer parameter of the clinical population - Cut-off 'A', (ii) When the scores progressed from a point that was closer to the clinical mean to one that was closer to the non-clinical mean - Cut-off 'B', and (iii) When the scores passed through the outer-parameter of the non-clinical mean - Cut-off 'C'. Figure 6.3 (below) reflects partially over-lapping clinical and non-clinical populations.

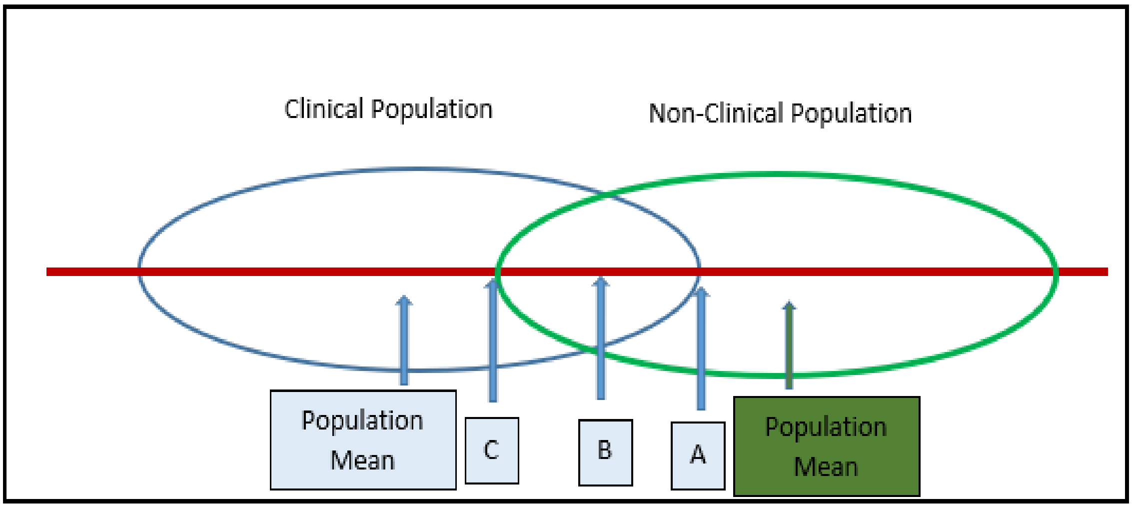


Figure 6.3 – Clinically Significant Change - Partially Overlapping Clinical and Non-Clinical Populations – adapted from Jacobson and Truax (1991)

The three cut-off points for the 'total score' for each measure are presented in Table 6.3 (below). The more detailed normative data relating to each measure, including cut-off's for subscales is presented in Appendix 4B. For the SADHS (Snyder et al, 1991) and CORE-OM (Barkham et al, 1998), there are differing normative data for the clinical and non-clinical means for males and females. The total scores for CORE-OM include the dimension of risk. It should be noted that SADHS and RSCQ (Robson 1989) are inverse-problem scored so the cut-off points decrease from A to C. CORE-OM is problem scored, so the cut-off points increase from A to C.

Table 6.3 – Clinical Significance and the RSCQ, SADHS and CORE-OM Outcome Measures – Cut-off Points

	Non-clinical		Clinical				
	Mean	**SD**	**Mean**	**SD**	**Cut-Off A**	**Cut-Off B**	**Cut-Off C**
SADHS - Total	50.48	5.62	46.22	8.9	64.02	48.35	39.24
RSCQ – Total Male	141	19.5	106	25.9	157.8	123.5	102
RSCQ – Total Female	139	20.5	106	25.9	157.8	123.5	98
CORE-OM – Total (Inc. Risk) Male	0.69	0.53	1.88	0.78	0.32	1.19	1.75
CORE-OM – Total (Inc. Risk) Female	0.81	0.61	1.85	0.77	0.31	1.29	2.03

Examining the Trajectory of Scores across the Course of Therapy

With regard to individual experience, the captured scores have also been presented graphically to allow visual comparison of the trajectories of the different elements examined. These graphs primarily reflect changes over time, with each measure presented separately to minimise visual confusion. The purpose has been to allow tentative reflection on the temporal synchronicity of changes in experience in relation to – (i) particular stages of the therapy process, (ii) specific elements of the Therapy Programme, and (iii) the intrusion of external events.

Analysing quantitative data analysis at the level of the 'group'

Alongside their significance within the Therapy Programme itself, and in developing individual stories of value and accessibility, the data arising from the completion of the measures has also been used to consider the programme with reference to the collective experiences of the group. Sample numbers were too small to offer reliable or credible statistical power with respect to any detailed analysis of the changes experienced (Murphy and Myors, 1998) and there was no control or comparison group that might have allowed robust statements of causal effect. As noted previously, any gains identified by participants at the end of therapy might only be said to have occurred within the same time-frame that the individual received the Therapy Programme. The consideration of collective scores, therefore, has only been concerned with the question of 'proof of concept'. This asks whether there is sufficient collective or mean change reported over the period of the delivery of the individual therapies to support an argument for further investigation of the approach. The combined data has been presented in tables and graphs for visual comparison, and examined with reference to descriptive statistics.

6.3.4 Collection and Analysis of Qualitative Data

Qualitative Date Collection

It has been noted that the priority purpose of this study has been the practical testing and evaluation of the Therapy Programme with a view to its improvement. In order to achieve that goal, the research has been designed to bring forth the essence of the experiences of service-user participants. There are a number of research approaches by which that agenda might be progressed (Cresswell, 1998; McLeod, 2001; Punch, 2005; Smith et al, 2009). The research process of preference for, both, IPA (Smith et al) and critical realism (Clark, Lissel and Davis, 2008) is the one-to-one interview. Qualitative research interviews can vary along a continuum of pre-determined structure from a prescribed interrogation format to a very loose and open conversation (Punch). In this research a semi-structured interview format was adopted. This offered, both, consistency of structure and flexibility of enquiry. A key question with regard to research design concerned the person of the interviewer, specifically, whether the research was best served with the feedback-interviews being conducted by the therapist or by an independent agent. This choice was explored with regard to considerations of philosophical and methodological coherence as well as pragmatism. Examination of the literature relating to critical realism and IPA failed to resolve the decision. The two dimensions of critical realism, complexity and construction (Bhaskar, 1975, 1993; Clark et al), appeared to equally support both positions. The positivist, ontologically-realist goal of seeking objective-feedback was regarded as supporting the facilitation of the interviews by a researcher not otherwise involved in the study. The constructivist, epistemologically-relativist goal of embracing the co-constructive processes, on the other hand, was adjudged to provide support for the therapist-as-interviewer. Furthermore, IPA (Smith et al) encourages the researcher to incorporate strategies designed to ‘bracket-off’ personal bias and to create distance in the process of data analysis and collection. It was not, however, deemed to offer any specific direction with regard to the question of whether a researcher might undertake an interview where there was a personal investment in the outcome or an historical relationship with the interviewee. Consequently, the design-decision was made with primary reference to issues of pragmatism. Although consideration of the pragmatic included reflections on the economic and resource implications of academic research, the principal determinant of the final decision with respect to this was the ‘insider-position’ of the therapist-as-researcher.

The concept of ‘positionality’ relates to the degree to which a person might be said to be part of a system, which might represent a body of people or of ideas. In discussing social groupings, Crow, Allen and Summers (2001) have noted that the concern with positionality and the distinction between 'insiders' and 'outsiders' has 'an enduring presence in people's accounts of community life' and that 'although the terminology in which such divisions are couched varies, it is possible to conclude that the insider / outsider distinction exists in all communities and societies, between those who belong, who are part of 'us' and those who may be experienced as foreign or alien' (p30). It is posited that this consideration might also apply to all research, but that it is most likely to be considered within the research-design when a practitioner is investigating a context of which they are a part (participant observation research – Adler and Adler, 1994; Bonner and Tolhurst, 2002; Morse and Field, 1996) or the outcomes of a policy, intervention or strategy to which they have contributed (practitioner action research – Dhillon and Thomas, 2019; Nakata, 2015). The specific dichotomy between 'insider' and 'outsider' has been challenged by a number of authors. In relation to social groupings, Kelly (2014) has talked of the commonality of 'border crossing and hybridisation' (p247) and Hellawell (2006) has reflected on *degrees* of insiderness and outsiderness. In the context of research, Dhillon and Thomas (2019) have argued for a perspective of multiple positionalities. They have noted that 'people are insiders in some respects and outsiders in others' and that, therefore, 'there is a need for a more nuanced conceptualization of insider-outsiderness to reflect the multiple positions that researchers may represent in a research project and the potentials and pitfalls of such fluidity in interpretation and analysis of data'. 'Furthermore', they point out, 'the same person can move between differing degrees of insider-outsiderness during the phases of a research project, from design to implementation, analysis and evaluation, which has implications for co-construction of situated knowledge' (p444). Whatever the specific conceptualisation, it has been proposed (Nakata, 2015) that the effective alignment of research purpose and design requires particular attention to this dimension.

Seikkula and Sutela have suggested that the delivery of a course of therapy creates a 'system of boundary' that encompasses the therapist (as a representative of their organisation) and the client (as a member of a wider family) in a unique relationship of mutual influence and cooperation (1990; Seikkula, 1994). Any practitioner-lead investigation of the research process, consequently, represents an evaluation by a researcher-therapist of a system of which they are a key member. That circumstance defines them as an 'insider' –

someone who has a close relationship (and history) with the individual (or group) who is engaging in the study. It is argued that that definition applies even when the system of boundary, itself, has only been created for the purpose of the research – since the therapy represents, both, part of the research agenda and a relationship that is experienced prior to the primary research processes (the data gathering in the feedback interview).

It appears to be generally agreed that the multiple concomitant and intersecting roles associated with the position of 'insider' in a research process can be experienced, pragmatically, as significantly challenging (Adler and Adler, 1994) in relation to, both, the collection and analysis of data. The position of 'outsider' in research is regarded as easier to manage (Bonner and Tolhurst, 2002; Dhillon and Thomas, 2019). There is, however, considerable debate regarding the relative merits of the two position, with acknowledgement that each is associated with, both, advantages and disadvantages.

Benefits identified as arising from the 'insider' perspective include those concerning relationships with people, the significance of ideas and understandings, and the economy or seamlessness of progressing the research process. Person-focused benefits include being more easily accepted, having less restricted access and a better rapport (Bonner and Tolhurst, 2002). Ideas-related benefits focus on the 'insider-positioned' researcher's access to privileged or situated knowledge and include having a greater familiarity with, or understanding of, the individual, group or culture being studied (Reed and Proctor, 1995) and, consequently, being less inclined to constructing stereotypes (Bonner and Tolhurst). Benefits linked to economy in the undertaking of research relate to the reduction in invasiveness of the researcher with regard to the normal flow of social interaction (Kennedy, 1999) and the reduced resources consequently required to engage participants in the process (Bonner and Tolhurst). There are, however, also disadvantages. Gerrish has argued (1997) that the greatest disadvantage of the insider-perspective is 'the risk that over-familiarisation with the setting might lead … to the making of assumptions about what is being observed without necessarily seeking clarification for the rationale behind particular observations' (referenced by Bonner and Tolhurst, p10). Bonner and Tolhurst have noted, in addition, that insider positionality has been linked to difficulties with separation and boundaries, role conflict and researcher biases towards particular understandings or interpretations. In contrast, the ‘outsider’ perspective has been associated with benefits relating to greater objectivity in observation and analysis, and the potential to notice what might be missed by someone more familiar. Its principle limitations are economic, the time required to establish trust, and too much separation, cultural distance and lack of connection (Bonner and Tolhurst).

The purpose of the feedback interviews was to gather experiential and observational reflections from the service-user participants in order to improve the Therapy Programme. By definition, the concept of improvement assumed the presence of imperfections and failings. A key pragmatic requirement of the research, consequently, was that participants be willing and able to critique their experiences, with the inclusion of critical observations and recommendations. With regard to pragmatism, therefore, the design question asked – ‘In what ways might the feedback interviews be influenced through their facilitation by the researcher or an independent stranger?’ And, in particular, ‘would a service-user-participant, at the end of therapy, be more likely to offer meaningful, honest and critical reflections to the therapist-as-researcher or someone else?’

The issue of positionality has implications for both the gathering and analysis of the qualitative data, but there is a key difference between the two parts. In the dynamic of the research process, the positionality of the researcher might be said to define the relationship between themself and the participant. That relationship will be informed, both separately and collectively, by the ways in which the researcher and participant regard the other and the manner in which they conceptualise the relationship between them. In the analysis of the captured data, the researcher’s positionality interacts with words on the page. Whilst an interpretative-informed analysis might include both self- and other-referential reflections, all of the biases at work emanate from the researcher. When the data-collection takes the form of a semi-structured interview, however, the biases or tendencies of both researcher and participant are made manifest in the room. Gergen (2011, 2015) argues that any conversation will always be unique to those individuals involved, informed by the biases of histories, perceptions and expectations that each brings. Any research-interview process, therefore, whatever the researcher's level of connection to the participant, or investment in the subject matter, will show evidence of some bias. It is likely, however, that, where a research-interview is facilitated by a researcher occupying a position as insider, those biases or tendencies of, both, researcher and participant are likely to intersect more closely with the principle thrust of the research agenda.

Interestingly both insider and outsider positions have been postulated to be associated with access to greater openness and honesty in participant contributions. Bonner and Tolhurst (2002) have suggested that 'having an established intimacy between researcher and participants ..promotes both the telling and judging of truth' (p9) – a position that is supported by Leininger (1985) and Robinson and Thorne (1988). An 'outsider' they suggest, might be more likely to be offered ''expected' responses rather than true attitudes or knowledge' (p16). On the other hand, Tolhurst has, also, reported on her experiences as an outsider-positioned researcher, being not viewed as a threat and, consequently, being trusted with complex and personal information not shared with an insider. On this basis, therefore, it was believed that both strategies had the potential to undermine the goal of openness and honesty – through the social-awkwardness of expressing negative judgements directly to the person concerned, or the social-reluctance to 'speak badly behind the back' of a familiar, respected other.

It was felt that the risks associated with either strategy might be mitigated through attention to participants' research-contracts. In discussing the distinctions between insider and outsider positioning, Dhillon and Thomas (2019) highlighted their relationships to 'participation' and 'engagement' in research. Participation, they suggested, involved the recruitment of a 'contract researcher, with no previous or continuing relationship with the research participants, being brought in by a research team to carry out semi structured interviews' (p443). They describe this research-relationship as objective, but cold and disconnected. In contrast, they observed, engagement involved the same interviews being conducted by a known other. They postulated that a research-relationship based on participant ‘engagement’ would be more likely to include trust, reciprocity and the manifestation of emotion.

The decision was for the interviews to be conducted by the researcher-therapist. In order to address the potential for participants to withhold honest, helpful feedback, the recruitment of service user-participants was specifically discussed in terms of creating a collaborative relationship with the therapist-researcher for the purpose of exploring the Therapy Programme from both sides of the ‘therapy-couch’. On that basis, the feedback interview was framed as representing a de-briefing between two partners in the research endeavour. This position highlighted the value of ‘seamlessness’ between therapy and research. To encourage openness in the feedback interviews, the importance of honesty was highlighted in the original meeting with the researcher-therapist, was modelled during the course of the delivery of the Therapy Programme and was strongly re-emphasised at the outset of the feedback-interviews. There was a clear message throughout that this was a programme under development, not yet perfected. In both the therapy and the feedback-interview importance was specifically directed to *improving* the Therapy Programme, not merely *liking* it. The feedback interviews took place 2 weeks after the completion of the individual’s therapy. Consistent with the definition of the research as a collaboration, participants were empowered to choose the time and place of the meeting. In each case this replicated previous discussions. Interviews were video-recorded and the recordings transcribed before being subject to analysis.

The feedback interview was envisioned as a forum to integrate the story that emerged from analysis of the completed quantitative outcome measures with each participant’s subjective sense of their experiences of the Therapy Programme. Each interview was, therefore, conducted in two parts.

Step 1 – The researcher fed-back a narrative of the participant's therapy as represented by the outcome measures and SUDS ratings completed throughout the process. Consistent with the commitment to pursue a strategy of seamlessness between therapy and research, this sharing of data was intended to be very similar to processes progressed throughout the therapy. It differed in the comprehensiveness and form (graphical representations) of the information shared, in the explicit purpose of the discussion and in the nature of the discussion that ensued.

Step 2 – The client was invited to offer feed-back and recommendations regarding the Therapy Programme and Participant Handbook. Each interview was organised within a common framework of key questions. The exploration of detail through ancillary questioning was, however, tailored uniquely to the circumstances and experiences of the participant. A list of key questions is presented in Table 6.4 below. This represented the central framework for the collection and analysis of the data. Guidance for the semi-structured interviews for this study, including organising questions, are included as Appendix 4C.

Table 6.4 – Central Organising Questions for the Feedback Interview

Key Questions in the Feedback Interview
What are your thoughts about how effective or helpful the therapy has been?
What about the accessibility of the programme – how easy, meaningful or enjoyable have you found it?
What do you think has most changed for the better as a consequence of the therapy?
What do you think has changed the least or even gotten worse?
What is different (for the better) in your life – in the way that you think or act – as a consequence of the therapy?
How much of that changing picture do you think would have happened anyway – even if you hadn't taken part in the Therapy Programme?
How has it left you feeling about the future?
Supposing that the Therapy Programme was helpful overall – what bits of it do you think were of most benefit?
Which bits felt least relevant?

If you could make 3 recommendations about how the programme could be improved, what would they be?
What about the resource manual (Participant Handbook)? How helpful did you find it as a resource?
Where does it need changing – is terms of style (how it is presented) or content?
Would you recommend it for other people to read?

At follow-up completer-participants were interviewed a second time with regard to their experiences. The conversations were less structured, guided by just four questions. How have things been? How much of the Therapy Programme does the person remember? What elements, if any, have they employed in the intervening period? Are there any further thoughts or observations about their experiences that the person would wish to share? These interviews were not recorded.

Qualitative Data Analysis

Smith and colleagues (2009) have described the process of IPA analysis as an 'iterative and inductive cycle' (p79) that focusses on illuminating the 'personal meaning-making' of the participant, but also acknowledging the constructive nature of research dialogue. They have noted that, in general, any analysis might progress from 'the particular to the shared and from the descriptive to the interpretative' (p79). They have defined a series of 6 steps (see below). Rather than focussing on the unit-by-unit detailed examination of the interview transcript, IPA considers the much wider and larger data-set of the transcript-plus-notes. A search for themes and patterns, consequently, focuses as much on the product of the interpretations, reflections and meta-questioning of the researcher, as on the specific conversation recorded in the transcript. To help balance an immersed and engaged insider-perspective with a more separate observer-observed outsider-perspective Smith et al (2009) encourage the researcher-analyst to utilise conscious questioning strategies, looking for divergence and convergence, similarities and differences. However, although they suggest some possible common processes, they, also, strongly emphasise that there should be no set or absolute rules about the doing of the analysis. Consequently, although this study has followed the general skeleton and spirit of the process described above, there has also been significant divergence. In relation to the question of 'timing' it is important to note that the analyses were not commenced until all of the interviews had been completed. A six-step process of analysis was followed.

Step 1

The first step of analysis in the IPA framework (Smith et al, 2009) is an immersive engagement with the raw data – a process of reading and re-reading the text-based material. In this study the process of immersion began with the transcription of the video-recordings of the interviews. This task was unanticipated at the stage of research design, becoming necessary due to technical difficulties. In the absence of accomplished touch-typing or short-hand skills, transcribing is a laborious and intense process, requiring repeated re-watching of the conversation. By the time, therefore, that the transcripts were confirmed as accurate, engagement with the material was advanced. As a consequence, each first 'reading' of an interview generated an immediate surge of ideas.

Step 2

Each transcript was subjected to three readings, providing a layering of attention to different aspects, consistent with the critical realist concern with the actual, real and empirical – see Figure 6.4.

Level 1 – A description of the key processes in the interview and the key observations of the service-user participant. This was consistent with the 'descriptive comments' phase of IPA, and the 'actual' element of critical realism.

Level 2 – An interpretative consideration of the greater complexity of what might be below the surface – the innumerate possible influencing factors, including generative mechanisms, that might be guessed from what was or was not said.

Level 3 – A reflective deconstruction of the multiple layers of hermeneutic process enacted within the interview and analysis, including those processes of mutuality and reciprocity between the researcher and the study-focus, the participant, the thesis to be written and imagined future readers. This reflected the critical realist concern with the empirical and with the dimension of construction.

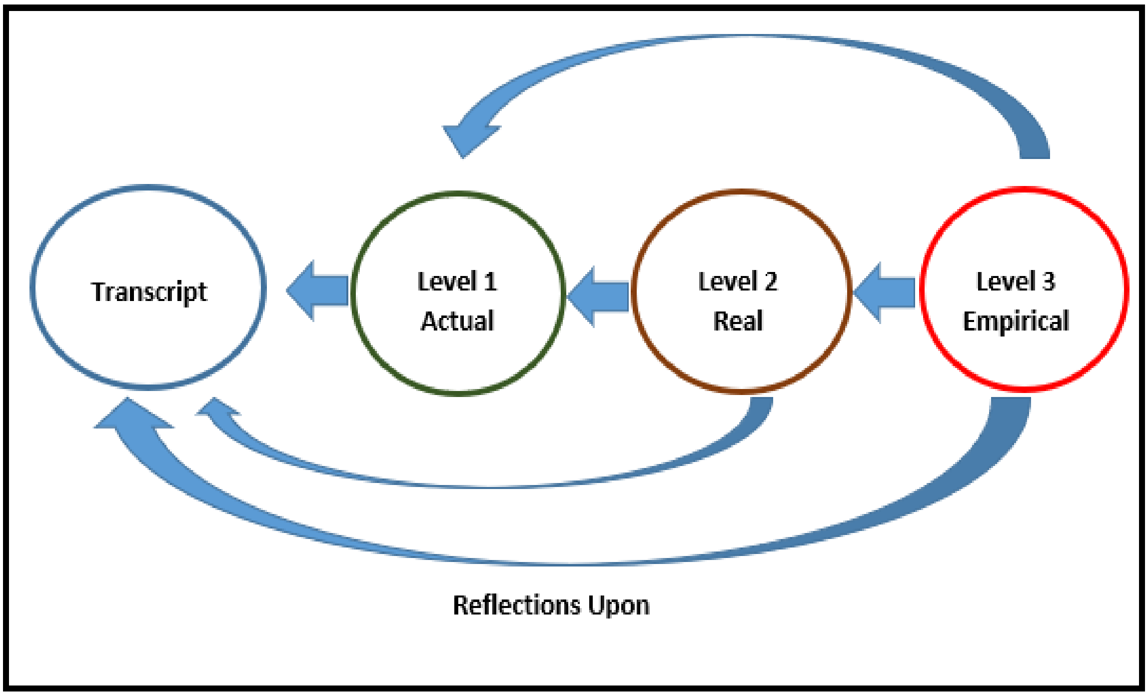


Figure 6.4 – 3 Layers (or levels) of Analysis of Each Transcript

Each level of interpretation involved not just a revisiting of the transcript, but also a re-reading of, and commenting upon, the previous notes (Figure 6.4). The transcript was analysed one segment of dialogue at a time. Interpretations were recorded as a separate file rather than hand written in the margins of a hard-copy of the transcript. All reflections were written using a ‘thought-streaming’ format, in which initial thoughts were allowed to develop in different directions, through sequences of logic or association. One consequence was that there was some blurring of the boundaries between the layers of curiosity described above. In available examples of work by Smith and colleagues (Smith, 2004; Smith, Flowers and Larkin, 2009) notes have taken the form of headline statements and bullet points – short and succinct. The ‘thought-streaming’ approach produced vastly more, but less tightly considered, content. The quantity and detail of emerging interpretative ideas was vast and the process laborious. As a result, each layer, as described, had to be conducted over a series of visits to the material. To minimise any inequity of attention at the ‘join’ between subsequent visits, each read-through was deliberately planned to break at different points in the document. Although most reflections were concerned directly with the word segment under consideration, the un-edited ‘thought-streaming approach’ also picked up on delayed thoughts with regard to previous segments, including the therapist-researcher’s memories of the therapy and their experience of the analytical process.

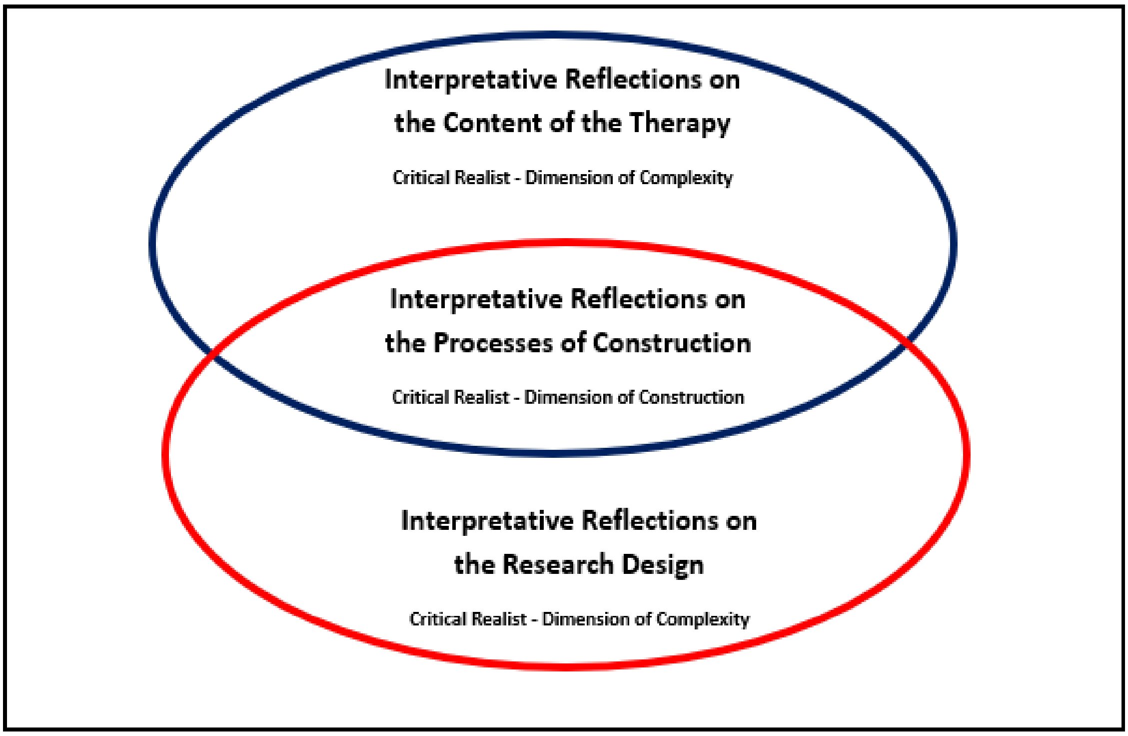


Figure 6.5 – Interpretative Reflections

This study has been contextualised quite specifically within a doctoral training programme. As such the study-process has, throughout, had two purposes – (i) the development of a complex intervention, and (ii) the academic journey of the researcher-student. Whilst the actual interviews with participant's focussed on their experience of the Therapy Programme (including the Participant Handbook), the various levels of interpretation, also, touched upon the research process.

Where observations made reference to the critical realist dimension of construction, they were considered to be relevant to both the emerging ideas about the Therapy Programme and to the credibility of the research design (Figure 6.5). Table 6.5 presents an example of a speech segment from the transcript and Table 6.6 provides a heavily abridged extract of the reflections arising in the three layers of the critical interpretative analysis. More detailed examples of the progression from transcribed words to thematic structure are presented in Appendix 4C.

Table 6.5 – MJ7 – Excerpt from Transcript

	Transcribed Words
Researcher	I know we're just talking about probably the first two meetings that we had, but what is it that you remember about those in terms of what was so useful.
MJ7	I think just talking openly and because I was talking about new things that I hadn't talked about before. So it was like the first time that I was talking about it to someone. So I think that helped. Just generally having someone listening to you, because you don't usually talk about yourself so much during the day, and have someone else talking just about you. So I think that helped having the one to one discussion. And I think you tried to put it into the whole bigger picture, so you tried to understand how at university when I started feeling lower, and I think you drew it out on a graph as well, and to pinpoint exactly when things started to go wrong and I think that helped in trying to understand it that way in terms of the timing. I just thought I was going downhill from the start, but

	there were specific times during university when I was doing OK and when things were getting too much.

Table 6.6 – MJ7 – Abridged Example of Critical Interpretative Reflections

Interpretive Analysis
What makes a difference? Talking openly? Talking about new things? Having someone to listen? These are all very generic – the central tenets of all therapies – not something that is specific to this programme. These observations talk to my skills as a therapist or to my personhood. They don't speak to this new programme – except to say that it needs to operate by the same rules as every other therapy programme of worth. 'Understanding the bigger picture' speaks to the importance of operating from a basis of a formulation of his experiences. I want to think about another level for a moment. My context sets certain pressures in relation to the research, I have to juggle a number of important thing. I get tired and, sooner or later, have to sleep. I am forced by circumstance to come up for air. When I come back to it I am cold. I have lost the thread of where my ideas are going more generally. I have to reread the transcript and some of my last observations – which means that, at the seams, my thoughts are an extra layer thick – overlapping from previous and current. Looking at the last few sections – it seems to me that I am naturally shifting between multiple hermeneutic layers – connecting with both the complexity and constructed elements of CR. Considering the question of context picks up the idea of multiple factors at work, some of which are more visible than others. Even those bits considered here could be taken deeper. The constructed elements might then connect with the intersection of stories MJ7 tells himself, those constructed in therapy with me, that each of us took away, and the story that I find myself constructing in this process of analysis – with an imagined reader / audience. 'You don't usually talk about yourself so much during the day.' Knowing what I know about the client – I might divide this statement into two different references:- (i) MJ7 is a very isolated and lonely individual. His life has closed down. He says he wants friends and a wife, but he struggles to develop these aspirations. He doesn't get to talk about himself with many people. (ii) It is unusual to be asked about self-confidence, self-esteem, self-concept etc – in any non-therapy context. There is another shift here as well – moving from the bigger picture to a much more narrow one – replacing the wide-angled lens with a zoom lens.

Step 3

The extensive notes, representing the researcher's interpretations of the interviews, were then examined with attention to emergent themes. Each segment was considered with regard to – (i) What broad issues were being considered? and (ii) What points were being made? Focal issues and encompassed points were listed in a separate file in emergent order, with each new issue and point being compared against the developing list. Different points speaking to the same issue were grouped together.

Step 4

The fourth step was to develop a multi-layered structure to bring together the identified focal issues and encompassed points in a coherent narrative of participants' experiences. The questions which set the parameters of the semi-structured feedback-interviews (see Table 6.4 above) offered a preliminary shape for this structure in terms of broad areas of attention.

The Therapy Programme.

1. Experience of the content of the Therapy Programme.
2. Experience of the process of its delivery.
3. Experience of the Participant Handbook and other resources.

The Research Process.

1. Critical Realism as an underpinning paradigm.
2. Recruitment and retention of participants.
3. Conducting the Feedback Interview (including the role of the researcher in shaping what was said).

Figure 6.6 presents a framework of themes and referential categories relating to some of the significant points arising from the interpretative reflections detailed in Table 6.4.

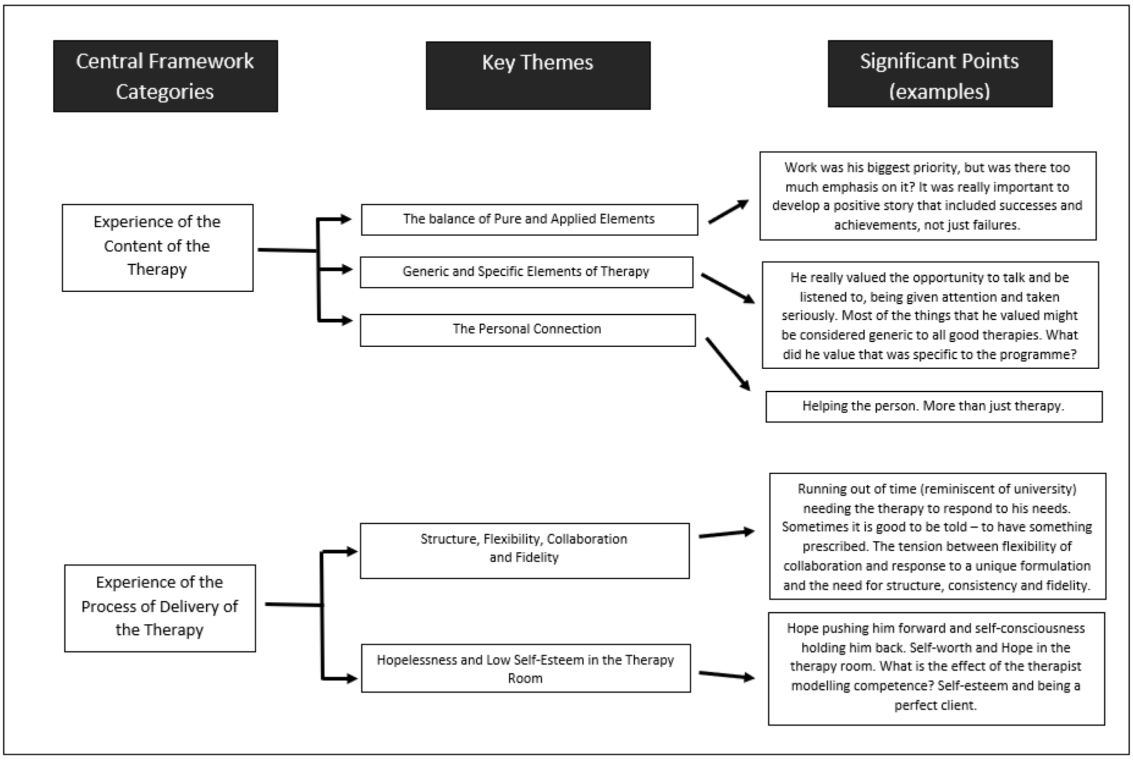


Figure 6.6 – MJ7 – Framework of Key Themes and Exemplar Significant Points for two Super-ordinate Categories

The primary objective of the research was to gather recommendations for the betterment of the Therapy Programme. Table 6.7 presents a summary of the key recommendations arising from the analysis of the interview with MJ7, including key themes and examples of associated points.

Table 6.7 – Example Recommendations arising from the Analysis of the Feedback Interview with MJ7

Focus of Recommendation	Observations
Focussing on Positives – Strengths, Competencies and Achievements	MJ7 really valued the focus on strengths. This was different from other therapies experienced. He recommended that it have more attention, and at an earlier point.
Developing a more Productive Story of Psychosis	MJ7 expressed feelings of particular negativity, hopelessness and self-criticism in relation to the diagnosis given (Schizophrenia). He suggested that it would be essential to address the negativity associated with this diagnosis and work towards a more hopeful and productive understanding. His recommendation was that this be made a formal part of the therapy, and that it should be addressed early in the process. He valued attention to both 'pure' aspects of his evaluations and 'applied' elements of therapy.
Ordering of elements of therapy	MJ7 felt that the first 2-3 sessions were disproportionately influential on the progress of the therapy and the outcomes as a whole. He suggested that the key to successful therapy was the attention to 'pure' aspects of treatment – which he thought should be considered first.
Structure and flexibility	MJ7 valued the collaborative flexibility of the therapy, but felt that sometimes more prescription might be better. He thought that a clearer structure for the programme might have given him more clarity and confidence as to what might be expected.

Step 5 and 6

Steps 5 and 6 involved repeating the process with the other interview transcripts and then looking for patterns across cases.

Table 6.8 – Experience of the Content of Therapy
Key Themes by Participant

Key Theme	**JH2**	**UH3**	**MJ7**	**LJ8**
The balance of Pure and Applied elements of the Therapy	-	X	X	X
The balance between Cognitive and Behavioural Elements of the Therapy	X	X	X	X
Illness Narratives - Psychosis	X	X	-	X
Critical Realism as an Organising Paradigm for the Therapy (Not just the Research)	-	X	-	-
Generic and Specific Elements of the Therapy	X	X	X	X
Endings and Sustainability of Outcomes	-	-	-	X
The Handbook	X	-	-	X
The Personal Connection	-	-	X	-
Simple vrs Complex	X	-	-	-

Table 6.9 – Experience of the Process of Delivery of Therapy
Key Themes by Participant

Key Theme	**JH2**	**UH3**	**MJ7**	**LJ8**
Structure and Flexibility (inc. Questions of Fidelity)	X	X	X	X
Hopelessness and Low Self-Esteem experienced in the Therapy Room	X	X	X	X
Sharing a Narrative of Therapy	X	X	-	-
Collaboration	X	-	X	X
Timing of when to deliver it	-	-	X	-
The ‘Feedback Interview’ as a booster session	-	-	X	-
Language	X	-	-	-
Motivation	X	-	-	-

Table 6.8 and 6.9 present a collective framework of key themes arising from the analyses of interviews, indicating which interviews were associated with which themes. Appendix 4C offers an example of the collective interpretative reflections relating to two key themes.

The philosophical paradigm of critical realism advocates that attention be given equally to the complexity of factors shaping an individual or collective experience and to the processes of construction through which those experiences are given form in the research narrative. Table 6.10 presents an aggregation of the occurrence of key 'construction-themes' arising from the analysis of each participant interview. It is important to acknowledge that there were few occasions within these interviews in which the protagonists directly discussed the research process or reflected upon the factors that might be influencing the dialogue.

Table 6.10 – Reflections on Processes of Construction
Key Themes by Participant

Key Themes	**JH2**	**UH3**	**MJ7**	**LJ8**
Reciprocity and Mutuality of Influence across the Interviews and Analyses	X	X	X	X
Participant's Wellbeing / Psychological State at the Time of the Feedback Interview	-	X	-	X
Therapist as Researcher - A co-constructed process	X	X	X	X
Structure of the Interview – the impact of the Introduction	X	X	X	X
Interviewer's Language and Personal Style	X	X	X	X
Inconsistencies and contradictions in the Participant's Feedback	X	X	-	X
Hopelessness and Self-Esteem in the Research Interview	X	-	X	X
Motivation of the Participant	-	-	X	-
The language of the interview – first and other languages	-	-	X	-

6.3.5 Assurance / Credibility

Any study that seeks to garner wider credibility needs to evidence processes of assurance with respect to claims made. Beyond those elements already addressed with the use of, for instance, validated outcome measures, this study has required that assurance be considered in relation to two key questions –

1. To what extent might the outcome of the qualitative data analysis be considered to fit with the collective reflections of participants?
2. To what extent might the participants' experiences of therapy be considered to fit with the Therapy Programme as formally described in Chapter 5 and in the Participant Handbook?

Assurance of the Qualitative Data Analysis

As reported in the previous chapter, critical realism represents a paradigmatic marriage of ontological realism and epistemological relativism. A study, therefore, which is organised with reference to that complex needs to incorporate strategies that seek, both, to explore the likely relationship between 'map' and 'territory' and to deconstruct the biases within the process of 'map-making'. In IPA that analysis is essentially interpretative. It reflects an iterative dynamic between the researcher and the material. To address this question of bias two complementary strategies were included in the design.

Researcher-Interview

The underpinning paradigm and methodology of the research located the person of the therapist-researcher as inseparably interwoven within the emergent, co-constructed narrative. They facilitated the therapy, and conducted, transcribed and analysed the feedback interviews. The intimacy of this connection is highlighted by the final stage of qualitative data analysis in which the key ideas, clusters and categories are drawn from the researcher's interpretative, processed reflections rather than the raw content of the interviews. Under those circumstances, strategies designed for 'bracketing-off' of the researchers 'finger-prints' were deemed to be philosophically inconsistent and pragmatically uneconomical.

Table 6.11 – Researcher-Interview compared with Participant-Collective Views - Recommendations

	Researcher-Therapist	**Participant Collective**
Motivation	-	X
Structure and Flexibility	-	X
Explicit Narrative of the Therapy	-	X
Addressing Hopelessness and Low Self-Esteem in the Therapy Room	-	X
Developing a more Productive Story of Psychosis	X	X
Recommendations re the Handbook	X	X
Focussing on Positives – Strengths, Competencies and Achievements	-	X
Process of Responding to Recommendations	X	X
Mode of delivery	-	X
Triage Assessment	X	X

It was, however, considered to be helpful to capture something of the researcher's thoughts after the completion of much of the therapy and prior to the first of the feedback interviews. This defined a 'beginning point' against which final conclusions might be compared. To achieve that end the researcher-therapist was interviewed by an ‘independent’ clinical colleague with experience of epistemologically relativist research. That interview was subjected to the same processes of analysis as the participant feedback interviews and the emergent themes included in the final structure of the narrative observations. Details of the ‘task’ of the Independent Interviewer are included in Appendix 4D. Table 6.11 (above) presents a list of anticipated recommendations arising from the analysis of the researcher-interview juxtaposed in relation to an aggregated list of the collective recommendations arising from analysis of the participant interviews.

Table 6.12 – Researcher-Interview compared with Participant-Collective Views - Research Design and Delivery

Key Theme	**Researcher-Therapist**	**Participant Collective**
Flexibility and Fidelity in the delivery of the intervention – When does individual adaptation compromise fidelity?	X	X
Questions to explore in further research	-	X
Generalisability of the Research Outcomes	-	X
Therapist as Researcher – Cost-Benefit considerations with regard to the validity or credibility of the Research Outcomes	X	X
Interpretative Analysis	-	X
Research Design – Participants’ preparation for the Research Interview	-	X
The therapeutic significance of the feedback interview	-	X
Biases in the Process of the Interview – a co-constructed process – inc. how to access honest critique?	X	X
Collating the group position – consensus and disagreement	-	X
Research Design	-	X
Purpose and delivery of the Researcher-interview	X	-
Critical Realism as the organising principle	X	X
Flexibility and tailored delivery in the research process	X	-

Table 6.12 (above) offers a similar comparison with regard to emergent key themes relating to the progress of the research. These tables allow a degree of consideration of the influence of the researcher on the ideas emerging from the participant interviews. The reflections on construction within the critical interpretative analysis speak to this question in more detail, and are examined accordingly in the next chapter.

Participant Check-Back

In order to consider the 'fit' of the researcher's interpretative reflections a summary of their interpreted narrative was shared with each participant for comment. An extract of one such summary is included as Appendix 4D. In the event no participant responded at that time.

Assurance of Fidelity to the Therapy Programme

In relation to the delivery of a therapy programme or intervention an audit of fidelity represents an evaluative comparison of what takes place between therapist and client against an established or defined standard as to what would be expected. Consideration of the studies examined in the systematic literature review (section 4.5) suggests that such audits are most commonly undertaken in intervention research that has larger sample sizes and / or the involvement of multiple therapists (e.g. Fowler et al, 2009; Jackson et al, 2009; Lecomte et al, 2008; Yanos et al, 2019). In these contexts, the principal purposes of the audit are to ensure consistency of approach and, consequently, to strengthen the validity of claims with regard to efficacy and the generalisability of results. As already discussed, the research under consideration had neither a large sample size, nor multiple therapists and questions of efficacy and generalisability were not significant with regard to purpose or design. In this situation, an audit of fidelity was undertaken to address three dimensions – (i) the therapist-researcher's personal confidence in the consistency of their clinical practice (in relation to a new therapy, never previously delivered and which intentionally integrated aspects of invariance with those of flexibility), (ii) the therapist-researcher's interpretative engagement with participants' narratives of therapy (having an evidenced understanding of the processes to which participants' referred in their feedback interviews), and (iii) the therapist-researcher's capacity to speak with authority when discussing the strengths and weaknesses of the Therapy Programme and the modifications to be recommended for its improvement.

The audit was undertaken by an independent clinician, a colleague with significant experience of the practice of CBT. In CBT intervention-research the 'gold-standard' is to observe the therapy sessions and to subject those observations to detailed audit against the specified criteria for the therapy (Bellg, Borrelli, Resnick, Hecht, Minicucci et al, 2004). In this study, therefore, all therapy sessions with all Service-User-Participants were video-recorded. The auditing of video-recorded therapy sessions is an established aspect of CBT training in the UK. Further, the organising body for CBT within the UK (the British Association of Behavioural and Cognitive Therapies or BABCP – www.babcp.com) have recently announced that accreditation will require evidence of clinical supervision received 'live' or in relation to video-recorded material. There is evidence that some service user-clients prefer not to have their therapy recorded and considerations concerning consent to record are, consequently, common to the negotiation of therapy contracts. As noted earlier in the chapter (section 6.3.2) the video-recording of the therapy sessions was defined as a contractual requirement for involvement in this research, for the dual purposes of (i) clinical supervision and (ii) the audit of fidelity. This contractual condition was made explicit in each step of the recruitment process. It was anticipated that this requirement might discourage some potential participants from agreeing to take part, which raised questions with regard to issues of both, pragmatism and ethics.

Pragmatically, there was a concern that the stated-intention to video-record the therapy might impact on the process of recruitment and, potentially, prevent the engagement of a sufficient number of participants. The research, however, planned to recruit just 8 participants from a service case-load, at the time, of 373 service users (see Chapter 7). It was believed that, even should some of those approached decline for this reason, it would be unlikely to compromise the research process in relation to recruitment. It was acknowledged that this might introduce an additional factor with regard to participant-self-selection, but, again, that was not considered of primary pertinence to the purpose of this research. Ethically, the concern was that some participants might wish to receive the therapy, but not to have their therapy sessions recorded and would, consequently, experience the situation as inequitable or discriminatory. To militate against that risk, it was agreed that anyone expressing this wish would be offered the chance to receive the therapy outside of the research process. The only concession was that there would be a longer delay before that therapy could commence, as the research had immediately available ring-fenced clinical time, whilst there was a waiting time for therapy within TAU.

It was planned that the independent auditor would conduct an evaluative review of a randomly-selected 10% sample of recorded therapy sessions. It was anticipated that there would be 128 recorded sessions (8 participants each receiving 16 sessions), and, therefore, 12-13 audit-reviews. It the event 97 therapy sessions were videotaped and the independent auditor evaluated 10. Sessions were saved to encrypted data sticks from which they were selected 'blind' by the auditor. Selection for audit took place each time 10 had been collected. Fidelity was audited using a bespoke tool, a copy of which is included in Appendix 4D, together with the instructions for the Auditor. Each review considered two central questions.

1. Are the process and content of the session consistent with established CBT practice?
2. Is the specific content of strategies or interventions observed consistent with the description of the relevant exercises in the Participant Handbook?

That part of the Audit Tool which was concerned with the question of consistency with CBT practice 'borrowed' from an established measure - the CTS-R (Blackburn, James, Milne and Reichelt, 2000). The CTS-R considers both the presence and quality of CBT practice. This evaluation of fidelity, however, was only interested in the question of consistency with CBT.

That part of the audit tool that was concerned with the question of ‘fit’ with the therapy as described presented a menu of the exercises detailed in the Participant Handbook and asked the auditor to note those observed (checklist) and to briefly discuss three (qualitative feedback).

6.4 Summary

This chapter has described the central architecture of the research design (purpose, research questions, philosophical paradigm, methodology and data form) and the practical strategies that were employed. Pragmatic attention has been given, in particular, to processes of participant-recruitment, the collection and analysis of, both, quantitative and qualitative data and strategies for addressing questions of assurance and credibility. An illustrative framework of the relationships between the component parts was presented in Section 6.1 (Figure 6.1). The emphasis in this chapter has been on what was done and why. The critical analysis of those decisions (or approaches) is included within the discussion in Chapter 8. This research sits within a wider plan for the development of a complex psychological intervention. Points of learning regarding study design have been considered, therefore, in relation to the application of those insights into future research endeavours.

Chapter 7 – Findings

7.1 Introduction

This chapter reports the data that has been generated by the research. That data consists primarily of – (i) the quantitative material relating to the outcome measures employed within the process of delivery of the Therapy Programme, (ii) the qualitative material arising from the feedback interviews, which relates, both, to the Therapy Programme and to the co-constructive forces at work within the undertaking of the research, and (iii) the checklist- and reflective-data arising from the audit of fidelity. The exploration of the results of the research has, also, had access to demographic data relating to the service user population of the host Early Intervention in Psychosis Service at the point that the research was approved and participants began to be recruited, and, more specifically, those service users who were approached. Finally, the analysis has considered available information relating to participant attendance for the Therapy Programme and, where relevant, details of the circumstances of their withdrawal from the research. This chapter has sought to synthesise those emerging strands of disparate information, together with the researcher's privileged knowledge with regard to the aims and aspirations of the developer of the Therapy Programme, aspects of the progress and interactions of the individual therapies and information arising from the literature review.

This research sits within a wider agenda of developing a unique, novel and complex Therapy Programme designed to address experiences of compromised hope and self-esteem in young people recently diagnosed with a psychotic illness. The primary objective of this particular study was to pilot an early version of the developing Therapy Programme, to evaluate it, primarily qualitatively, and to produce a series of recommendations for its betterment. It was suggested in Chapter 1 that the ideal in the development of any new Therapy Programme is that it is experienced by participant-clients to be accessible and engaging, and as having value. The findings from the research are discussed below with regard to these three aspirations. As noted in chapter 6, there is a hypothesised reciprocity between the second and third of these, in that, someone who experienced the therapy positively is likely to have taken more from it, and someone who perceived the Therapy Programme to have had value is likely to have offered more positive and inspired observations with regard to engagement. Explication of experiences of, and attitudes towards, engagement and perceived value are each addressed by, both, the quantitative and the qualitative data. For the purpose of clarity, the quantitative data will be presented and discussed prior to the qualitative. This chapter is presented in 5 parts.

1. An analysis of the quantitative data relating to demographic characteristics of participant-completers and non-completers, as well as the wider host service, patterns of attendance and of withdrawal from the therapy, and the scores recorded on both formal and informal outcome measures. This information is considered with reference to the three key considerations of accessibility, engagement and the findings arising in relation to the outcome measures employed.
2. The triangulation of quantitative and qualitative data relating to individual participant experiences of the therapy. This section is concerned with narratives at the level of the ‘single-case’.
3. An analysis of qualitative data arising from the feedback interviews of research-completers, with a prioritisation of the collated recommendations for the betterment of the approach. This section is, therefore, concerned with narratives at the level of the ‘group’.
4. An analysis of qualitative reflections on participants experience of the research, with reference to processes of co-construction. This speaks to the subjectivity of the interpretations presented and recommendations made.
5. An analysis of the results of the audit of fidelity, which addresses the question of fit between the Therapy Programme as delivered and that articulated in the Participant Handbook.

It is important to recognise that the sample number of participants who agreed to take part in the research, subdivided into those who completed and those who did not, has been deemed to be too small to support meaningful statistical analysis in relation to questions of significance (Murphy and Myors, 1998). Where tables have been included in this chapter their purpose has been to provide visual comparison of the data. Brief synopses of the research-completer participants and their therapy-journeys are included within section 7.5, which addresses the analysis of participants' experience with reference to individual narratives (point 2 above). Synopses of the research-non-completers are included in Appendix 5A for purposes of comparison.

7.2 Accessibility

'Accessibility' was defined in Chapter 1 in terms of the qualities of invitation, physical availability, conceptual (and language-) understandability and appeal. The Therapy Programme was, by design, delivered flexibly to meet the pragmatic needs of the participant, was offered in a language that was understood by the recruited participants and was free at the point of delivery. Questions of 'accessibility', therefore, can only be approached with regard to appeal and recruitment. They can be examined with reference to the demographic data of those who were approached, comparing the characteristics of those who were recruited with those who declined. Before considering that comparison, however, it is important to establish the representativeness of those approached in relation to the wider population of the host EIP Service. Table 7.1 presents a comparison between those groups with regard to age, gender and ethnicity. A detailed table of the demographic data of all of those approached is included in Appendix 5B. Based on this available data, it might be argued that the pool of individuals directly approached to take part in the research, and to receive the Therapy Programme, was broadly representative of the population of the host service. The only possible difference relates to ethnicity, where there was a slightly greater percentage of British-Asian service-users approached than reflected in the wider population and a correspondingly smaller comparative percentage of individuals who did not have British citizenship.

Table 7.1 Representativeness of Research-Participants – Comparison of the demographic data between those recruited to the study, those approached and the population of users of the host EIP Service

	Users of the Host Service	**Service Users Approached**
Number	373	26
Mean Age **Age Range**	26.33 15-38	25.65 18-36
Gender		
Male	64.0%	65.4%
Female	36.0%	34.6%
Ethnicity		
White-British	51.6%	50.0%
British-Asian	20.7%	30.8%
Black-British	10.9%	11.5%
Other (Non-British)	16.8%	7.7%

Table 7.2 compares the demographic data of those recruited to the research with those who declined. Twenty-six individuals were approached. Eight were recruited. Sixteen declined and two were excluded on the grounds that they did not meet the inclusion criteria. It might be argued that those last two individuals might be included amongst those who perceived the programme to be accessible. Due to the inconsistencies between their self-reports and scores on the completed outcome measures, the decision was made not to include their details in the analysis below. For those who were approached, more detailed demographic data was captured, including information with regard to education leaving age, social living circumstances, employment status and having dependent children.

Table 7.2 Accessibility and Recruitment – Comparison of the demographic data of those who were recruited to the study and those who declined

	Service Users Who Elected Not To Take Part	**Service Users Recruited**
Number	16	8
Mean Age	24.75	27.63
Age Range	18-36	19-34
Gender		
Male	68.75%	62.5%
Female	31.25%	37.5%
Ethnicity		
White-British	43.75%	62.5%
British-Asian	37.5%	12.5%
Black-British	18.75%	0%
Other (Non-British)	0%	25.0%
Employment		
Yes	37.5%	37.5%
No	37.5%	37.5%
Student	25.0%	12.5%
Other	0%	12.5%
Education Leaving Age		
16	25.0%	37.5%
18	31.25%	12.5%
18+	43.75%	50.0%
Social Living		
Family of Origin	43.75%	37.5%
Single Mother	6.25%	0%
Single	37.5%	25.0%
Family of Marriage	12.5%	37.5%
Children		
Yes	18.75%	12.5%
No	81.25%	87.5%

The demographic data suggests that the composition of those who were recruited and those who declined was broadly similar in all dimensions except for those relating to age and ethnicity. With regard to age, those who were recruited were slightly older (mean age of 27.63) than those who declined (mean age of 24.75). In relation to cultural composition, the numbers of Black-British service users approached was representative of the service population, but none agreed to take part. Two non-British service users were recruited (one African and one South-American), a higher percentage than reflected in the group of those who declined. It was noted in Chapter 6, with regard to inclusion criteria, that there has been a suggestion that there might be unique, or idiographic, cognitive-styles associated with different cultural groups and that the specific cognitive-processing of a ‘standard’ CBT programme might not be consistent with all ethnicities. It is possible that the ‘selling’ of the ‘research-and-therapy’ package for this study was deemed to be less attractive to certain cultures and racial groups. Sample numbers are, however, very small and a change in the perspective or response of, even, one person has the potential to dramatically affect the shape of the picture. It is, consequently, difficult to know what might be extrapolated from these observations.

It would be interesting to consider the question of what percentage of those approached considered the Therapy Programme to have appeal. This dimension is not routinely reported within the intervention-literature, but has profound significance to the aspiration of high and equitable accessibility. The design, however, was to approach individuals one-by-one until eight were recruited. The resultant numbers, therefore, cannot offer a percentage factor with regard to appeal. All that can be said is that it took twenty-six attempts before that number was reached.

Questions of accessibility and appeal are complicated, furthermore, by the dual recruitment requirements of a combined package of therapy and research. It is difficult to be sure what factors might have been most significant in influencing the decisions of those approached. Individuals who declined to be involved, having expressed an initial interest, were not formally followed-up to explore those decisions. It was predicted in the designing of the study that some potential participants might be put off by the requirement that therapy sessions be video-recorded for the joint purposes of clinical supervision and the audit of fidelity. A cost-benefit analysis concluded that the impact on recruitment to the study was likely to be limited, that ethical concerns of inequality or discrimination might be mitigated by the offer of 'therapy without research' under a separate organisational care pathway, and that the anticipated benefits of including the video-recording strategy, therefore, outweighed the potential risks. Consistent with this prediction, informal feedback received from the key-workers involved in negotiating recruitment suggested that decisions might have been influenced, at least in part, by this requirement, although none of those approached elected to pursue the 'therapy without research' option. This constitutes a factor specific to the research agenda, and, therefore, not an issue of accessibility or engagement with regard to the Therapy Programme itself. Under those circumstances, it seems not unreasonable to hypothesise that the research components were likely to be more a source of discouragement than appeal. The one possible exception to the above was FH2. An academic-researcher by occupation, in her follow-up interview she expressed an overall sense of enjoyment and satisfaction at having taken part in the research. This view, however, was only verbalised in the context of considerable contentment with her circumstances of the time and an explicitly articulated gratitude for the therapy offered. That perspective was not voiced either at the time of the delivery of the Therapy Programme or in the feedback interview.

In addition, it is not possible to distinguish between different factors that might have influenced appeal. There was no feedback to indicate to what extent it was the unique focus of the Therapy Programme that was significant, or its immediate availability. It should be noted, here, that 'appeal' applies to the agreement to take part in the research, a decision made prior to meeting the therapist-researcher. It is likely that participants will have made some anticipatory judgements about the therapist, based on the introductory letter and information sheet written by him and comments made by key-workers. It is suggested, however, that therapist qualities and the nature of the therapist-client relationship were not significant with regard to the question of appeal.

In summary, the picture regarding accessibility is very unclear. It is possible that the structure, content and focus of the novel Therapy Programme is more appealing to those who are slightly older. It is possible that this form of Therapy Programme is less appealing to those from a Black-British racial background. These questions would benefit from specific and direct investigation in future research.

7.3 Engagement

The question of 'engagement' relates to the experience that the person has of the Therapy Programme, the importance that they accord it and their commitment to seeing the process through to the end. It has been evaluated in relation to considerations with regard to retention within the programme. In this section engagement is explored through examination of the differences between completers and non-completers of the Therapy Programme. Comparisons include – (i) information relating to the contexts of participants' withdrawal from the research, (ii) demographic data, (iii) SUDs data relating to the trajectory of self- and future-evaluations over the course of the therapy sessions attended, and (iv) rates of attendance for therapy sessions.

7.3.1 Circumstances of Participant Withdrawal

Three participants withdrew from the Therapy Programme. Five completed the Programme - including GH5. For each of those who felt unable to pursue the Therapy Programme to its conclusion, there were valid reasons offered for their withdrawal. On no occasion did these reasons directly implicate the content or process of the Programme. MS1 was progressing an appeal against a home office decision to reject his application for status as a refugee. His withdrawal from the Therapy Programme, and, in fact, from all contact with the host EIP Service, occurred in response to information received by him that a deportation order was imminent. AC4 appeared to engage with the Therapy Programme in depth. Her attendance, however, was made inconsistent by concomitant physical health concerns, which were periodically debilitating. Her exit from the programme followed attempts (in the context of increased self-confidence) to renegotiate difficult relationships with her mother and partner. Neither had been supportive of her commitment to the therapy. It is possible that it was these endeavours, and the responses of others to them, which precipitated her withdrawal. MM6 experienced a significant deterioration in his mental health associated with alcohol and substance misuse, was admitted to hospital under a section of the mental health act and, was discharged on a Community Treatment Order (see Chapter 3). This was clearly defined as an exclusion criterion for the research (see Chapter 6). No-one of those who dropped out made reference to concerns about the process of the Therapy Programme or the demands of the research in the period immediately prior to their discontinuation. Neither did any agree to re-engage or to provide feedback regarding their decisions.

7.3.2 Engagement and Demographic Data

In considering comparisons with regard to retention, the dimension of 'Therapy-completers / non-completers' has been given preference over 'Research-completers / non-completers'. A review of the demographic data in Table 7.3 suggests that the composition of the two groups – therapy-completers and non-completers were broadly similar, but differed with regard to two factors – (i) education Leaving Age – in that all therapy-completers had engaged with education until at least 18 years, and four of the five had studied at higher-education levels, whilst none of the non-completers had stayed in education beyond 16 years of age, and (ii) social living circumstances – in that all completers lived with a family of origin or of marriage, neither of the two single participants completed, and the other non-completer lived in a social group that was beset with conflict.

Table 7.3 Engagement / Retention – Comparison of demographic data of completers and non-completers of the Therapy Programme

	Participants who did not complete the therapy	**Participants who completed the therapy**
Number	3	5
Mean Age	27.0	28.0
Age Range	19-34	21-35
Gender		
Male	2	3
Female	1	2
Ethnicity		
White-British	2	3
British-Asian	0	1
Black-British	0	0
Other (Non-British)	1	1
Employment		
Yes	0	3
No	2	1
Student	0	1
Other	1	0
Education Leaving Age		
16	3	0
18	0	1
18+	0	4
Social Living		
Family of Origin	0	3
Single Mother	0	0
Single	2	0
Family of Marriage	1	2
Children		
Yes	1	0
No	2	5

The therapeutic paradigm of CBT has the capacity to be flexible to variations in intellectual and cognitive ability, such that these dimensions are not regarded as criteria by which to determine appropriateness (Whelan, Haywood and Galloway, 2007). Nevertheless, the approach has a strong leaning towards cognitive reflection, psycho-education and academic language. As noted in chapter 5, the delivery of CBT often includes the provision of bibliographic material – books or hand-outs used to provide adjunctive support to the discursive process. All such material for the novel Therapy Programme had been brought together within a participant handbook. Designed to be explored with the therapist as a guide, it was written to a reading age of approximately 17-18, rather than the lower reading age traditionally associated with self-help guides (Martinez, Whitfield, Dafters and Williams, 2008). It is possible that this particular CBT-informed Therapy Programme might generally have been experienced as less engaging, or too difficult, for those with less historical commitment to education. It is, also, possible that the participant resource (handbook) might have, very specifically, been experienced as off-putting – not least if it had been found to be too turgid or complicated. As noted, those individuals who elected to discontinue therapy before it’s completion, also, declined involvement in any research exploration of their experiences. Of the three only one (AC4) discussed with the therapist their decision to withdraw and she did not attribute that decision to any aspect of the educational or conceptual demands of the programme, but, rather, requested permission (which was granted) to keep the handbook as a source of continuing guidance. Of the other two non-completers, MS1 had appeared to engage effectively with, and value, the programme (and reading material) prior to his abrupt disappearance. Only MM6 seemed not to connect with the process and book.

With regard to Social Living Circumstances, research concerning the relationship between emotional environment and relapse would suggest that experienced criticism, hostility and other aspects of high expressed emotion are rarely conducive to an effective recovery from psychosis (Barrowclough and Tarrier, 197; Vaughn and Leff, 1976, 1981). In addition, level of family support might impact on issues of engagement in therapy through two potential pathways – (i) the presence or not of direct family encouragement to continue, and (ii) an interaction between family support and the Therapy Programme.

7.3.3 Engagement and Outcome Measures

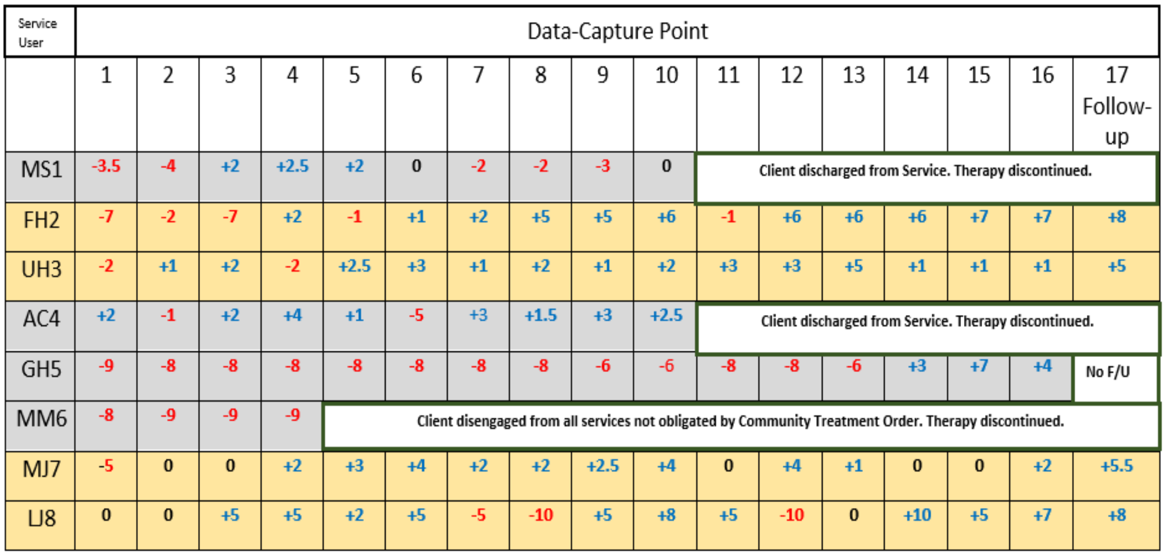
In general, research-completers recorded SUD scores in every therapy session and at follow-up, as well as returning the majority of outcome measures, appropriately completed and on time. Research-non-completers, however, whilst relatively comprehensive in recording SUD scores for those therapy sessions attended, were largely more erratic in returning the more formal outcome measures. Considerations with regard to engagement in relation to the trajectory of scores on outcome measures is limited to a review of the available SUDs data. Tables 7.4 and 7.5, respectively, present the SUDs data for hope and self-esteem for all participants. As noted in chapter 6, SUDs data was captured at the beginning of each therapy session and in the follow-up meeting – resulting in 17 data-capture-points. The two aggregated tables of SUDs data (Tables 7.4 and 7.5) are colour coded. The key to colour is included in the tables. This colour coding offers an immediate visual representation of the aspirational sweep of therapy from red to blue. The left of both tables is dominated by reds and the right by blues. The non-completers show, in general, more red and less blue. The similarity of the two sets of scores is consistent with the central assumption of the Therapy Programme, that there is likely to be a strong element of reciprocity between evaluations of self and the future.

The data encapsulated in those tables is also presented in graphical form, with the trajectories of therapy-completers and non-completers plotted on separate diagrams. Figures 7.1 (completers) and 7.2 (non-completers) present the hope SUDs data, and 7.3 (completers) and 7.4 (non-completers) the self-esteem SUDs data.

Table 7.4 Hope SUDs data from all Research-Participants

Research-Completers are highlighted in brown and Non-Completers in grey.

17 data-capture points – Therapy sessions 1-16, and follow-up.



Service User	Data-Capture Point																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17 Follow-up
MS1	-3.5	-4	+2	+2.5	+2	0	-2	-2	-3	0	Client discharged from Service. Therapy discontinued.						
FH2	-7	-2	-7	+2	-1	+1	+2	+5	+5	+6	-1	+6	+6	+6	+7	+7	+8
UH3	-2	+1	+2	-2	+2.5	+3	+1	+2	+1	+2	+3	+3	+5	+1	+1	+1	+5
AC4	+2	-1	+2	+4	+1	-5	+3	+1.5	+3	+2.5	Client discharged from Service. Therapy discontinued.						
GH5	-9	-8	-8	-8	-8	-8	-8	-8	-6	-6	-8	-8	-6	+3	+7	+4	No F/U
MM6	-8	-9	-9	-9	Client disengaged from all services not obligated by Community Treatment Order. Therapy discontinued.												
MJ7	-5	0	0	+2	+3	+4	+2	+2	+2.5	+4	0	+4	+1	0	0	+2	+5.5
LJ8	0	0	+5	+5	+2	+5	-5	-10	+5	+8	+5	-10	0	+10	+5	+7	+8

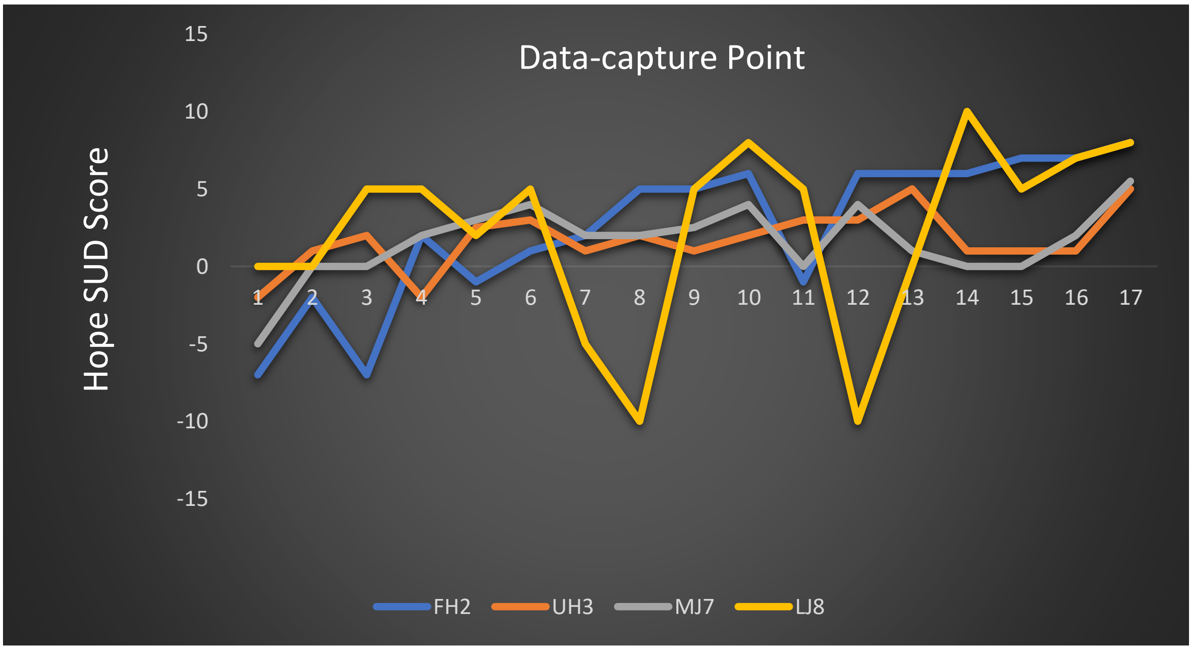


Figure 7.1 Hope SUDs data for Research-Completers

SUDs plotted against Data-Capture Point

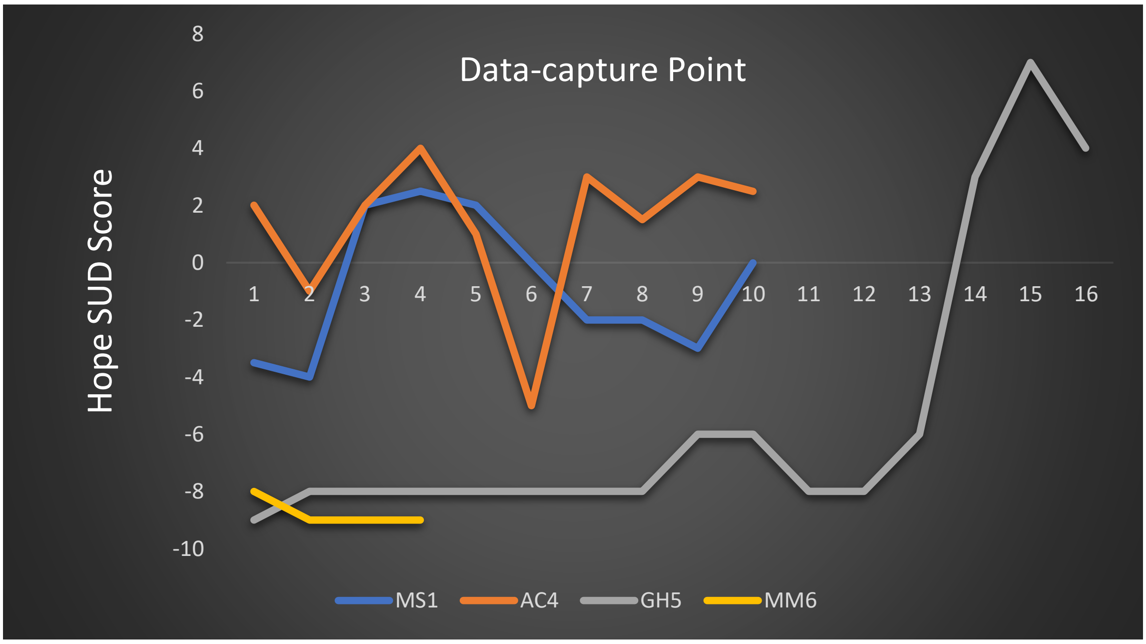
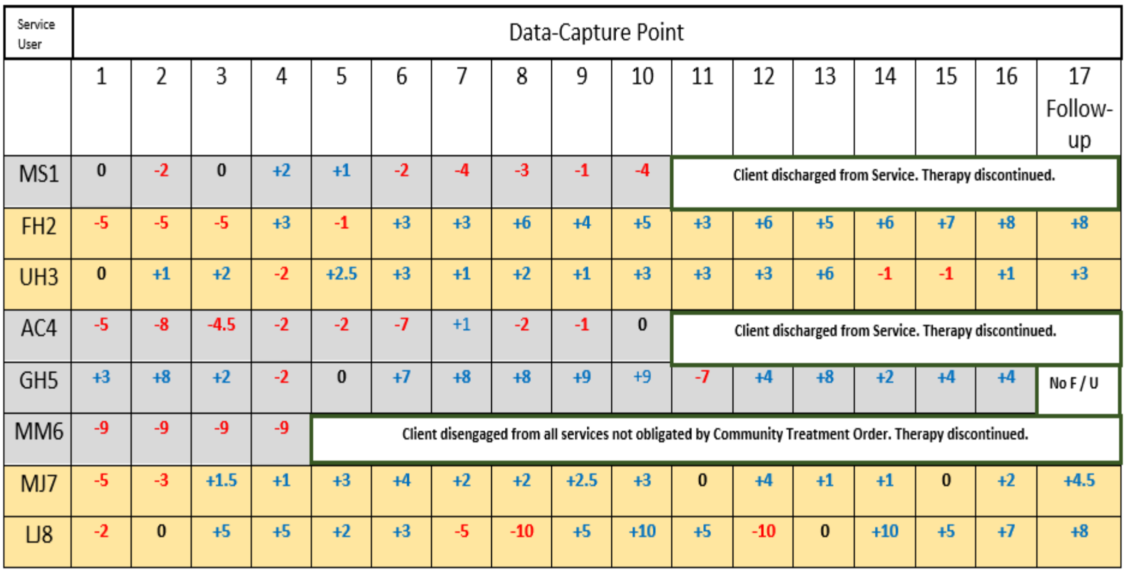


Figure 7.2 Hope SUDs data for Research-Non-Completers
SUDs plotted against Data-Capture Point

Table 7.5 Self-Esteem SUDs Data for all Research Participants

Research-Completers are highlighted in brown and Non-Completers in grey.
17 data-capture points – Therapy sessions 1-16, and follow-up.



Service User	Data-Capture Point																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17 Follow-up
MS1	0	-2	0	+2	+1	-2	-4	-3	-1	-4	Client discharged from Service. Therapy discontinued.						
FH2	-5	-5	-5	+3	-1	+3	+3	+6	+4	+5	+3	+6	+5	+6	+7	+8	+8
UH3	0	+1	+2	-2	+2.5	+3	+1	+2	+1	+3	+3	+3	+6	-1	-1	+1	+3
AC4	-5	-8	-4.5	-2	-2	-7	+1	-2	-1	0	Client discharged from Service. Therapy discontinued.						
GH5	+3	+8	+2	-2	0	+7	+8	+8	+9	+9	-7	+4	+8	+2	+4	+4	No F / U
MM6	-9	-9	-9	-9	Client disengaged from all services not obligated by Community Treatment Order. Therapy discontinued.												
MJ7	-5	-3	+1.5	+1	+3	+4	+2	+2	+2.5	+3	0	+4	+1	+1	0	+2	+4.5
LJ8	-2	0	+5	+5	+2	+3	-5	-10	+5	+10	+5	-10	0	+10	+5	+7	+8

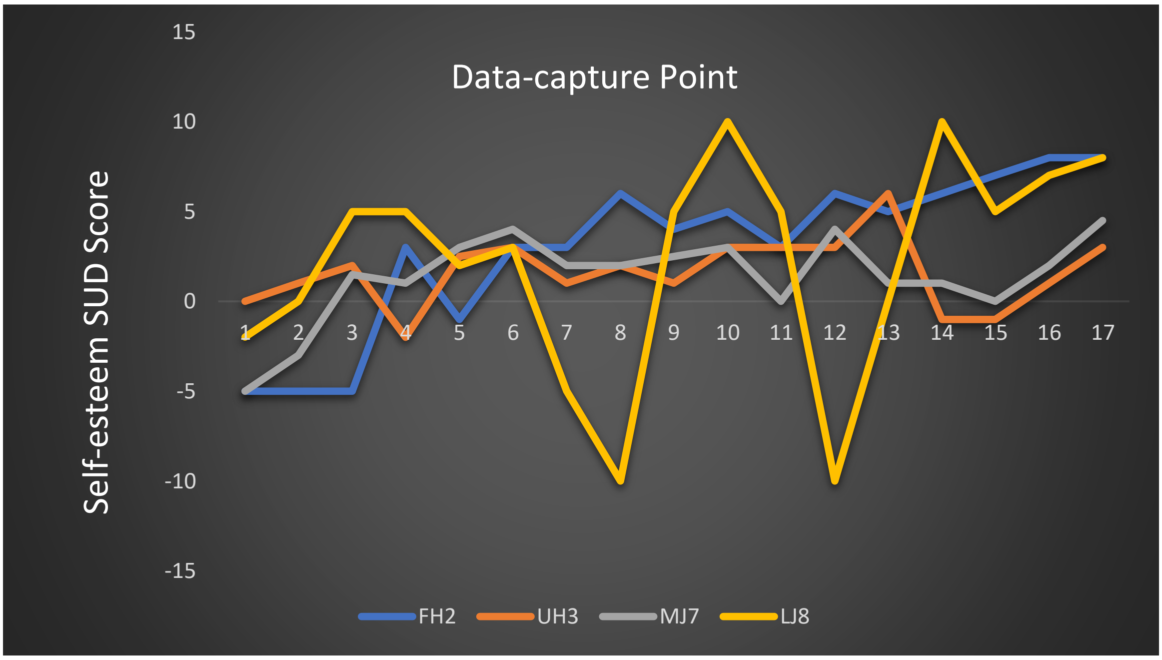


Figure 7.3 Self-Esteem SUDs data for Research-completers
SUDs plotted against Data-Capture Point
17 data-capture points – Therapy sessions 1-16, and follow-up.

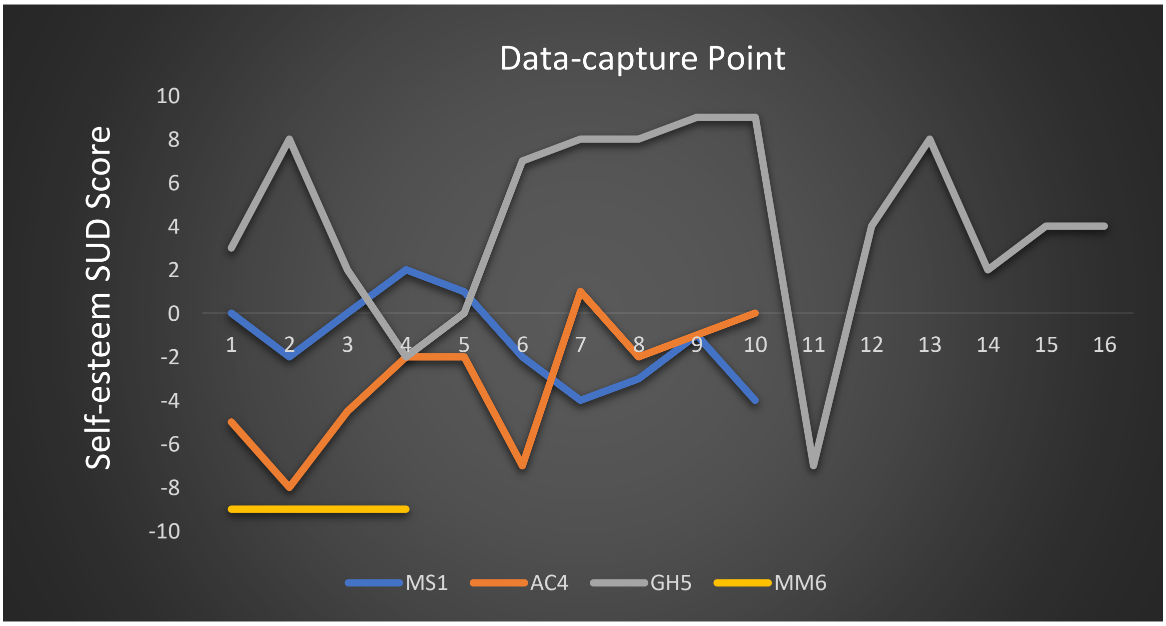


Figure 7.4 Self-Esteem SUDS data for Research-non-completers
SUDs plotted against Data-Capture Point
17 data-capture points – Therapy sessions 1-16, and follow-up.

With regard to the question of engagement evidenced in the trajectories of the SUD scores, the picture is cloudy, but does appear to suggest that completers (with the exception of GH5) showed a slightly different progression of SUD scores to non-completers. All participants experienced some peaks and troughs in their reported scores. The scores of two of the completers (FH2 and MJ7) showed a general and consistent positive progression over the course of therapy. Those of UH3, also, showed consistent progress, peaking in session 13, when he returned to university. Unfortunately, a subsequent brief psychotic relapse was reflected in a significant dip in his reported hope and self-esteem, which had only just begun to ‘rebound’ right at the end of therapy. LJ8’s scores present an overall positive trend, but with considerable volatility and stability did not manifest until after the Therapy Programme was complete. In addition, all completer-participants experienced comparatively positive responses in the very early part of therapy.

Non-completers didn’t appear to achieve any early gains and subsequent progress was very mixed. At the point of withdrawal MS1’s SUD scores indicated an increase of 3.5 points in hope, but a reduction of 4 points in self-esteem. AC4 had only experienced an increase of 0.5 in hope, though +5 in self-esteem (from -5 to 0). MM6 presented with extremely low scores in the first appointment (-8 hope and -9 self-esteem) and had seen no improvement at all at the point that he discontinued. It is tentatively hypothesised that a lack of clear and consistent improvement, in both hope and self-esteem, might have undermined faith in the therapy and therapist to the point that motivation to continue was compromised.

The progression of SUD scores for GH5 high-light an additional point. By his own admission, at the commencement of therapy, GH5 experienced a sense of fragile high self-esteem – in that his view of self was maintained at an artificially high level so long as he restricted his life to a very well-defined path. As therapy proceeded, he began to try more new things and his SUD scores for self-esteem reduced. He was, however, able to recognise that he was becoming more ‘realistic’ in his evaluations and, therefore, perceived the reduction as positive, a perspective that seems to have been reflected in the substantial gains in hope that he reported late-on in the therapy.

7.3.4 Engagement, Withdrawal and Attendance Rates

The Therapy Programme for each participant was delivered in 16 sessions. Table 7.6 compares research-completers with non-completers in relation to the mean-time (and range) that it took to convene each quarter of the therapy. Visually longer average delays experienced in convening meetings from the second quarter onwards appear to predict eventual non-completion of the programme. Attention to the ‘ranges’ shows overlap up to the second quarter, but complete separation thereafter. Sample numbers are too small to allow meaningful statistical analysis and, consequently, a direct association cannot be proven. This does, however, highlight the possibility that later discontinuation from therapy might be anticipated, based on earlier engagement behaviours and might consequently be pre-empted or therapeutically addressed before the event – a consideration that has particular relevance in the context of client tendencies to negative evaluations of self and the future.

Delays were primarily consequent to cancelled or unattended appointments rather than convening issues. A number of reasons were reported, most, though not all, of which reflected aspects of participants’ personal lives - physical health (AC4), children’s holidays (AC4), nuclear and extended family discontent with therapy (AC4), deteriorating mental health (MM6), disengagement from services (MS1 and MM6), venue availability (GH5) and work commitments (GH5). Whilst each individual cancellation might have been considered as legitimate, the collective results seem to suggest that cancellations, non-attendance and the prioritisation of other commitments within the first part of the therapy might have been indicative of ambivalence or compromised motivation.

Table 7.6 Comparison of time between appointments (ranges and means) between completers and non-completers of the Research Programme

	Research Completers	**Research Non-Completers**
Number	4	4
Quarter 1 Number of Days from Sign-Up to Session 4		
Mean	38.5	44.75
Range	33-51	39-59
Numbers of Participants	4	4
Quarter 2 Number of Days from Session 4 to Session 8		
Mean	45.5	116.67
Range	28-90	52-230
Numbers of Participants	4	3
Quarter 3 Number of Days from Session 8 to Session 12		
Mean	35	94
Range	27-48	94
Numbers of Participants	4	1
Quarter 4 Number of Days from Session 12 to Session 16		
Mean	92	196
Range	52-171	196
Numbers of Participants	4	1

7.3.5 Engagement – Summary

In summary the presented data suggests that – (i) Family support might encourage engagement, and in the absence of family, or positive family support, other factors relating to engagement might need to be actively promoted. (ii) Education leaving age might influence attitudes to aspects of the Therapy Programme more associated with academic material. Those undertaking the Therapy Programme who left education early might require additional support to interpret and engage with cognitive and psychoeducational elements, including, but not limited to, those relating to any bibliographic material made available as part of the therapy. (iii) Early gains and a subjective perception of value are likely to promote a sense of engagement. In the absence of these, and especially, when attendance is showing signs of inconsistency, direct attention might need to be given to service-users' experience of the therapy. (iv) Even with good family support, conceptual and intellectual connection with the material, and evidence of gains (and, therefore, value), other contemporaneous factors might still undermine effective engagement. (v) Explicit attention to the therapy process within the Therapy Programme might pre-empt an impending discontinuation.

It is important to acknowledge that there is little that is completely new in any of these observations. The impact on wellbeing of family relationships and the emotional environment of the person's living circumstances is well-established (e.g. Barrowclough and Tarrier, 1997). Equally, the importance of adapting the delivery of CBT to the cognitive and conceptual capacities of clients has been highlighted in, both, the field of learning disabilities (e.g. Whelan et al, 2007) and with reference to culture and language (e.g. Muroff, 2007; Rathod and Kingdom, 2009). Reading age (and associated intellectual capacity) has been a central consideration in the use of self-help literature as an adjunct to CBT (e.g. Martinez, Whitfield, Dafters and Williams, 2008). Finally, 'quick wins' or 'early gains' have been shown to be predictive of better longer-term outcomes in the delivery of CBT with a number of mental health difficulties, including depression (Lutz, Stolz and Koch, 2009), obsessive-compulsive disorder (Krompinger, Monaghan, Gironda, Garner, Crosby et al, 2017), eating disorders (Turner, Marshall, Wood, Stopa and Waller, 2016) and panic disorder (Lutz, Hoffmann, Rubel, Boswell, Shear et al, 2014). These considerations, however, have received less attention with regard to the very specific concern of engagement in therapy. In addition, whilst the articles examined in the systematic literature review (presented in chapter 4) routinely reported attrition, or withdrawal, rates from both the therapy and research process, very little was suggested with regard to the reasons for such withdrawal, either in relation to personal narratives or patterns of demographic characteristics.

It is argued here that the development of an effective therapeutic intervention or programme requires some understanding of the patterns of, and reasons behind, meaningful participant engagement. It is proposed, therefore, that there is value to reflecting upon such questions even where the sample size is very small and, consequently, observations made can only be tentative, with little authoritative power. Reflections arising from this current study, whilst having limited weight in themselves, might contribute to a developing understanding of the issues when built upon by further studies undertaken in the progression of the Therapy Programme under development.

7.4 Findings Relating to the Outcome Measures

In the context of the research design employed for the current study the question of 'findings' has the potential to be contentious. The sample size was extremely small, there was no control or comparison group and participants received extensive concomitant support (TAU) throughout the period in which the therapy was delivered. As a consequence, it is impossible to show causal connection between the therapy and any changes noted. It is important, therefore, to clearly establish from the outset that any changes identified might only be said to have manifest during the period of therapy. No statements of authority or certainty can be, of have been, made concerning the role of the therapy in the occurrence of those changes, irrespective of the subjective judgements or expressed opinions of those involved.

Nevertheless, in the development of any novel intervention considerations with regard to the worthiness of the endeavour, whether focussed on ‘proof of concept’ or issues of generalisation and uptake, will inevitably include evaluations of the capacity of the approach to achieve its purpose. In the case of a psychological therapy programme that judgement of achievement will relate to measures of success in ameliorating the problems against which the intervention is targeted, whether through the subjective perceptions of those involved, attention to the negotiated, behavioural-therapy goals or the employment of outcome measures. In the current study the issue of ‘findings’ has additional significance with regard to the interpretation of participant feedback of experience. It has been suggested (Section 6.3.3) that participants’ memories of their therapy-experiences will exist in recursive relationship with their evaluative-attitudes of the therapy. Participants’ evaluations will, in turn, be informed by their beliefs regarding the degree to which they have achieved the goals identified at the beginning of therapy and to what extent they consider the therapy to have been responsible for any such changes in wellbeing, functioning or circumstances. That association of relevance, it is proposed, will exist irrespective of whether any such causal links might be objectively proven. Questions of subjective perceptions of value, consequently, cannot be disregarded.

In this section the term ‘findings’ is considered primarily with reference to the changes in states of hopefulness, self-esteem and wellbeing manifest in the outcome measures employed. Throughout this section changes are described and discussed with reference to size and pattern, but not to cause. In addition, as explained in 6.3.3, consideration of the scores recorded at follow-up focus on whether achieved gains were subsequently lost (a standard of failure of the programme). The analysis does not engage in hypotheses as to whether such outcomes might be positively attributed to the intervention. Participants’ subjective perceptions of the Therapy Programme with regard to value are discussed in section 7.6. Detailed tables of outcome data are presented in Appendix 5C. Examination of the 'outcome data' from the research speaks to two distinct considerations –

1. With regard to the experiences of each individual participant. It is postulated that the attitudes and opinions regarding the Therapy Programme that were articulated in the feedback interviews would have reflected participants' subjective perceptions of the value of the programme. That would have included the benefits that they believed had accrued from their engagement in the process, manifest, in part, in recorded changes from baseline to end of therapy.
2. With regard to the experiences of participants as a collective. It is suggested that aggregated results might be regarded as speaking tentatively to the issue of 'proof of concept' and, therefore, to the question of whether further development of the Therapy Programme might be justified.

The aggregated quantitative data has been considered in three parts – relating, respectively, to reported changes in experiences of Hopefulness, Self-Esteem and General Wellbeing. Each part considers – (i) A comparison of trajectory - a table of results with corresponding graph which allows visual comparison of the change in scores of individual participants, (ii) Size of Change – a table presenting the aggregated data of the relevant participants, examining change over the course of therapy and at follow-up, using the 3 indices of change as described in Chapter 5 – numerical change, percentage change from baseline and percentage change across the full scale of the measure, and (iii) Clinical Significance of Change – an illustrative diagram showing the changes from pre-therapy to post-therapy and to follow-up, plotted against Jacobson and Truax's (1991) 3 defined cut-offs with respect to the question of clinical significance (see section 6.3.3).

Those sections considering Hope and Self-Esteem include reference to the SUD scores (presented in the previous section), as well as the more validated outcome measures – Snyder's Adult Dispositional Hope Scale (SADHS -Snyder et al, 1991) and Robson's Self

Concept Questionnaire (RSCQ – Robson, 1989). Given the absence of meaningful data relating to the formal outcome measures for research-non-completers, only the recorded scores of research-completers have been considered. For all of the formal outcome measures, SADHS, RSCQ and CORE-OM (Barkham et al, 1998; CORE Systems Group, 1998; Evans et al, 2002), data was collected at 6 points only – as detailed in the associated tables. The SADHS and CORE-OM have a number of composite subscales. To simplify (and emphasise) the presentation of the data, only the total scores are included in the tables below. In the case of the CORE-OM, that is the 'Total Score including Risk'.

7.4.1 Hope

SUDs Data

Table 7.4 (Hope SUDs data) indicates that the 'pre-therapy to post-therapy' changes to the scores of 3 of the 4 research-completers (FH2, MJ7, LJ8) were substantial – a range of +7 to +14 points. The SUDs scores of LJ8 showed considerable oscillation through the course of the therapy. Consequently, the immediate post-therapy score could not be regarded as showing evidence of stability. At follow-up, those gains had been mostly sustained and, in three cases, including LJ8, improved upon, with all 4 research-completers showing changes in the range of +7 to +15.

SADHS Data

Figure 7.5 presents the collective scores of research-completers on the SADHS. Participant LJ8 did not return any completed outcome measures for the 'end of therapy' evaluation. In order to map the graphs, therefore, in each case the week 12 score has been replicated for 'post therapy'. The SADHS was developed to measure traits in hope and was designed deliberately to be less responsive to fluctuations in state-hope associated with factors in the immediate context. In addition, it was completed less frequently than the SUDs ratings. The resultant representations of participant journeys are consequently less volatile. They do support the SUDs data in describing a pattern of substantial gains in reported hope over the period in which the therapy was delivered, although for LJ8 there do appear to be inconsistencies in the scoring of the SUDs and SADHS at points on the journey. Table 7.7 presents the gains recorded by the SADHS for the 4 research-completers – calculated with regard to the 3 defined indices of change. These calculations are offered with regard to changes, both, to the end of therapy and to follow-up. In order to compare with the previous intervention studies (Chapter 4) only for the calculation of percentage change from baseline, the SADHS scores were 'adjusted' from an 8-64 scale to a 0-56 scale.

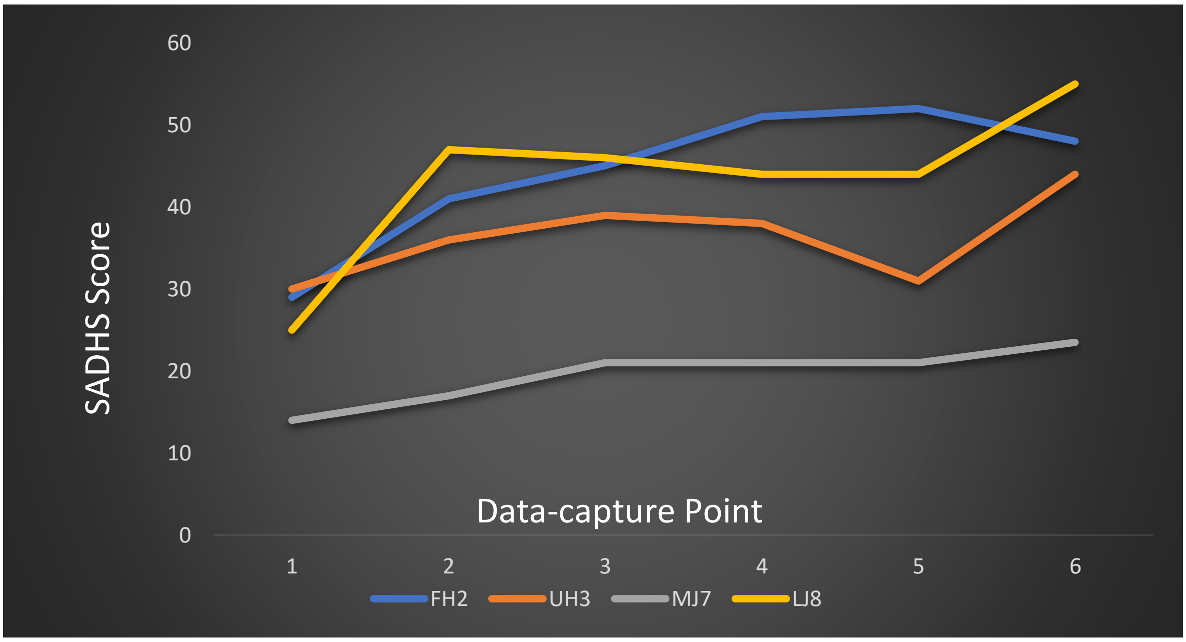


Figure 7.5 Research-Completers - SADHS data

The 6 'data capture points' were pre-therapy, sessions 4, 8, 12 and 16 (end of therapy) and follow-up.

Table 7.7 Research-completers - Changes to SADHS Scores over the Course of Therapy and at Follow-up

		Change to End of Therapy				Change to Follow-Up			
	Baseline Score (Adjusted Baseline Score)	**End of Therapy**	**Point Change**	**% Change from Baseline**	**% Change across the Range**	**Follow-up**	**Point Change**	**% Change from Baseline**	**% Change across the Range**
FH2	29 (21)	52	23	109.5	44.2	48	19	90.5	33.9
UH3	30 (22)	31	1	4.5	1.8	44	14	63.6	25.0
MJ7	14 (6)	21	7	116.7	12.5	23.5	9.5	158.3	15.2
LJ8	25 (17)	44	19	111.8	33.9	55	30	176.5	53.6
Mean			12.5	85.6	23.1		18.13	122.2	31.93
Range			1-23	4.5-116.7	1.8-44.2		9.5-30.0	63.6-176.5	15.2-53.6

Figure 7.6 presents an illustration of these reported gains in SADHS scores with respect to the Jacobson and Truax's (1991) criteria for defining clinical significance. Although participant MJ7 achieved a 116.7% gain from baseline to end of therapy, arising to 158.3% at follow-up, his baseline scores were so low that the changes did not result in a transition across any of the identified cut-offs.

As noted previously, UH3 was only just beginning to recover from his crisis by the end-of-therapy evaluation. He reported only limited overall gains on the SADHS, showing no clinical significance. At follow-up, however, his scores did reflect clinical significance, though at the most lenient level. The greatest gains at end of therapy and follow-up were reported by the two female research-completers. Participant FH2 showed very high clinically significant gains to the end of therapy – crossing both cut-off C and B, as well as both of the population means. The data suggests that only a very small part of that measurement improvement was lost at follow-up. Participant LJ8 reported gains of low clinical significance at the end of therapy, but very substantial clinical significance at follow-up. The SADHS failed to capture the lability of her scores as reported in the SUDs. Consequently, the trajectory of the scores appears to be more steady than perhaps it was. Similar observations apply to her scores with regard to self-esteem.

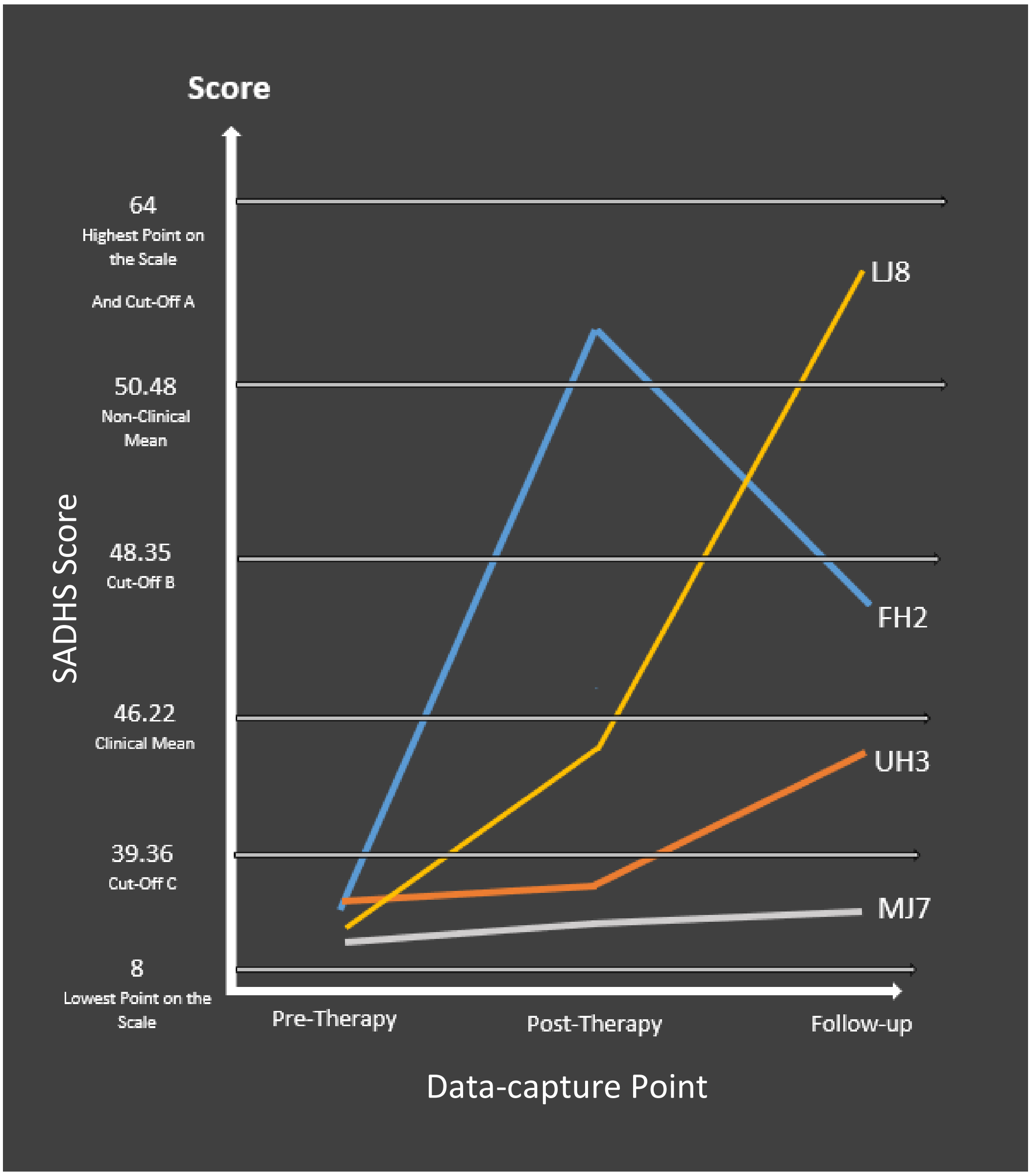


Figure 7.6 Research-completers - SADHS - Evaluating Clinical Significance

7.3.2 Self-Esteem

SUDs Data

Table 7.5 (Self-Esteem SUDs data) indicates that the post-therapy changes to the scores of three of the four research-completers (FH2, MJ7, LJ8) were substantial - a range of +7 to +19 points. As with her hope SUD scores, the self-esteem scores of LJ8 show considerable lability, raising questions about the 'stability' of the post-therapy score. At follow-up those gains had been sustained and improved upon, with all 4 research-completers showing change in the range of +3 to +13.

RSCQ Data

Figure 7.7 presents the collective scores of research-completers on the RSCQ. Table 7.8 presents those gains calculated with regard to the 3 defined indices of change. As before, these calculations are offered with regard to changes, both, to the end of therapy and to follow-up. Figure 7.8 presents an illustration of these reported gains in RSCQ scores with respect to the Jacobson and Truax's (1991) criteria for defining clinical significance. In general, the RSCQ scores support the SUDs data in describing a pattern of substantial gains in reported self-esteem over the period in which the therapy was delivered. As with the previous section there do appear to be some inconsistencies between the SUDs for Self-esteem and the RSCQ as reported by LJ8 at sessions 4 and 8. Her failure to return completed outcome measures for session 12 adds further uncertainty to the interpretation of these mid-therapy reports.

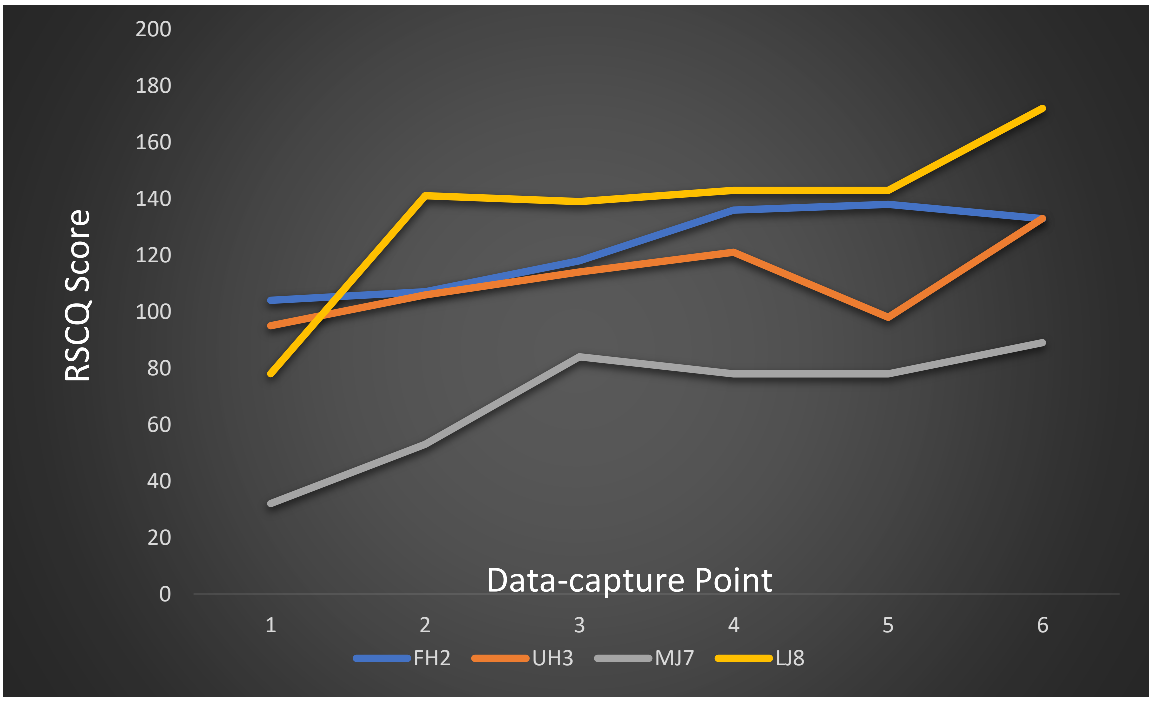


Figure 7.7 Research Completers RSCQ data

The 6 'data capture points' were pre-therapy, sessions 4, 8, 12 and 16 (end of therapy) and follow-up.

Table 7.8 Research-completers - Changes to RSCQ Scores over the Course of Therapy and at Follow-up

		Change to End of Therapy				Change to Follow-Up			
	Baseline Score	**End of Therapy**	**Point Change**	**% Change from Baseline**	**% Change across the Range**	**Follow-up**	**Point Change**	**% Change from Baseline**	**% Change across the Range**
FH2	104	138	34	32.7	16.2	133	29	27.9	13.8
UH3	95	98	3	3.2	1.4	133	38	40	18.1
MJ7	32	78	46	143.7	21.9	89	57	178.1	27.1
LJ8	78	143	65	83.3	31.0	172	94	120.5	44.8
Mean			37	65.7	17.6		54.5	91.6	25.9
Range			3-65	3.2-143.7	1.3-31.0		29-94	27.9-178.1	13.8-44.8

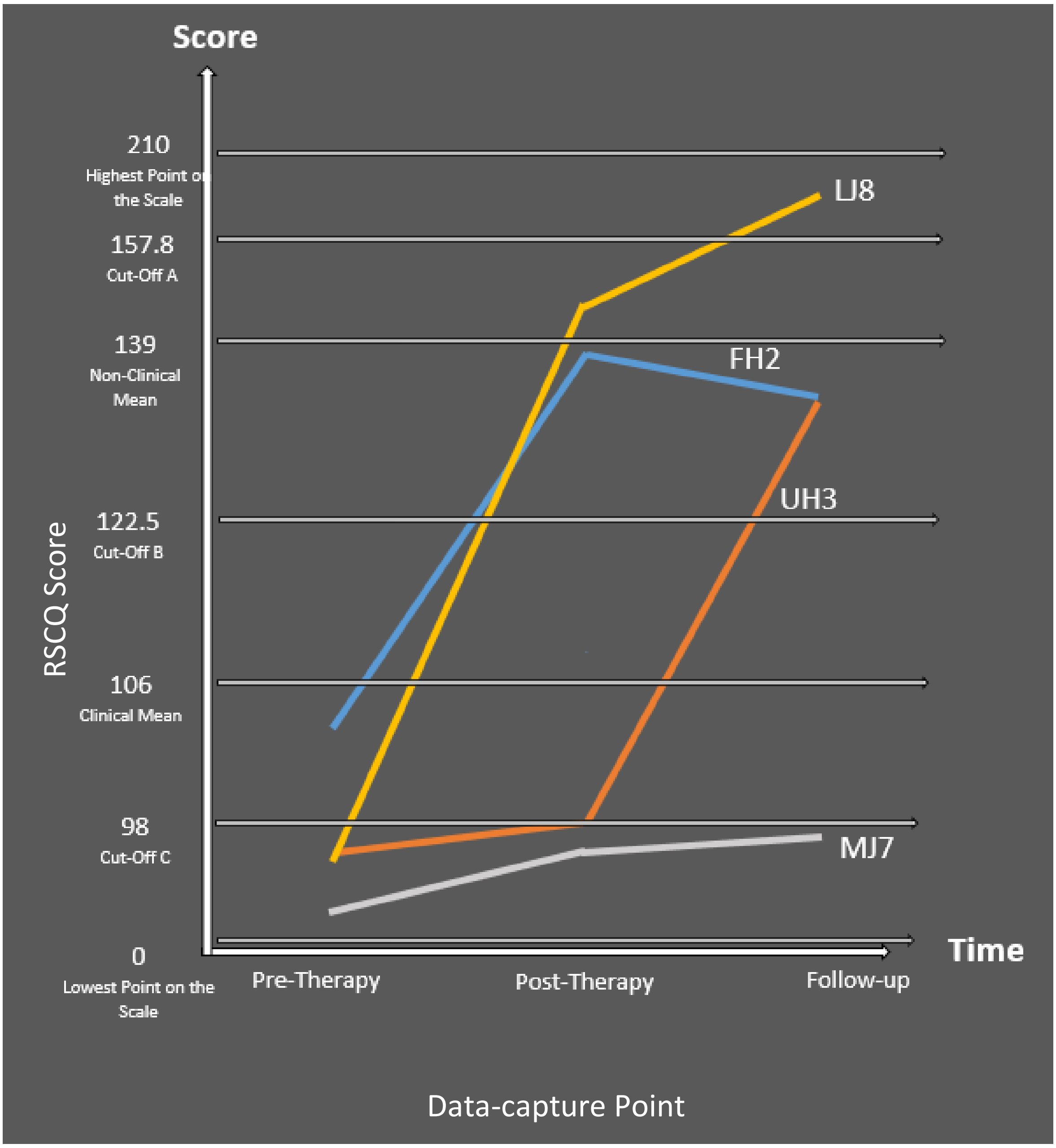


Figure 7.8 Research-completers - RSCQ data - Evaluating Clinical Significance

MJ7, again, achieved considerable (143.75%) gains from baseline to end of therapy, rising further (178.1%) to follow-up. His baseline scores were, however, so low that the changes did not result in a transition across any of the identified cut-offs. UH3, also, reported only limited gains on the RSCQ to the end of therapy (3.2% from baseline), showing no clinical significance. At follow-up, however, his scores did reflect considerable clinical significance, having crossed Cut-offs C and B and moving from below the clinical mean to almost the point of the non-clinical mean. FH2, again, reported changes in scores which reflected considerable clinical significance – crossing Cut-off B, whilst moving from below the clinical mean to almost the non-clinical mean, then dropping back fractionally between the end of therapy and follow-up. Whilst the greatest gains in terms of percentage change from baseline were reported by participant MJ7, the most improvement in terms of scale-point change were evidenced by participant LJ8, who also achieved the strongest clinical significance – moving from below the clinical mean to above the non-clinical mean at follow-up, crossing all 3 Cut-offs in the process. This apparent substantial improvement in self-view is consistent with the improved personal circumstances described in the follow-up interview.

7.4.3 - Wellbeing

CORE-OM Data

Figure 7.9 presents the collective scores of research-completers on the CORE-OM. Table 7.9 presents those gains calculated with regard to the 3 defined indices of change, to end-of-therapy and follow-up. Unlike the SADHS and RSCQ the CORE-OM is 'problem-scored' in that higher scores represent a greater level of difficulty. Improvement in wellbeing (whatever the cause) would, consequently, be indicated by a reduction in scores. In order to allow a direct visual comparison with the Scores reported in prior intervention-studies (Chapter 4), the CORE-OM (only for the purpose of this table) has been adjusted numerically to an 'inverse-problem scored scale'; for example, the score of 1.8 on a problem-scored scale of 4 to 0, becomes 2.2 on an inverse-problem-scored scale of 0 to 4.

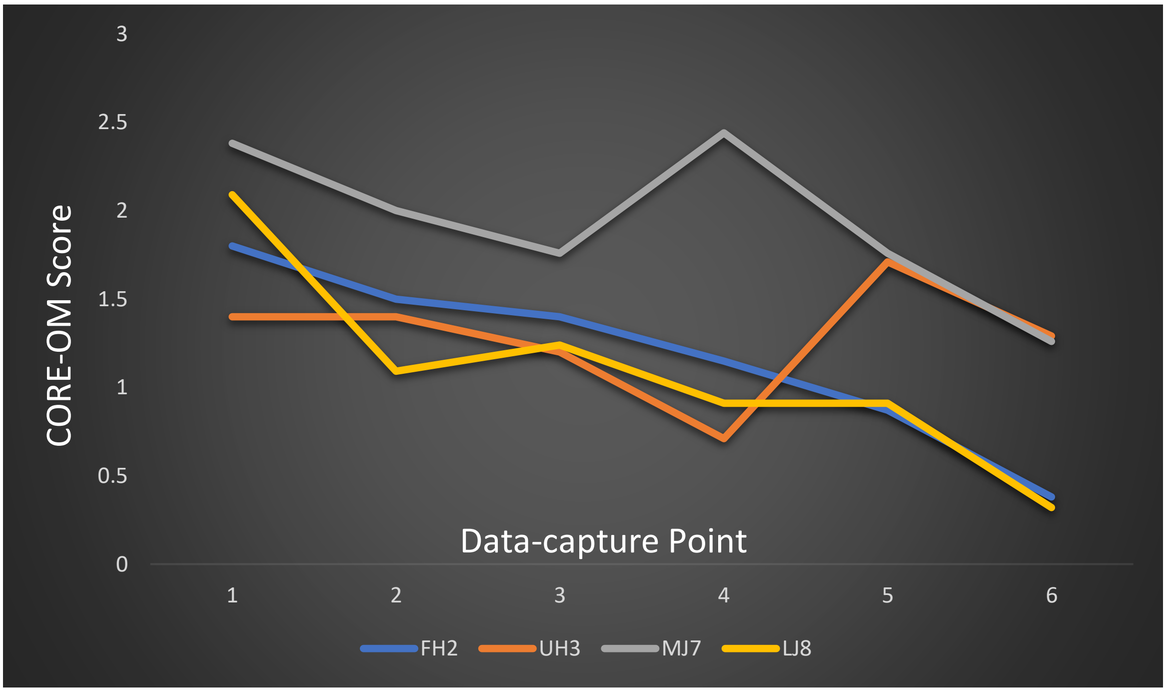


Figure 7.9 Research-completers - CORE-OM data
The 6 'data capture points' were pre-therapy, sessions 4, 8, 12 and 16 (end of therapy) and follow-up.

Table 7.9 Research-completers – Changes to CORE-OM Scores over the Course of Therapy and at Follow-up

	Baseline Score (Adjusted Score)	Change to End of Therapy				Change to Follow-Up			
		End of Therapy (Adjusted Score)	Point Change	% Change from Baseline	% Change across the Range	Follow-up (Adjusted Score)	Point Change	% Change from Baseline	% Change across the Range
FH2	2.2	3.13	0.93	42.3	23.25	3.62	1.42	64.55	35.5
UH3	2.6	2.29	-0.31	-11.9	-2.98	2.71	0.11	4.23	2.75
MJ7	1.62	2.24	0.62	38.3	15.5	3.68	1.77	92.67	44.25
LJ8	1.91	3.09	1.18	61.8	29.5	3.68	1.77	92.67	44.25
Mean			0.61	32.6	16.32		1.11	57.65	27.63
Range			-0.31- +1.18	-11.9- +61.8	-2.98- +29.5		+0.11- +1.77	+4.23- +92.67	+2.75- +44.25

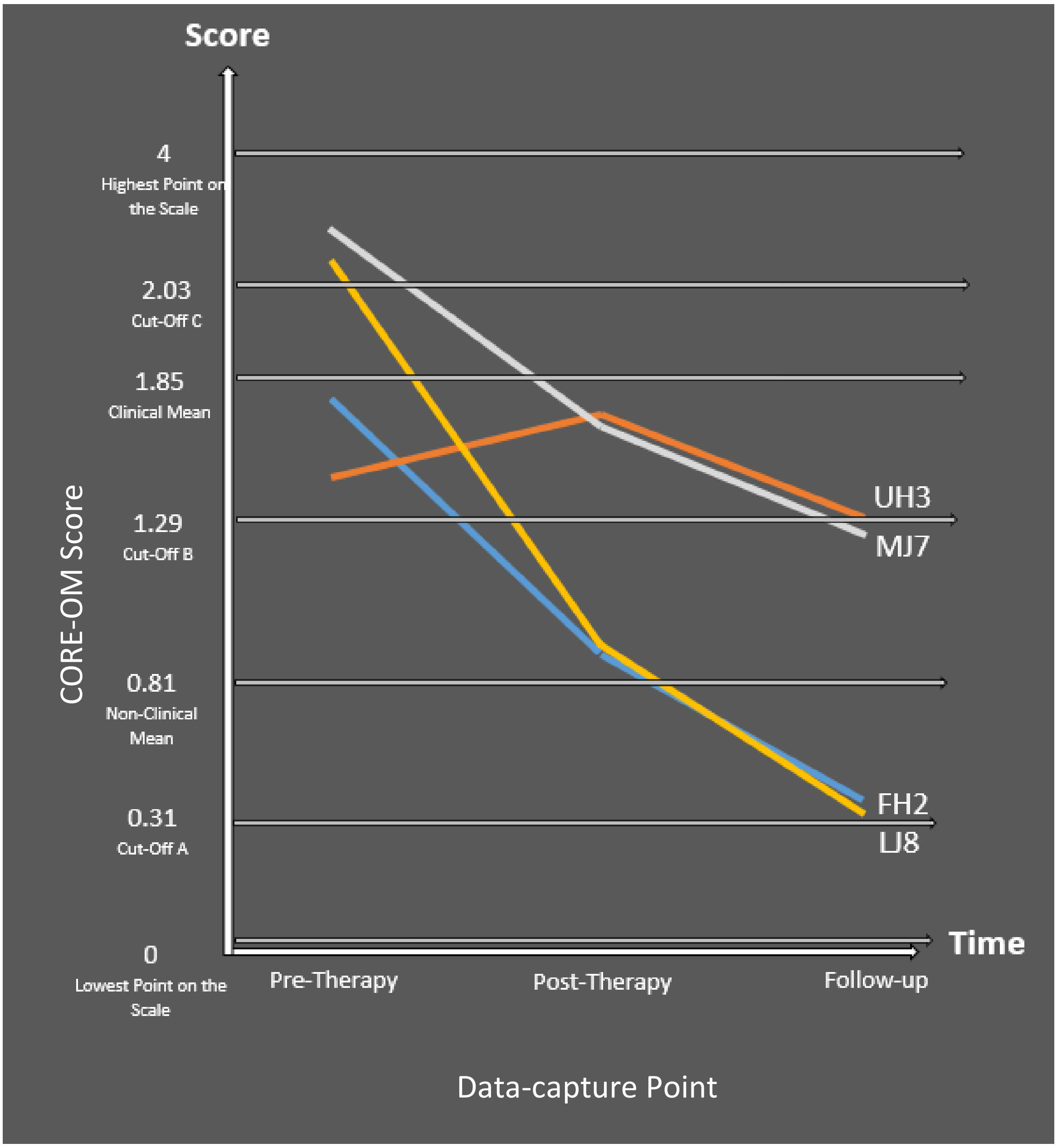


Figure 7.10 Research-completers – CORE-OM - Evaluating Clinical Significance

Three participants (FM2, MJ7 and LJ8) all showed substantial improvement from pre to post-therapy, sustained and progressed at follow-up. For the two female participants (FM2 and LJ8) these gains were fairly consistent and progressive. Participant MJ7 experienced a period of deterioration at session 12, synchronous with an unsuccessful job-interview. Earlier gains were, however, re-established by the end of therapy and extended at follow-up. UH3's circumstances seem to have been reflected in the CORE-OM scores as they were in both the SADHS and RSCQ. Figure 7.10 presents an illustration of the reported 'gains' in CORE-OM scores with respect to the Jacobson and Truax's (1991) criteria for defining clinical significance. With the exception of those reported by participant UH3, the improvements in CORE-OM scores of research-completer-participants showed strong clinical significance post-therapy, rising to very strong clinical-significance at follow-up. Once again, the largest gains were described in the scores of the two female participants.

7.4.4 Findings Relating to the Outcome Measures - Summary

As noted above, the data relating to the findings speaks to two questions –

- Proof of Concept.
- Participants' experiences and valuing of the Therapy Programme.

The quantitative data (supported by verbal feedback in the follow-up meeting) suggests that research-completers achieved negotiated goals, as well as seeing a substantial improvement in hope, self-esteem and wellbeing across the period of therapy and to follow-up. Both the formal and informal evaluation-measures showed progression across the width of the therapy and beyond. The SUDs data (completed in each therapy session) was more sensitive than the validated outcome measures in picking up on changes on a week-by-week basis. For reasons of research design, as already noted, a direct relationship cannot be assumed between the person's involvement in therapy, the scores recorded in the outcome measures employed and the gains experienced by them with regard to wellbeing, functioning and circumstances. Furthermore, the extensive time-delay to follow-up, with the potential for influence from innumerable unidentified or uncontrolled factors, limits any additional observations to the acknowledgement that - those gains achieved during the time that therapy was delivered were not lost in the subsequent period. Nevertheless, it is suggested that the evidence of improvement, concurrent to the delivery of the novel Therapy Programme and not lost at follow-up, supports an argument for further investment in the development and exploration of the approach. This might be said to constitute ‘proof of concept’.

The relevance of those gains to attitudes in the feedback interview is discussed in 7.5 below. One observation from the analysis of those interviews that is important to make here, is that three of the participants (UH3, MJ7 and LJ8) experienced the feedback interview as positively therapeutic, serving, they said, to crystalize the learning from the Therapy Programme and focus attention on maintaining healthy strategies going forward. Unintentionally, it seems, these interviews were experienced as a ‘booster-session’, a point that was expressed explicitly by UH3. Therapeutically this observation supports the possibility of including planned booster sessions in a future version of the programme. With regard to the research design, however, it raises questions about the strategy of ‘seamlessness’ between therapy and research, intended, through familiarity, to encourage greater confidence in participants to speak frankly and critically about their experiences of the therapy. This point is addressed in chapter 8.

7.5 Triangulation of quantitative and qualitative data at the level of the case

In describing the core principles of IPA, Smith and colleagues (1999) emphasise that the credibility of any collective statement or generalisation is dependent upon the integrity of robust engagement with the essence of experience of the individual. They recommend that, where a small group of participants are interviewed, there should be a progression from the idiographic to the normative, with each case being examined in its own right before moving to consideration of connections or patterns across the collective. Within critical realism this perspective is aligned with the need to explore the stratified complexity of experience from ‘underlying mechanisms’ to surface presentation – the words spoken and the layering of meanings behind them.

In this section completer-participants have been considered separately. Individual narratives have been developed through the triangulation of available information. Hesse-Biber (2010) defines triangulation as a ‘convergence of the data collected by all employed methods’ (p26), with the purpose of examining the ‘same dimension of a research problem’ (p2) and creating greater depth of understanding through the complementarity of different data forms. The data available within the current study included participant characteristics, history and motivation at the commencement of their therapy, the therapist’s knowledge and experience of the participant’s unique therapy journey, the quantitative data relating to the recorded scores on formal and informal outcome measures, key themes that emerged from participants’ qualitative reflections on their experiences of the therapy process and aspects of researcher interpretation arising in the IPA analysis of the feedback interviews. Where key-themes are discussed they are organised with reference to the process of interpretative analysis (Step 2) and the framework of collective integration (Step 4) from IPA methodology (Smith et al, 2009), as described in Section 6.3.4. For each participant the data from the three validated outcome measures has been presented in table form. In order to allow a perspective of visual comparison, and consistent with the approach to analysis of outcome data employed in the Systematic Literature Review (Chapter 4), the outcome data from the SADHS (Snyder et al, 1991) and CORE-OM (Barkham et al, 1998) has been adjusted. The SADHS has a range of 8-64. For the purpose of calculating percentage change from baseline (only) the SADHS Baseline Score has been adjusted (in brackets) to a 0-56 range. The CORE-OM is normally problem-scored, with a range of 4-0 in terms of improvement. The scores have been adjusted to reflect an inverse-problem-scored scale, with a range of improvement from 0-4.

The primary point of conversation between the various sources of information relating to each participant, including, in particular, the quantitative and qualitative research-outcome data, concerned participants' experiences of the intervention with regard to judgements as to its value. Those judgements might be said to encompass reflections relating to *engagement* and *value*. In the integration of the different available data, therefore, priority has been given to these two considerations. The integrated individual narrative of each completer-participant includes 3 elements - (i) A brief synopsis of the service-user-participant's therapy journey – including their circumstances at the outset, key problems, goals and prioritised interventions, (ii) Engagement with the Therapy Programme – including participants' patterns of attendance, their critical reflections on the experience of the therapy and recommendations for change, and (iii) Quantitative Findings - with reference to the changes experienced, both, during the period in which the therapy was delivered and the subsequent period until follow-up, incorporating recorded scores on outcome measures, the achievement or otherwise of therapy-goals and other changes to life-style or wellbeing. It is important to re-state here that, in this analysis, no assumptions have been made regarding causal links between the therapy, gains recorded in the repeated outcome measures or benefits accruing within participants' lives. Where the findings relating to the outcome measures have been discussed, the analysis has been concerned with the integrated triangulation of outcome scores with participants' reflections on the therapy and, where made directly, participants' expressed beliefs as to the role of the intervention in the achievement of their therapy goals and altered circumstances.

7.5.1 FH2

Synopsis of Participant Therapy-Journey

FH2 is a female of South-American origin. At the commencement of her therapy she was 35 years old and living with a long-term partner. She had a strong academic background and was employed in a challenging role. English was not her first language and her fluency tended to fluctuate in response to her levels of perceived stress and self-confidence. She was, however, sufficiently articulate and self-expressive to meet the relevant inclusion criteria for the study. There were historical tensions in her relationships with her family of origin, linked in part to issues of gender and power. She described herself as having always felt driven to prove herself. She set very high standards for herself and was deeply self-critical when perceiving herself to be achieving at less than her potential. Her psychosis had presented as infrequent, but severe, extremes of mood (bi-polar disorder), accompanied by delusional beliefs that others were conspiring together to punish her for her failings ('punishment paranoia' - Chadwick, Birchwood and Trower, 1996). At the point of referral her self-confidence at work and in social contexts was extremely low. She was over-working to compensate for perceived poor performance, was consequently tired, struggling with energy and motivation and beginning 'in reality' to not deliver within her role. She was on a probationary contract and, with some justification, was deeply concerned that it would not be extended. Her initial goals for therapy involved improved confidence in dealing with others at work and socially. It was agreed that these might be measured through a combination of psychological wellbeing, evaluated work-performance and relationships with colleagues. During the course of therapy, she identified additional goals relating to her prioritisations in life, in particular the relative balance of importance given to herself as a worker (and academic), partner (or wife), mother, daughter and sister.

Meetings with FH2 were primarily weekly, though with occasional longer durations between sessions to accommodate holidays and other commitments. Key issues addressed by the Therapy Programme included (i) her difficulties understanding the nature of her psychological struggles in general, and mental health problems specifically, which were accompanied by feelings of powerlessness and hopelessness, and an inability to conceptualise operational or practical goals for herself, (ii) the imposition of extremely high standards for herself with regard to vocational performance, social integration and 'intellect', with a tendency to perceive, interpret and dwell on ideas of failure, and (iii) an overfocus on external validation of her worthiness by individuals associated, in her mind, with criticism and power.

Engagement with the Therapy Programme

FH2 attended the therapy sessions consistently, with no cancellations and no non-attended appointments. She was on-time and prepared for every meeting. Homework was completed meticulously. She described the therapy as having been '*really important*' to her. There were two key intersecting themes identified with reference to engagement, and which also ran through her reflections of her difficulty's pre-therapy, her experiences of the therapy, her critical observations of the Therapy Programme and her recommendations for its improvement – (i) knowledge, and (ii) language.

Prior to therapy she said, she'd felt '*lost*' in the '*darkness*' of understanding what was happening to her, and not knowing how to contend with her struggles. She felt powerless, weak, frightened and without energy or motivation. *'It was like a wall in front of your eyes. I was completely lost in the dark.' 'You don't know nothing about this … you suffer from the pathology but you don't know nothing … you don't have any previous training in the problem.' 'When you have this kind of crisis and feel completely low and lost somehow, you might not have the energy to do anything.'* Although supported by her partner, she was in a foreign land, geographically separated from her family, with few friends, and struggling to engage with others. She felt alone, a situation significantly exacerbated by her perceived limitations of language. *'I was isolated before'.*

An intelligent woman, successful academically in her country of origin and other countries of shared language, in the UK she had found herself inarticulate at the depth to which she was accustomed. She experienced herself as less capable and felt diminished in her relationships with peers. This was the case in both employment and social contexts. Her negative self-evaluations were being projected into her experiences of others and she felt embarrassed to present her ideas or opinions for fear of judgement and rejection. These patterns of thought, also, manifested in the therapy relationship. Her experience of that process, especially in the early stages, was organised with regard to the degree to which she felt heard, respected, taken seriously and not judged. She was '*happy*', she said in the feedback-interview, that she had found help. Her principal evaluations of the therapy were, as a consequent, primarily related to these pre-therapy concerns and to her experience of the 'human-qualities' of the therapy process, rather than the specific content of the intervention. *'It was like a real discussion ….it helped me to think seriously about my problems.' 'It was very important that I could find a competent person.'*

Her observations linked ideas of 'seriousness', 'competence' and knowledge – in, both, her evaluations of herself (and fear of the judgements of others) and of the therapist and therapy. Knowledge was associated with status and empowerment and she identified particular value in those elements of the intervention which provided her with a greater sense of understanding. That included discussions of psychosis, hope or self-esteem and of the various strategies employed. Her confidence (and hopefulness) in regard to the therapy were mediated, she said, by her evaluations of the therapist as '*knowledgeable*' and '*competent'*. In her working life and the therapy, these central considerations of knowledge, intelligence and, consequently, self-worth, were made manifest through language. Engagement in therapy, therefore, included careful attention to the negotiation of understandings with regard to, both, the specialist language of the therapeutic paradigm and English as not her first language.

These two themes, also, underscored her critical reflections with regard to the Therapy Programme – picking up on the importance of clarity and understanding in relation to the organisational structure of the programme and the complexity and structuring of language in the Participant Handbook. Regarding the organisation of the programme, she felt, at times, inhibited in her engagement by a lack of clarity in her understanding of the purpose of a particular exercise or the reason for its incorporation at a particular point. '*Sometimes it was a game and I couldn't understand why there was a reason for these different activities'. 'It's difficult to understand why this task is important in this place'*. She insisted that the therapist's use of language was '*proper'*, and attributed issues of understanding to herself. She observed, however, that her engagement with, both, the therapy as a whole and the book specifically, would probably have benefitted from a more explicitly articulated and earlier-presented plan for the 16 meetings of the course of treatment. In relation to the handbook, she noted that the vocabulary and structures of the book were different from '*normal English'*, but, at the same, time, less challenging or technical than the academic texts to which she was accustomed. She, also, observed, however, that she had struggled with the book at the beginning of therapy, finding its size and the complexity of the language-employed to be challenging at a time when her confidence in herself was low. Initially, therefore, it had added to her feelings of inadequacy, whereas later-on in the process of therapy, it was a source of encouragement and an aid to understanding and empowerment. Over-all she felt, she said, that the book was '*really helpful'*, but would benefit from, either, being smaller and less complex in content, or used in a different way.

Findings Relating to Outcome Measures

The quantitative data relating to FH2's scores on the three formal outcome measures (SADHS – Snyder et al, 1991; RSCQ – Robson, 1989; CORE-OM – Barkham et al, 1998) is summarised in Table 7.10 below. See page 293 for the explanation regarding 'adjustment' of the scores.

Table 7.10 FH2 – Changes to Scores on SADHS, RSCQ and CORE-OM over the Course of Therapy

		Change to end of Therapy		
	Baseline	**End of Therapy**	**%Change from Baseline**	**% Change across the Range**
SADHS (Adjusted score)	29 (21)	52	109.5	44.2
RSCQ	104	138	32.7	16.2
CORE-OM (Adjusted scores)	2.2	3.13	42.3	23.25

The scores show substantial, and clinically significant, gains across all 3 measures over the period during which the therapy was progressed (see also FH2's SUDs data - Tables 7.4 and 7.5 and Figures 7.1 and 7.3). These measured changes in her perception of herself with reference to hopefulness, self-esteem and wellbeing were paralleled by significant changes in, both, her psychological processes and her practical circumstances. The former included, in particular, substantial changes in her attitudes to self and the prioritisation of various aspects of her life. The latter included developments with regard to her relationships with her partner, family of origin and manager and her life-style choices. Over the course of the period during which she engaged in the therapy she was able to make significant improvements in her work performance, was offered a substantive contract, received extensive positive feedback from her manager and colleagues and was asked to represent the organisation in international contexts. At the same time, she and her partner reported improvements in their relationship and they began to establish a more socially embedded and active life within this country.

Although it is not possible, given the research design, to speak with authority regarding the causal directionality of these differences, on several occasions during the course of therapy, and in particular in the final appointment (Session 16), FH2 expressed the view that these achievements in her life were directly consequent to the therapy and therapist. However, although her manner and tone and the evaluations offered in the post-therapy feedback interview suggested a positive valuing of her experiences, she did not explicitly verbalise those causal connections at that time. Furthermore, there was a strong suggestion that her openly acknowledged gratitude towards the therapist might have influenced aspects of her reflections in the feedback interview. Although, in response to direct questioning, she did express some critical observations with regard to certain elements of the intervention and handbook, these were presented with a certain amount of hesitancy and were partially retracted when the researcher-therapist probed for more concrete detail.

At follow-up FH2 had become a mother, was in the process of returning to work from maternity leave, and was planning her wedding. The meeting took place in her recently purchased new home and she sat with her daughter on her lap as she talked about her experiences of the therapy and the subsequent period of her life. The outcome scores completed at that time (presented in Table 7.11 below) indicate maintained gains in wellbeing, hope and self-esteem, consistent with two of Jacobson and Truax's (1991) criteria of clinical significance.

Table 7.11 FH2 – Changes to Scores on SADHS, RSCQ and CORE-OM from Baseline to Follow-up

			Change to Follow-up		
	Baseline	**End of Therapy**	**Follow-up**	**%Change from Baseline**	**% Change across the Range**
SADHS (Adjusted score)	29 (21)	52	48	90.5	33.9
RSCQ	104	138	133	27.9	13.8
CORE-OM (Adjusted scores)	2.2	3.13	3.62	64.55	35.5

In that meeting a manifestly contented FH2 spoke with passion and fluency (in English) about her life at work and home over the period since the end of therapy. She described a virtuous cycle of increased positivity towards self and the future, more confident, invested and successful progress at work, a sense of improved work-home balance, a greater closeness to her partner and some initial progress in addressing long-standing tensions with regard to her parents. Whilst directly verbalising the opinion that the Therapy Programme was largely instrumental in these achievements, she, also, identified the importance of a much wider ecology of support. This included a multitude of factors relating to the joy she took in her daughter, the support of her partner, encouragement of her manager and colleagues, willingness of her family of origin to listen to her historical frustrations and the care received from the host EIP Service (TAU). She suggested that they had all intersected with the Therapy Programme to inspire and nurture her transformation. Finally, she noted that, at times of uncertainty during this period, she had used the handbook as a reference-point, a reminder of the therapy, and as a guide for self-management.

7.5.2 UH3

UH3 is a male of White-British origin. At the time of his referral for therapy he was 21 years old, recently back living ‘at home’ with his single mother, having experienced two psychotic crises in comparatively rapid succession. Both had occurred whilst he was attending university in another city. The second of these episodes, approximately 4 months prior to his referral, had presented as a ‘feverish’, confused and agitated mania, accompanied by bizarre, paranoid beliefs and out-of-character behaviour. He was particularly troubled by his poor recollection of events and a lack of understanding as to the cause of the crises. He felt, he said, that this had left him with deep feelings of powerlessness concerning the risks of re-occurrence. He reported an almost overwhelming sense of embarrassment regarding his actions and communications whilst in crisis (those that he could remember and those that he imagined might have taken place) and consequent fears as to how others might now view him. Although previously regarded as academically strong, the period of his mental deterioration had compromised the organisation of his studies. Much of his work in the latter stages of his time at university was un-submitted, unfinished or rushed. Following this second episode, he was persuaded to take time out from his studies.

At the point of commencing therapy, the psychotic and affective phenomenology were largely resolved, but he remained disorganised in his routines. At the behest of his parents he had taken-on a volunteering role, but was otherwise largely un-occupied in any ‘meaningful’ form. In the first assessment meeting he articulated a strongly-held view that his struggles with organisation and motivation were directly consequent to a diminished sense of self-confidence, along-with periodic, but frequent feelings of hopelessness. His TAU prior to engagement in the research had included attention to, both, the nature of psychosis and strategies for preventing relapse. His understandings of his mental ill-health, however, appeared to still be very limited. He held a confused aetiological picture, with attention oscillating between biological imperatives and characterological flaws, and his approach to therapy was compromised by fears of future chronicity and failure. He reported that his university had offered him the opportunity to recommence his studies in the forthcoming autumn, five months from the point at which the therapy was convened. The uptake of his place, he explained, was, however, subject to the successful completion of a series of academic assignments. These were set by his tutors as a test of his capacity to deliver on the course. His issues of disorganisation and compromised motivation, underpinned by hopelessness and low self-esteem, he noted, were impeding his completion of these tasks. This academic agenda created the context for the identification of his therapy goals, the ordering of the delivery of component elements of the programme and the negotiation of a schedule of appointments.

The first 12 therapy sessions with UH3 were convened prior to his return to university and were explicitly framed as preparatory for that eventuality. The final 4 sessions were planned to be convened at less frequent intervals during his first semester. The therapy sessions were offered weekly at the beginning, with the intersession gap increasing through the summer months. Key issues addressed in the therapy included (i) developing a more positive and less self-critical narrative of his illness, (ii) addressing the ‘not-remembering’ of the events of his psychotic crises and helping him to move towards a position of ‘safe-uncertainty’ (Mason, 1993, 2019), (iii) exploring the timeline of his struggles with self-confidence, pre- and post-morbidly, with specific focus on the inter-relationship with his social-engagement and sense of social-belonging, (iv) attention to motivation, with consideration of, both, intrinsic and extrinsic factors, and (v) working towards greater self-discipline with regard to the organisational management of academic, and other, tasks. This last included the development of more effective problem-solving skills, coping-strategy enhancement and activity scheduling.

UH3 was able to complete all assignments required and returned to university in the autumn as planned. He appeared to do well at first, both socially and academically, but experienced a third psychotic crisis towards the end of the first academic term.

Engagement with the Therapy Programme

UH3's 'engagement' with the course of treatment might be said to have followed through three stages. To begin with therapy sessions were scheduled at weekly intervals and held, at UH3's request, in the office of the therapist. The convening of the first five meetings, however, took over two months, with multiple cancelled (and rearranged) appointments. UH3 appeared unprepared for those sessions attended, was inconsistent with homework tasks and, although reporting extensive reading of the handbook, seemed unfamiliar with the material when it was discussed. Early attention to the practical demands of university assignments, which he requested, bore limited success. He became increasingly frustrated. A 'breakthrough' at around the point of Session 5 was associated with his taking more responsibility for time-management and the completion of his first assignment. Although there was a small set-back in the following 2 weeks, this time also saw a significant shift in his attitude to the Therapy Programme. Over the next eight meetings, prior to and shortly after his return to college, his attendance was significantly more consistent, with only one appointment requiring a rescheduling and that because of a competing arrangement to meet with his tutors. The last of these meetings took place 10 days after his return to university and involved a greater-than 4 hours round trip to attend. Unfortunately, shortly there-after he began to experience an insidious deterioration to his wellbeing. His decision, at that time, to increase the inter-session gap intersected with a (subsequently acknowledged) reluctance to 'disappoint' the therapist by admitting to difficulties. Appointments were postponed, but attributed to the progressive demands of his studies. He relapsed. The final three therapy sessions took place after his return home and in the context of a decision to withdraw completely from his course. His final therapy appointments were characterised by an overriding sense of frustration with himself and ambivalence towards the therapy. This picture of engagement with therapy is paralleled by the SUD scores for Hope and Self-Esteem reported in each session (see Table 7.12).

Table 7.12 HOPE and Self-Esteem SUDs Data for UH3 over the Course of the Therapy

16 data-capture points representing Therapy sessions 1-16.

Transition points are highlighted corresponding to the timing of sessions 5 and 13

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Hope	-2	+1	+2	-2	+2.5	+3	+1	+2	+1	+2	+3	+3	+5	+1	+1	+1
Self-Esteem	0	+1	+2	-2	+2.5	+3	+1	+2	+1	+3	+3	+3	+6	-1	-1	+1

The ambivalence discussed explicitly in the final therapy appointments appeared to, also, be present in the early part of the feedback interview. The meeting was arranged to take place at UH3's mother's house. He seemed surprised when the researcher arrived, not admitting to having forgotten, but clearly not prepared for the conversation. At the beginning of the interview he noted that '*at the moment I'm not particularly that happy with how things are going as I seem to be drifting along and not motivating myself to take action or to follow the suggestions about planning out my week …. sleeping until the afternoon lots. I'm just dubious about everything at the moment.' 'It just feels like a huge step back'*. It was unclear whether he blamed the set-back on himself, the Therapy Programme, therapist, or other factors. He was, however, irritable in his presentation and inclined, throughout the meeting, to correct small details in the researcher-therapist's summations. In that context, his valuing of the Therapy Programme was tepid with some suggestion that gains made might have just been a matter of time and 'distance' allowing for a change in perspective – '*It seems like, over the whole time from when I started up [the therapy] until going back to uni, there was a progression where I was kind of moving further away, like further in time from when I had my psychotic episode and, like, learning to view that in maybe a slightly different way, maybe more positively and focus on the progressions to be able to get back to uni in the* *end.'* Asked directly about this, he observed – *'I don't think that's what I was saying in this context really – it was like, with the help of each session, I was going along.'*

In the first part of the interview he struggled to identify any particular aspects of the therapy that had helped things to be 'going along'. *'I mean, I wouldn't say that there's any part of things which was unhelpful and everything had a purpose at each point. I'm trying to think of anything beyond the – I mean the fact of just having the conversations each time and knowing there was an impartial space just to talk about things was useful in itself.'* As he engaged with the discussion, however, he began to talk with more specificity about his experiences of the programme. His reflections were shaped by two key intersecting considerations- (i) organisation, and (ii) the balance of attention to pure and applied elements of the approach, which, for him, also mapped onto a cognitive-behavioural split.

The issue of organisation was central to the experience, and presentation, of his mental health difficulties throughout the course of his therapy, was echoed in his circumstances at the time of the feedback interview, and reflected in his approach therein. It was, also, key to his recollections of the course of treatment and his recommendations for change. In the process of therapy, 'disorganisation' had represented, both, a deficit, consequent to compromised self-confidence, hope and motivation, but, also, a function, allowing a reason, or 'excuse', to delay further self-exposure to the judgement of others. Every step forward in increased competence regarding the discipline of self-management had been associated with identified feelings of increased risk. In his feedback he questioned whether the approach might have benefitted from greater organisation – which he appeared to equate to a combination of increased clarity of explanation and more authoritatively imposed prescription of the composite interventions. The theme of organisation connected further with his thoughts regarding the relative balance of attention given to 'pure', cognitive elements of the programme (see Section 7.6.1 for a more detailed exploration of the 'pure' and 'applied' dichotomy). In the course of therapy, he had argued strongly for an early focus on issues of motivation and organisation and for the need to 'urgently' develop behavioural strategies to address his 'applied' goals, which were related to the time scale of academic demands. That prioritised focus on the ‘behavioural’ and ‘applied’ was reflected in UH3’s observation that ‘*when I was talking about the thoughts and feelings and things, it felt, at the time, more like just having a conversation’. ‘If there wasn’t something like a structured way to go about doing something – it was just talking.’* He noted that he couldn’t ‘*remember reflecting back on anything that had been talked about – only what I was taking away from the sessions – the things I had to do.*’ With regard to his recommendations for improvement of the programme, however, he noted that the balance had possibly been wrong and that perhaps the therapist needed to have been more insistent on addressing the elements of therapy in a different chronological order - ‘*it does make sense to me that, if we’d added the strengths and values in there from closer to the start, maybe not straight away, but that it will have been something to add to each week and go back to briefly, maybe to kind of build up.’*

Of his engagement with the Participant Handbook UH3 noted that ‘*I think at the beginning I probably went away and looked through quite a few chapters’* (note – the book has only 3 chapters) ‘*and tried to get an overview of things and try to figure out what we might do in future sessions and things like that. And then there were other points later in the programme where I had to read something specific, but I didn’t read it cover to cover.*’ He felt, however, that it ‘*seemed to be geared more towards somebody who already had a kind of a psychological knowledge.’ ‘It is accessible, but not in laymen’s terms necessarily. It’s slightly specialised.’* He recommended that it be rewritten as two separate-but-connected, books. ‘*It makes sense to me to have something that is relevant to both the patient and the practitioner; that there’s some common grounds where you can say this is why I’m doing this; so it doesn’t seem like it’s just handed down. But it makes sense to have maybe a separate thing; one thing where there is a more detailed description of everything that’s relevant to the therapist, but a separate thing that is shorter for the patient.’*

Findings Relating to Outcome Measures

The quantitative data relating to UH3's scores on the three formal outcome measures (SADHS – Snyder et al, 1991; RSCQ – Robson, 1989; CORE-OM – Barkham et al, 1998) is summarised in Table 7.13 below. See page 293 for the explanation regarding 'adjustment' of the scores.

Table 7.13 UH3 – Changes to Scores on SADHS, RSCQ and CORE-OM over the Course of Therapy

		Change to end of Therapy		
	Baseline	**End of Therapy**	**%Change from Baseline**	**% Change across the Range**
SADHS (Adjusted score)	30 (22)	31	4.5	1.8
RSCQ	95	98	3.2	1.4
CORE-OM (Adjusted scores)	2.6	2.29	-11.9	-2.98

The scores on the three outcome measures at Session 12, immediately prior to UH3's return to university, indicated improvements from baseline of 36.4% for hope, 27.4% for self-esteem and 26.5% for wellbeing, and those relating to, both, the Core-OM and RSCQ were clinically significant (Jacobson and Truax, 1991). By the end of therapy, however, UH3 had experienced his relapse of psychosis and the hope and self-esteem scores recorded at that time suggest negligible gains in relation to baseline, whilst wellbeing, understandably, showed a deterioration from UH3's circumstances at the beginning of therapy. These 'end-of-therapy' results reflected a picture of unachieved goals, diminished circumstances and uncertainties regarding the future. At the point of departure for university, UH3 had been enthusiastic in his praise for the therapy and therapist, explicitly attributing his feelings of success to the Therapy Programme. In the context of a recent crisis and judgements of failure, he was unclear where to allocate responsibility and made no attributional connections between the programme and his previous sense of wellbeing.

At follow-up the picture was very different. The follow-up scores are presented in Table 7.14 (below).

Table 7.14 UH3 – Changes to Scores on SADHS, RSCQ and CORE-OM from Baseline to Follow-up

			Change to Follow-up		
	Baseline	**End of Therapy**	**Follow-up**	**%Change from Baseline**	**% Change across the Range**
SADHS (Adjusted score)	30 (22)	31	44	63.6	25.0
RSCQ	95	98	133	40.0	18.1
CORE-OM (Adjusted scores)	2.6	2.29	2.71	4.23	2.75

In that meeting a much more relaxed, positive and animated UH3 talked with enthusiasm about his current circumstances. He described himself as '*pleased to have the opportunity to catch-up and to being able to report on all of the changes'* in his life that were reflected in the substantially improved scores on the outcome measures. He had, he said, been employed in the service sector for more than a year, but was in the process of working his notice in preparation for a return to college – a new university, new subject and new mentality. Above all he wanted to talk about his sense of social belonging, of friendships developed and his first romantic relationship. He felt, he said, that the relationship (the young woman) had been the thing that '*changed* [his] *life'*. He expressed thanks, however, for the role that he felt the therapy had played in helping him to have the confidence to '*take the risk*' of seeking employment, reaching out to others and, ultimately, approaching her. He observed that the journey had not been easy and that he had experienced considerable anxiety at times. He made reference to some of the exercises that he had ‘*found myself using’* to deal with his fears and self-doubt. The handbook, he said, had been particularly useful in helping to remind him what to do.

7.5.3 MJ7

MJ7 is a male of British-Asian origin. At the time at which his therapy commenced he was 30 years old, living at home with his parents and two younger sisters. He was unemployed and without direction in life. He had been successful academically at school and into university. That had required a degree of single-mindedness that, he acknowledged, minimised the importance of developing social skills and building peer relationships. At college, away from home, he came to the conclusion that he was lonely and his life out of balance. Whilst continuing to invest energy in his studies, he endeavoured to, also, try to develop friendships and seek romance. His efforts, though, were hampered by issues of, both, low self-confidence and poor practical social competence. He felt inadequate and didn’t know how to go about changing things. He was undertaking a vocationally-defined training which had represented a specific direction of travel since his early teens. The escalating ‘storm’ of emotionality and uncertainty, however, compromised his academic focus and, in spite of several attempts to complete his studies, he was forced eventually to abandon the programme. He returned home, further diminished in his self-view, angry with the world for his failures and without any clear sense of direction for the future. His family, he was certain, were ashamed of his failures and embarrassed by his presence in the house. He became depressed and withdrew, avoiding human contact and making little effort to find employment. That situation continued for the following 7 years. His psychotic symptomology emerged in the context of this picture of minimal activity and excessive rumination and took the predominant form of paranoia, oscillating between suspicion and certainty that his failures had been mediated by the malevolent intent of a fellow student.

In his early contact with the host EIP Service the majority of MJ7’s focus regarding the resolution of his difficulties was on medication. Whilst that strategy appeared to be successful with regard to his psychotic symptomology, his emerging 'insight' contributed to an internalisation of stigma (Yanos et al, 2015) which fuelled a progressive negativity about himself and his future. Prior to his referral for CBT, and inclusion in the research, the package of support from the EIP Service (TAU) had concentrated on his struggles with regard to motivation and goal-setting, and his request for more structured psychological intervention was accompanied by a commitment to seek employment. At the time of his assessment for inclusion in the study, MJ7's scores for hope and self-esteem (measured using the SADHS and RSCQ respectively) were 14 and 32. The principal use of these measures within the research was to establish reported change in the experiences of each individual rather than direct comparison between participants. It is important to acknowledge, however, that the 'cut-off- scores for inclusion in the study were 36 and 106, and that MJ7's baseline scores were considerably more than 2 standard deviations below the means for the 'clinical' population (according to the normative data provided by the developers of the respective measures - Robson, 1989; Snyder et al, 1991).

Although the therapy process was organised in large part by MJ7's desire to find employment (or to return to his studies), he, also, identified goals with regard to his understanding of his experiences, his negative judgements of self across dimensions of physicality, capability and social status and his relationships with others (beginning with his family). Specific interventions included the re-storying of his experiences at university, the detailed deconstruction of his self-judgements and problem-solving regarding the development of effective strategies with regard to the pursuit of meaningful vocation. He held a narrative with regard to his capabilities that he could not complete the challenges that he set himself - that he would '*stop at the last hurdle'*. He identified this pattern in relation to his studies, attempts to find employment, his commitments to attend a gym, and even his plans to go out for a walk. Particular attention was given to the triad of thoughts, feelings and behaviours associated with this pattern of avoidance and its significance in relation to his self-criticisms and feelings of hopelessness. Alongside his involvement in the therapy, he accessed a 'return to work' course facilitated by the local employment centre in collaboration with a private business. The culmination of the course, for those considered to be deserving, was a job-interview. His therapy, consequently, included additional support with regards to the writing of job applications and letters of enquiry to universities, as well as more targeted intervention to encourage opportunities for him to experience task-completion.

Engagement with the Therapy Programme

Although his communication style throughout appeared to play down any sense of significant enthusiasm, MJ7's attendance for therapy was punctilious and committed. He was psychologically-minded, thoughtful and self-reflective in the sessions. He attended each appointment with a clear agenda and all agreed homework was undertaken with evident investment of time and effort. His appointments were regularly spaced and he completed the 16 therapy sessions in a little over 4 months. Asked about his experience of the programme he focused primarily on the human and personal qualities of the process – '*I think just talking openly and because I was talking about new things that I hadn't talked about before. So it was like the first time I was talking about it to someone. I think it helped – just generally having someone listening to you, because you don't usually talk about yourself so much during the day and having someone else talking just about you'*. He also pointed to the importance of feeling able to be open about his concerns, an issue that he identified as particularly significant to his feelings of self-confidence – '*There is something that holds you back. But, because I thought – 'it was therapy', I thought it was best just to come out and say what I was really thinking. I didn't really think about what you were going to think or what you were going to say.*' With regard to his engagement with the programme, he put most importance on (i) 'being taken seriously' – '*you recognised that it was important. That was good. Some people would just say 'oh no – it's just all in your head', but you didn't'. You listened and tried to put things in context. You always came back with another question as if you were really interested and wanted to help*.', and (ii) practical support – '*Well one thing I would say, is like, how I was grateful .. I don't know if that's the right word … pleased perhaps, that you gave me the time and some input into the actual practical side of it as well – like writing that letter to the university – helping me to problem-solve about who to write* *to? Where? What I would say? Because I had sort of messed that up before. I wasn't expecting that help from you and I was glad I came to those sessions. So, thank you for that.'*

The theme of the 'personal' was, also, reflected in MJ7's comments regarding the handbook. He didn't read it from start to finish, he explained, but rather '*went to the page or section that I wanted to read and skimmed it in between*'. He found it, he said, a little too complex in places and too long overall. He thought that it needed to be smaller, perhaps split into two – *'like having all the scientific input in one side, and the studies … I really liked the studies .. you know, where you say – 'this person went through this and that' .. it's really useful for people receiving the therapy. But I would put that in the other side*.' Most significantly, he observed, that there wasn't enough of the person of the author (the researcher-therapist) in the book – '*You need to put in more of your own experience as a therapist. Because then it's like you're talking to the reader one-to-one and you're saying 'this is what I've noticed in people I've worked with'*.'

Findings Relating to Outcome Measures

The quantitative data relating to MJ7's scores on the three formal outcome measures (SADHS – Snyder et al, 1991; RSCQ – Robson, 1989; CORE-OM – Barkham et al, 1998) is summarised in Table 7.15 below. See page 293 for the explanation regarding 'adjustment' of the scores. MJ7's baseline scores for all three measures, as already noted, were low – those for hope and self-esteem being particularly so. Although, therefore, the scores post-therapy indicate substantial percentage changes from baseline, the percentage improvement across the range is comparatively modest. Furthermore, not only did the changes to hope and self-esteem not achieve clinical significance at even the most liberal of the three cut-offs identified by Jacobson and Truax (1991), they didn't even rise as far as the normative means (Robson, 1989; Snyder et al, 1991) for the clinical population.

Table 7.15 – Changes to MJ7’s Scores on SADHS, RSCQ and CORE-OM over the Course of Therapy

		Change to end of Therapy		
	Baseline	**End of Therapy**	**%Change from Baseline**	**% Change across the Range**
SADHS (Adjusted Score)	14 (6)	21	116.7	12.5
RSCQ	32	78	143.75	21.9
CORE-OM (Adjusted Scores)	1.62	2.24	38.3	15.5

These scores appear to reflect the ‘headline’ news with regard to MJ7’s circumstances. He had completed his ‘back-to-work’ training, but had been unsuccessful in his post-course job interview. He had written to four universities to explore the possibility of returning to his studies, but had received flat rejections from two (without even the opportunity to present his case) and was still awaiting responses from the others. In his feedback interview, however, MJ7 insisted that these realities missed part of the point. He pointed out that his attendance for the interview was, itself, a huge achievement for him – ‘*Yeah. I think I was going for that interview and I was thinking – ‘do I really care if I get the job or not?’ Something I do quite a lot is when it gets close to the time, I just close it out and stop. Like, if I’m doing a course, computer course, I will not look forward to it, but will have it in mind that I’m going on that day – and, then, when it comes close to it, I won’t do it. I used to just stop at the last hurdle. I would get to a certain point and then the slightest thing would put me off – do a complete U-turn and say I don’t want to do it. But it was like just – you gave me a bit of a nudge, a bit of encouragement, and I think that’s all I needed really. I can remember what you were saying, like, ‘You’ve done well so far, go to it and see what happens, instead of already making the outcome in your mind’. So now I won’t fall into that trap again. If that’s in work then work. If it’s in education then it will be in that area where maybe I start a course or something, or go to it and keep going to it. I used to miss out on chances – to learn and stuff like that. It’s going to be different now.’* He was, he insisted, pleased with his progress – even if he wasn’t there yet.

The therapy sessions had, at his request, taken place in the therapist's office. He had not wanted to meet at his home, with family members in the vicinity, because of, both, his embarrassment at his own failings and his unhappiness with their historical lack of support. At follow-up he was still living with family, but the circumstances were considerably improved. He had been able to talk with his parents (his father in particular) and address some of what had been left unspoken since his return from university. He felt, he stated, much more supported by them. He asked for the meeting to take place at home. In that conversation he reported that he had been in full-time employment for the previous 12 months, in a role allied to his past vocational training. He had engaged the services of a private tutor to help him to reconnect with his academic work and had now been accepted by a local university to commence a new degree. This progress was reflected in the continuing upward trajectory of the scores reported on the three outcome measures (see Table 7.16 above). The final scores for hope and self-esteem, however, remain not clinically significant.

Table 7.16 MJ7 – Changes to Scores on SADHS, RSCQ and CORE-OM from Baseline to Follow-up

			Change to Follow-up		
	Baseline	**End of Therapy**	**Follow-up**	**%Change from Baseline**	**% Change across the Range**
SADHS (Adjusted Score)	14 (6)	21	23.5	158.3	15.2
RSCQ	32	78	89	178.1	27.1
CORE-OM (Adjusted Scores)	1.62	2.24	2.74	69.14	28.0

7.5.4 LJ8

LJ8 is a white-British woman. At the time of her involvement in the Therapy Programme she was 29 years old, recently married and living with her husband on his family's remote farm. Prior to her marriage she had been employed in a challenging professional role, but had elected to leave that position in order to help her husband and in-laws with the running of the farm and its wider businesses. The couple had been planning to start a family. LJ8 had been given reason to believe that she had conceived, but the 'pregnancy' turned out to be a form of ovarian cancer. In the context of the changes to her social belonging, employment status and living circumstances, together with the perceived threats to her health and her dreams, she experienced a psychotic crisis. The crisis was shaped by an excessive fear of others, and her initial psychotic symptomology was characterised by a combination of persecutory convictions relating to the possibility of 'unprovoked' physical attacks from relative strangers and 'justified' judgemental rejection from her husband's family.

At the point of engagement with the Therapy Programme the primary psychotic symptoms had resolved, leaving her with overwhelming feelings of anxiety, which included a substantial loss of self-confidence and 'desperate' fear of the future. She was described, by herself and others, as having appeared pre-morbidly to be very driven, successful and confident – someone who had always achieved the goals to which she had aspired. The events of her crisis, triggered by and following on from the circumstances of her false pregnancy, had undermined her confidence in her capabilities and physical self. She felt unable to undertake even quite basic or routine tasks. This uncertainty was compounded by her perceived difficulties in her immediate relationships, reflecting, both, a negativity towards self and mistrust of the actions and intentions of others. She was acutely conscious of the stigmatisability (Goffman, 1963) of her circumstances and diagnosis and was anxious about engaging in any social contact outside of a limited family circle. Within those continuing contacts her style of relating had become dominated by reassurance-seeking (hope-seeking). That behaviour, also, came to be reflected in her therapeutic relationship with the researcher-therapist and other members of the host EIP team, and was still somewhat evident in the research-interview conducted following the end of therapy.

Exploration of the timeline of her struggles with self-confidence identified an historical fragility to her superficial high self-esteem. Her positivity with regard to herself had been maintained by the employment of a careful balance between perfectionistic and avoidant coping strategies - or ‘rules for living’ (Fennell, 1999). Her difficulties at the time were compounded by an inability to use attention on success in employment or social positioning to counter-balance her perceived failures as a wife and ‘mother’ and her sense of internalised stigma (Yanos et al, 2015). Her circumstances had stripped away the veneer of self-value, exposing previously unacknowledged and unaddressed insecurities.

Over the course of the five months of her involvement with the Therapy Programme, key issues covered included - (i) working through the previously unaddressed complex of grief and fear associated with the ovarian cancer and ‘loss of her baby’, (ii) deconstructing her pessimistic illness narratives, developing more productive understandings of her crisis and directly challenging her fears of stigma, (iii) exploring the development of her core schema with regard to self - examining ownership in relation to the standards that she set herself and questioning her interpretation of the perceived evidence of her failings, (iv) developing more effective and consistent coping strategies, more methodical problem-solving and a reduction of her tendency to avoidance, and (v) encouraging more invested and sustainable relationships – beginning with increased, open communication with her husband, and extending her trust to wider family and friends.

Engagement with the Therapy Programme

At her request the therapy sessions with LJ8 took place in her own home. She was consistent in, both, her attendance and preparation for therapy, although less reliable, especially at first, with regard to the undertaking of homework tasks, including the completion of the outcome measures. For these she needed to be repeatedly ‘chased’. She appeared to invest particular hope in the therapy and therapist and presented as intensely attentive to the therapist’s observations and reflections. The therapy process reflected her psychological conflict between the desire to achieve and the fear of failure, and the tension between habitual coping strategies to strive for perfection or to avoid. She frequently sought reassurance regarding herself and the future, overtly preferred to receive directed guidance and openly acknowledged that she was least comfortable with those elements of the therapy that required more self-determination. In LJ8’s reflections in the feedback interview there was a clear proximal relationship between her perceptions of risk, fear and personal choice on the one side and control, structure and therapist prescription on the other. She noted that there was a shift in her relationship with these themes as the therapy progressed. At the beginning - ‘*I just didn’t believe in myself then. If you said to me ‘do it’, I would do it. I was more motivated if someone asked me to do something. But, If I did it off my own back, I was a bit – ‘oh – I can’t really’’*. She noted that her engagement with the programme might have been enhanced by greater clarity regarding the overall plan for therapy – *‘An order thing of what we were going to talk about each week. I think I would have really liked that. Sometimes I didn’t know where things were leading. And then I worried …’how am I going to get better sort of thing’. If I’ve got something where someone’s got a plan, if I know that I can get there beforehand and prepare … so, you know, that I’m on board with it.’*

The therapy developed in three stages, equating to ‘steps’ in her engagement with life - (i) renegotiating her relationships with her husband and in-laws, (ii) returning to ‘meaningful’ employment, and (iii) moving on from a reliance on the therapy and therapist. Each step was associated with a progressive increase in self-confidence, less necessity for the therapist to be directive, and less need for reassurance. Each transition from one stage to the next, however, was associated with a transient, but substantial challenge to her self-confidence and sense of hopefulness. The first two such ‘set-backs’ were captured by her SUD scores, which were reported on a session-by-session basis (see Table 7.17 Below).

Table 7.17 HOPE and Self-Esteem SUDs Data for LJ8 over the Course of the Therapy

16 data-capture points representing Therapy sessions 1-16.

Transition points (and associated 'set-backs') are highlighted corresponding to the timing of sessions 7/8

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Hope	0	0	+5	+5	+2	+5	-5	-10	+5	+8	+5	-10	0	+10	+5	+7
Self-Esteem	-2	0	+5	+5	+2	+3	-5	-10	+5	+10	+5	-10	0	+10	+5	+7

The third was evident in the feedback interview, characterised by repeated interruptions with requests for reassurance – (i) about her job and the driving it entailed - *'What do you think about the 40 minute journey? What would you suggest?'*, (ii) about her diagnosis and mental health difficulties - *'Do you think …. are there many people that you see that are similar to me .. in my situation?'*, and, towards the end of the feedback interview, (iii) about the possibility of further support in the future – *' Am I going to be having more sessions or something?'*. In relation to the last of these, interestingly, there was, also, some evidence of a recognition for the need for greater self-reliance – *'I don't know whether things just need leaving now. Whether I just need to get on with my life.'*

Findings Relating to Outcome Measures

The quantitative data relating to LJ8's scores on the three formal outcome measures (SADHS – Snyder et al, 1991; RSCQ – Robson, 1989; CORE-OM – Barkham et al, 1998) is summarised in Table 7.18 below. See page 293 for the explanation regarding 'adjustment' of the scores.

Table 7.18 – Changes to LJ8's Scores on SADHS, RSCQ and CORE-OM over the Course of Therapy

		Change to end of Therapy		
	Baseline	**End of Therapy**	**%Change from Baseline**	**% Change across the Range**
SADHS (Adjusted Score)	25	44	111.8	33.9
RSCQ	78	143	83.3	31
CORE-OM (Adjusted Scores)	1.91	3.09	61.8	29.5

The data collected using the validated outcome measures failed to capture the lability of her states of hope, self-confidence and wellbeing over the course of therapy. They indicate considerable gains with regard to each consideration – with clinical significance at Jacobson and Truax's (1991) Cut-off 'C' for hope, and, both, Cut-offs 'C' and 'B' for self-esteem and wellbeing. As noted previously, these gains reflect changes during the period in which the therapy was delivered. They do not offer evidence of a direct link between the therapy and the gains experienced. It is, however, important to note that the fluctuations in SUD scores (both increases and decreases) occurred in direct temporal proximity to the challenges and achievements of key therapy and life goals.

In the feedback interview LJ8 noted that she had '*had a little doubt [about the therapy] sometimes. Sometimes I felt like … 'is any of this going to help me to get better?' … I couldn't see how just by talking it would help. But I found it easy just you coming around and talking and just giving me exercises that I should be doing. And that was good enough for me. But, in the end, I think that it's been really helpful. Obviously, it's been helpful.*' The hesitance in that final statement reflected her sense of only partial success – her situation was better, but she was still very concerned about a relapse – both in relation to her psychotic crisis and lost confidence. '*I am hoping that this is it. I don't want …. I am just hoping …. I am just hoping that this is towards the end, and I'm not going to have to go back. …. That it's not going to happen again.*'

Her confidence for the future, to the extent that she could believe in it, was rooted in specific changes in her attitudes and her approaches to her circumstances, in particular (i) an approach to life generally that was less risk-averse and less avoidant, (ii) an increased capacity to recognise the positives in herself and her life, and (iii) a changing perspective towards her illness. The increased preparedness to do more was, she said, directly consequent to, both, the ability to use positive-data-logging to rebalance occasions of negative rumination and the capacity to regard her recent difficulties with less self-blame and a greater sense of normality. With regard to her focus on positives she noted that – *'I'm better at trying to pick out the positives. I keep saying all of the time, like when I find myself feeling down .. I kind of say to myself .. 'well, I live on a farm. I've got no money worries. I might be driving a distance to work, but I'm doing because I want to – not because I have to. And I'm enjoying it'. Though .. I've been meaning to do it more than I am. I don't think I do it enough.'* Of her attitudes to illness she observed that, previously, she had been so concerned about the idea of psychosis, and other people's judgements, that she had '*shut it [the handbook] in a drawer, out of sight.'* Now, she said, '*I always remember the graph that you did … about the stress and vulnerability thingie … that's totally stuck in my head. I even showed my friend the other day. I said – 'Everybody's on this. It's not just me.'*

At follow-up LJ8 was still employed by the same company, a job that she described as enjoying immensely and missing (as she was on maternity leave, having recently become a mother). She reported her marriage to be much stronger and her relationships with her husband's family less tense. She had difficulty, she said, remembering her previous problems. Her scores on the three measures at that point are presented in Table 7.19 below. Her reported settled confidence in, both, herself and her future is matched, in the numbers, by a picture of sustained (and, in fact, increased) gains. At this time all three measures indicated clinical significance at, at the least, Cut-off's 'C' and 'B' and, in each case, scores had progressed from substantially below the normative means for the clinical population to above the normative means of the non-clinical population.

Table 7.19 LJ8 – Changes to Scores on SADHS, RSCQ and CORE-OM from Baseline to Follow-up

	Baseline	End of Therapy	Change to Follow-up		
			Follow-up	**%Change from Baseline**	**% Change across the Range**
SADHS (Adjusted score)	25 (17)	44	55	176.5	53.6
RSCQ	78	143	172	120.5	44.8
CORE-OM (Adjusted scores)	1.91	3.09	3.68	92.67	44.25

In this meeting, LJ8 did not directly or exclusively attribute the identified gains, in her scores and life circumstances, to her involvement in the Therapy Programme. She talked extensively of her husband's enduring support and her greater appreciation for his family and her friends. She did, however, she said, want to express her gratitude for the therapist's help.

7.6 Participants' Experiences of the Therapy Programme

The strategies of data collection and analysis described in chapter 6 evidence the commitment of this research to understanding the individual narrative. The previous section explored elements of those individual narratives with reference to the triangulation of data arising from, both, the quantitative and qualitative strategies of the research. The primary purpose of the research, however, has been to generate a caucus of collective recommendations for the betterment of the Therapy Programme. The emphasis of this results chapter, therefore, is on the aggregation and integration of those individual stories. This section explores these collective participant experiences with regard to (i) the content of the Therapy Programme, (ii) the process of delivery of the Therapy Programme, (iii) he Participant Handbook. It has sought to present a coherent narrative, synthesised from the various strands of available information - participants' direct comments, researcher's interpretative reflections, available quantitative data relating to those considerations, the content and nature of conversations progressed during the delivery of the Therapy Programme, the researcher's aims and aspirations with regard to the novel Therapy Programme and the theory and evidence garnered from the literature review.

The observations of participants were wide ranging, with numerous aspects of experience considered. Word-limitations in the writing of this thesis exclude the detailed examination of all points raised. Priority attention has been given to those issues that have been adjudged to offer the greatest informative and instructive benefit. That agenda has been focussed towards understanding the impact of the Therapy Programme and improving its potential accessibility, engagement and efficacy for future recipients. For each aspect of experience explored there is a linked table in Appendix 5D, presenting relevant specific reflections made by participants.

7.6.1 Experiences of the Content of the Therapy Programme

Within the super-ordinate category heading of 'experiences of the content of the therapy', the two key themes considered in detail are -

1. The conceptualisation and balance of 'Pure' and 'Applied' elements within the delivery of the approach.
2. The importance of challenging unhelpful, pessimistic and self-stigmatising understandings of psychosis and encouraging the development of more hopeful, self-compassionate and productive illness-narratives.

‘Pure’ and ‘Applied’ elements of therapy

The term ‘pure’ was coined to refer to strategies that specifically targeted the constructive elements of hope and self-esteem. Such interventions were primarily concerned with attitudinal (or cognitive) change and any behavioural elements were focused directly towards the enactment of those changes within the person’s immediate environment. The term ‘applied’, in contrast, was used to define interventions in which the gains in self-esteem or hope were directly linked to more meaningful and operationalised goals – primarily in the realms of vocational, social or health functioning. Neither term was regarded as relating exclusively to one construct only, but it was noted that the attention within Hope Therapy towards achieving wider life-style aspirations inclined it more to an ‘applied’ focus (Cheavens et al, 2006; McDermot and Snyder, 1999).

As noted in Chapter 5, the novel Therapy Programme was developed with the explicit aspiration of achieving sustained gains through the utilisation of ‘applied’ ideas from McDermott and Snyder (1999), Rosenberg (1965) and Fennell (1999, 2016). In practice that aspiration was operationalised through assertive identification of meaningful life-goals in the early stages of therapy, the explicit linking of existing negative evaluations of self and the future to any prior failure to achieve those goals and a persistent interweaving of attention to evaluative attitudes and life goals throughout the course of the Therapy Programme. These applied goals were seen to be reciprocally interlinked with negativity about self and the future.

To an extent participants’ articulations on the distinctions between ‘pure’ and ‘applied’, along-with the researcher’s reflections, mapped onto a cognitive-behavioural split. ‘Pure’ elements were associated with psychological processes and the ‘applied’ to behavioural approaches to living. It is, however, important to appreciate that ‘pure’ elements of hope and self-esteem were seen as being maintained by, and maintaining of, behaviours that were one step at least removed from what might be regarded as key goals of living. Equally life-style behaviours were considered to be rooted in cognitive and affective aspects of decision making. The constructs were also defined in relation to the distinction between ‘process’ and ‘content’. The ‘pure-process’ appeared to be associated with changes in evaluative attitudes which unpinned a raft of relationships with others, things and ideas, and the ‘applied-content’ to the very specific selected targets of life-change.

Participants identified value in ‘applied’ conversations about marriage (FM2 and LJ8), motherhood (FM2 and LJ8), the possibility of romantic relationships and access to sexual intimacy (UH3), academia (FM2, UH3, MJ7 and LJ8), employment (FM2, UH3, MJ7 and LJ8) and the management of mental illness (UH3 and LJ8). They included in their validation therapeutic elements relating to project and time management (UH3), problem-solving (UH3), encouragement (a nudge) to attend an employment interview (MJ7), practical guidance and support in making an academic application (MJ7), and rehearsal of potentially difficult conversations, with an estranged sibling (FM2) and new work associates (LJ8).

Attention to questions of conceptualization was primarily a function of the critical interpretative process. Participants reflected much more on the comparative balance and ordering of ‘pure’ and ‘applied’ elements within the course of the Therapy Programme. These two points, order and balance, appeared to have been inextricably interlinked. It was observed, directly or indirectly, in the interpretative reflections of all feedback-interviews that the first few meetings had a disproportionate influence on the progress and experience of the therapy as a whole. There were competing arguments for using the first few meetings to establish the capacity for more positive evaluations of self and the future, or to achieve some quick behavioural ‘wins’, in order to encourage greater hopefulness in the therapy.

The plan made in the devising of the Therapy Programme was that early interventive conversations would focus on the examination of specific experiences of hope and self-esteem, before attention to ‘applied’ change. Those two completers (FH2 and MJ7) whose therapy most conformed to that plan both remembered the ‘pure’ aspects of the

Programme in detail and evaluated those elements particularly positively. ‘Applied’ aspects of therapy were still accorded significance, but within an appreciation of the central importance of internal change. UH3 and LJ8, however, began the Therapy Programme in circumstances of greater immediate pressure with regard to ‘applied’ aspects of their circumstances and this skewed the early conversations towards a more rapid engagement with those practical considerations. For both, the primary focus of their feedback comments was on the importance of achieving changes in their external circumstances. Their feedback suggested that attention to the ‘applied’ was experienced as highly engaging and was associated with comparatively rapid achievement of identified goals, but fragility with regard to those gains. They suggested, however, that that focus did tend at times to overshadow the ‘pure’ elements, even when the relevance of the ‘pure’ had been established early. Attention to ‘pure’ aspects of the Therapy Programme, progressed later in the process, was regarded positively, with the strategies being seen as helpful in providing a scaffold or splint to strengthen the embedding of gains. Both participants commented that they might, in retrospect, have benefitted from earlier discussion of these themes.

Encouraging hopeful, self-compassionate and productive illness-narratives

It has been argued that evaluative attitudes in the aftermath of a psychotic crisis, or following the diagnosis of a psychotic illness, are likely to be shaped by the nature of the illness narratives to which the person has been exposed. The tenor of self- and future-directed evaluations in the narratives of psychosis are especially linked to understandings regarding aetiology and prognosis, which might be regarded as reflecting the key dimensions of the psychosis illness-journey.

In all feedback interviews participants raised issues with regard to their experiences of engaging in such conversations. In each case reflections were offered directly, without encouragement from the researcher-therapist. All supported the view that engagement with these questions had been of particular importance in the over-all progression of their therapy. Individuals differed, however, in the specifics of their judgements. Attention to narratives of illness included (i) the provision of knowledge in the relative absence of understanding, (ii) the development of deeper understanding in situations of 'insufficient' detail, (iii) the promotion of more accurate stories in situations where participants had accumulated and, on occasion assimilated, incorrect, apocryphal or mythical information, and (iv) the introduction and nurturing of more hopeful stories, where participants had previously bought into a 'version of facts' that organised a tendency towards pessimism, self-blame or perceptions of brokenness, or that emphasised statistical probabilities with regard to dangerousness, deteriorating functionality and poor prognosis.

The first two of these perspectives might be regarded as reflecting degrees of deficit within a continuum of knowledge. The latter two draw a distinction between publicly available stories which are consensually deemed by mental health professionals in the field to be incorrect and those perspectives adjudged to be unhelpful according to the criteria reported in Chapter 3, but which are associated with division within the field. Lack of knowledge, incorrect understandings and stories that emphasise negativity can all be experienced as dis-empowering. Re-empowerment, it might be argued, benefits from a deeper understanding of the condition. One of the outcomes reported by all participant-completers during therapy, in the feedback interview or at follow-up, was their sense of engagement with a more empowered and optimistic appreciation of their difficulties.

7.6.2 Experiences of the Process of Delivery of the Therapy Programme

Within the super-ordinate category heading of 'experiences of the process of delivery of the therapy' the two Key Themes considered in detail have been –

1. Reflections on structure, flexibility and fidelity.

2. The manifestation of hopelessness and compromised self-esteem in the dynamic of the therapy.

Reflections on structure, flexibility and fidelity

The theme of flexibility and structure emerged in the interpretative reflections of the qualitative analysis in relation to two interconnected, but distinct, threads – (i) Structure and flexibility, collaboration and the place of prescription of elements of the Therapy Programme, and (ii) Structure and flexibility, fidelity, credibility and the potential replicability of the approach. The first of these is concerned with the experiences of the participants and therapist in the dynamic of doing therapy. The second relates to the wider agenda of developing a Therapy Programme that might be progressed in further research or that might be delivered by other clinical practitioners.

The question of structure and flexibility with regard to collaboration and prescription concerns the triadic relationship between client, therapist and Therapy Programme. The Therapy Programme was designed to be delivered flexibly, tailored to the unique needs and formulation of each participant. ‘Flexibility’ and ‘tailoring’ were managed through a process of dialogical collaboration between the expertise of the therapist and that of the participant-client. Understandings and plans for action were developed conjointly, considered and adopted, amended or discarded through consensus. Although all completer-participants talked positivity about this approach during the therapy, only UH3 thought it worthy of note in the feedback interview. Asked directly about collaboration and the sharing of power, all participants expressed a tentativeness about lack of experience and confidence and a desire to put trust in the decisions of the therapist. LJ8 expressed the view that she might have engaged more effectively, for instance with the Participant Handbook, if she had been given greater guidance. ‘Guidance’, in this context, appeared to be defined in relation to (i) Greater clarity about the direction of, and steps within, the course of the Therapy Programme, and (ii) Greater prescription of action, followed-up with a critical evaluation of compliance. The first of these points speaks to the clarity of the therapy narrative as much as to structure. It might be argued that a significant purpose of the Participant Handbook, as a therapy resource, was to provide such information. That guidance is, of course, only available if the Handbook is used. It should be noted, however, that the Participant Handbook was purposefully written to avoid specifying any one sequence or ordering of strategies as the most right or true. Others suggested that there was sufficient explanation along the way, that they had involvement in the direction that the therapy took, or were largely happy to simply follow.

The second point speaks to the tension between the value of collaboration and flexibility to human need and to prescription in the progression of the therapeutic process. The relationship between collaboration and prescription might be viewed as a single dimension, with graduations between the two poles. That represents, however, a narrow and limited understanding of prescription. From the observations of the research-participants, prescription might itself be regarded as operating at two levels. At one, it is defined or driven by the expertise of the therapist and sits counter to collaboration as a process. In this scenario, authority, power, but, also, responsibility reside with the therapist. The second level of considering prescription might regard it in terms of its operational function rather than its attitude towards, or assumption of, power. Operationally, prescription might represent a motivational strategy requested by the client. Some people, LJ8 suggested in the follow-up meeting, don’t want to be asked. They want to be told, to be freed from the personal responsibility attendant upon the act of deciding.

The second ‘Significant Point’ of the flexibility-structure theme relates to considerations of fidelity and credibility, and the platinum-standard goal for all new psychological interventions – that they be capable of being taken up by other therapists and being offered to other clients. It is argued that wider up-take requires a clarity of structure, content and delivery that defines an intervention as distinct from other intersecting programmes or even a more generic label as simply ‘CBT’ or ‘CBTp’. In discussing the nature, purpose and content of the novel Therapy Programme, in Chapter 5, it was argued that, whilst the intervention might be regarded as sitting within the broader definitions of CBT and CBTp, it, nevertheless, represented a unique approach in its own right. Comparisons were made with, for example, Narrative Enhancement and Cognitive Therapy (Roe et al, 2014; Yanos et al, 2012), WELLFOCUS (Schrank et al, 2015), COMET (Korrelboom et al, 2009; van der Gaag et al, 2012), Cognitive Therapy for Self-Stigma (Morrison et al, 2016) and Social Recovery Therapy (Fowler et al, 2019; Fowler, Hodgekins and French, 2019; Hodgekins and Fowler, 2010). In the context of this research, review of the therapy journeys of the four completer-participants identified significant differences with reference to the areas covered, component techniques or strategies employed. There was a substantial measure of variance in the programmes delivered. This raises the question of how to distinguish between variance that represents flexibility within the boundaries of a defined intervention and variance that reflects a lack of sufficient definition or clarity to justify its status as a novel programme. Evidence from the audit of fidelity (see section 7.9 and Appendix 5D) suggests that all of the Therapy Programmes were consistent with, both, the central therapeutic ethos of flexibility to the unique circumstances, experiences and conceptualisations of the individual client and the map of the intervention as formally articulated within the Participant Handbook and operationalised in the fidelity check-list.

In the development of an intervention that is designed to be delivered flexibly a second question regarding programme-variance might consider the possibility of a ‘best’ or ‘preferred’ variant. Whilst this represents a legitimate consideration with regard to the multiple stages of intervention-development recommended by the Medical Research Council (Craig et al, 2008), in this study, with its very small number of participant-completers, that question cannot be meaningfully addressed. At this stage in the broader process of development of the Therapy Programme issues of credibility are likely to attach more to consensus recommendations for improvement, rather than to any one of the four individual journeys. The results do, nevertheless, suggest that further development of the Therapy Programme will need to consider the balance of structure and flexibility in order to address, both, the challenge of optimising the approach for the individual client (structure, collaboration and prescription) and strengthening the credibility of any future claims regarding generalisation to others (structure, flexibility and fidelity).

The manifestation of hopelessness and compromised self-esteem in the dynamic of the therapy

The conceptualisation of the hope-self-esteem construct discussed in Chapter 5 identified relationships with others as central to experiences with regard to views of self and the future. A key element of self-evaluation, according to Rosenberg (1965, 1979) and developed in this intervention, relates to social positioning, which includes issues of acceptance and belonging organised around 'received-evaluations' from others. Put simply, people mostly want to be liked and accepted. Those with low self-esteem or fragile high self-esteem often are generally insecure in their relationships (Fennell, 1999; Rosenberg, 1965). That might reflect convictions that they are not liked, respected or valued, worries that they might not be or, perhaps, merely concerns that they will not be liked or valued if others 'really knew' (stigmatisability – Goffman, 1963). These thoughts might be experienced in the context of any social relationship, including that within therapy. In the feedback conversations with participants these issues appeared to be implicated in the therapy-relationship (the 'system of boundary' - Seikkula and Sutela, 1990) in relation to four factors – (i) wanting to please and to be liked, (ii) therapy as an act of hope – including putting faith in the therapist at the expense of faith in self, (iii) the risk of trying for a win, and (iv) the therapist as an object of comparison.

The 'need' to be liked by the therapist was associated with, both, a desire to please and a sensitivity to criticism. No participant directly admitted to a 'need' to be liked during the therapy or in the feedback interview. Only UH3 commented on this and that inconsistently. He dismissed the possibility that he might be motivated to seek positive opinion and yet later commented that he had failed to report early signs of his psychotic relapse because of an unwillingness to disappoint. Of all participants, he appeared during the course of therapy to be least apprehensive about the therapist's response to unaddressed or incomplete homework. On the other hand, he was punctilious about attendance, even to the point of returning from another city exclusively for a one-hour meeting. In contrast, LJ8 presented throughout the course of therapy as anxious about possible criticism. This might account for her failure to acknowledge her discomfort with the word ‘psychosis’ on the title page of the Participant Handbook and consequent reluctance to use it as it was intended. FH2 struggled with motivation throughout the early part of therapy. As an academic by vocation she was embarrassed about her loss of confidence in the assimilation, in particular, of information written in English, which infected her engagement with the Participant Handbook. She, too, had been unwilling to share her concerns. It was noteworthy throughout the course of each Therapy Programme that participants were uncomfortable with being asked to critique the therapist and programme, even where the offering of critical comments was encouraged and modelled. This point has been picked up below in relation to the research process with reference to the significance of the therapist-as-researcher.

Snyder (2000a) has suggested that embarking on a course of therapy represents an ‘act of hope’ in which the person identifies the therapy and its mediator as significant elements in a pathway to success. One of the observations that emerged from the Pearson study (2010) was that an over-emphasis on the therapist as a figure of hope might result in a diminishing of self-directed investment. LJ8 was ashamed of her sense of inadequacy with reference to both the recent onset of psychosis and historical problems with academia. In the therapy process she invested her ‘pathway beliefs’ in the therapist rather than herself or even the therapy. That fact was not disclosed until the feedback interview which also represented the effective end of the therapeutic-relationship. Her manner in that interview implied an over-reliance on the therapist and lack of confidence in herself.

Low self-esteem is associated with a tendency towards defensive strategies aimed at trying to avoid losing, where ‘losing’ is reflected in experiences of pain, distress, rejection, criticism and failure. Therapy, on the other hand, might be described as ‘trying for a win’, where ‘winning’ is about changing the prevailing experience of life by, amongst other things, doing things differently and trying to achieve more. On that basis, although, as Snyder (2000a) has suggested, therapy might represent an act of hope, it might, also, be experienced as involving an element of risk. In the context of therapy, of wanting to please the therapist and being sensitive to criticism, the dangers of trying and failing are magnified. That experience might be exacerbated further if the therapist elects to invest more of themselves in the pursuit of a specific therapeutic objective. During the course of their Therapy Programme, FH2, UH3 and LJ8 all expressed unhappiness with the experience of being subjected to others' expectations. Asked directly in the feedback as to what extent they had experienced pressure in relation to the therapist's expectations or had been concerned about trying to achieve, none acknowledged that this had been a difficult consideration. MJ7 noted that he had benefitted significantly from such a 'nudge' by the therapist, although it is interesting that there were significant discrepancies between his and the therapist-researcher's recollections of this exchange.

Interpretative reflections on the enactment of compromised self-confidence in the therapy process also picked up on the dynamic of the therapist as a potential object of comparison. Rosenberg (1965) has noted that the process of comparing self with others in common to most people, but that in those who experience low self-esteem such comparisons are rarely in the person's favour. That tendency to comparison with others includes the possibility that the therapist might become an object of such evaluations. If, as Snyder (1991) suggests, therapy does represent an act of hope in that it is organised in relation to pathways to goal-achievement, it might, also, be regarded as investing faith in a therapist. The more respect that the person has for the therapist, the more hope they will have in the outcomes of the therapy process. It is, therefore, in the interests of inspiring hope, that the therapist project confidence in themselves and the therapy, alongside that for the client. Qualities of intelligence and compassion in the therapist, their experience, qualifications, histories of success and achievement, even physical attractiveness, might all influence the client's belief in them and in the therapy. In the context of social comparison, however, those qualities might, equally, be regarded as standards against which a client might judge themselves to be failing. This consideration was not expressed directly by any participant, but did emerge within the interpretative analysis. It is unclear whether that reflected an unspoken thought within the room or a more tangential connection with recollections of the therapy.

7.6.3 Experiences of the Participant Handbook

This section is discussed in two parts –

1. Reflections on the place and value of the Participant Handbook, including experiences of the processes of its delivery.
2. Experiences of the presentation, structure and content of the Participant Handbook.

The place and value of the Participant Handbook

When reviewing participant's reflections upon the content and processes associated with the handbook it is important to acknowledge something of their specific relationships with the material. The provision of the Handbook was discussed with participants prior to the start of their therapies. It was supplied to them in the first meeting and was referred to in every conversation. Participants were directed to specific sections to answer questions and encouraged to refer to it to back-up homework exercises. It was not, however, prescribed as a requirement of the course of therapy and participants were not tested on their familiarity with it. In spite of that, engagement with the Participant Handbook was less invested than anticipated, with no participant in their feedback interview describing the handbook as having played a central role in their treatment package. Amongst the four, however, the attitudes and explanations were somewhat varied.

LJ8 was uncomfortable with the word 'psychosis' in the title. She was acutely worried about stigma and the loss of status and deeply embarrassed about the possibility that others might see the handbook and guess at her circumstances. In addition, she reported in the feedback interview that she had always struggled with academic texts. She shut the book away, referred to it rarely and never engaged with it spontaneously. During the course of therapy

UH3 regularly reported positive engagement with the handbook. In the feedback interview, however, he was vague about how much he had read, reported limited memory of content or form and was much more restrained in his praise. MJ7 also amended his story in the feedback interview. Having appeared to utilise it well during the therapy, he then noted that his engagement was more superficial and his reading of the handbook more surface than depth. FH2 reported reading the handbook quite extensively, but not until towards the end of the course of therapy. At the beginning of therapy, she was unconfident in her use of it, struggled with the language and found the requirements of concentration to be quite challenging. Her observation that it was easier to engage with the handbook once her self-esteem (and linked confidence) had started to improve was echoed by UH3, who reported at follow-up that he had found it a useful resource in the period post-therapy.

This collective tentativeness sets some limits on both the depth and detail of participants' feedback about the handbook. Although the handbook was utilised throughout the therapy process with all participants, it was invariably referred to in language that defined it as adjunctive to the Therapy Programme – a useful, potentially important resource, but not a central component. As noted in Chapter 5 it presented explanatory and reference material that might, elsewhere, be provided as handouts. In the feedback interviews participants' observations were muted, with few strong opinions, positive or negative, regarding the content or structure. The format and presentation (colour and design) received praise. The volume and some of the language were criticised. Where participants could remember specific sections, the feedback was encouraging. The example vignettes were particularly well-received. It was, however, evident that, in preparing their thoughts for the feedback interview, participants had given less consideration to the handbook than the therapy more generally.

It was stated in Chapter 5, and again at the beginning of this chapter, that the Therapy Programme aspired to be accessible to, and engaging of, recipients. It might be argued that participants' incomplete engagement with the handbook should be interpreted as an indictment of its perceived accessibility and usefulness and, therefore, its value to the therapy. That raises the question of whether a handbook (this handbook) warrants inclusion as part of the process. The argument for the utilisation of biblio-graphic material is well-established, whether in the form of notes and handouts, reference texts or self-help books (e.g. Bennett-Levy and Padesky, 2014; Guest, 2017; Martinez, Whitfield, Dafters and Williams, 2008; Sears, 2017; Tallon, McClay, Kessler, Lewis, Peters, Shafran, Williams and Wiles, 2019). Furthermore, in their follow-up meetings all participants spontaneously referred to more invested engagement with the handbook post-therapy, attributing significant value to it as a reminder of the importance of maintaining vigilance regarding the potential to fall into old habits of negativity towards self and the future, as well as a reference guide to issues addressed and strategies agreed. Given the research design, in which the therapist facilitated these two interviews with each client (post-therapy feedback and follow-up), such positive testimonials need to be viewed with considerable caution (see, also, Chapter 8). Nevertheless, the general utility of written material as adjunctive to therapy and the specific critique of this handbook, with positives, negatives and recommendations for change, support the dual steps of amending the content of the handbook (including its presentation) and reviewing the processes by which it is employed in the course of the therapy. This last includes, in particular, issues of timing and the associated guiding narrative.

The style and content of the Participant Handbook

Overall, the implicit (and, in parts, explicit) feedback from participants was that the packaging of the handbook, in terms of colour and design, was considered attractive and the content regarded as important. MJ7 was very encouraging about the style of writing, detailed, yet informal, and, both, he and FH2 highly valued the ‘service user stories’, which were included to help illustrate elements of the approach. On the other hand, there was a general consensus that its size, and the complexity of concept and language made it off-putting. This was regarded as particularly significant for someone feeling less confident, as, by definition, was the case at the start for all those who took part. There was no feedback to suggest that the handbook was experienced as undermining or elsewise actively detrimental.

7.7 Recommendations

All of the discussion to this point has been concerned with setting the context and developing the argument for a series of specific recommendations for the betterment of the Therapy Programme. Those recommendations represent a summary of that discussion. They are detailed below with regard to the categorisation employed in the preceding sections – (i) Content of the Therapy Programme, (ii) Process of Delivery of the Therapy Programme, and (iii) Participant Handbook.

7.7.1 Content of the Therapy

The vast majority of recommendations for change, arising from the analyses of both the qualitative feedback and quantitative data, relate to the process of delivering the Therapy Programme or to the content and style of the Participant Handbook. Evaluations of the content of the Therapy Programme were mostly very positive, with particular praise for the emphasis on positive psychology – including the focus on strengths, capabilities and achievements. Recommendations regarding changes to the content of the Therapy Programme were restricted to –

1. The formal and pre-planned inclusion of attention to **Illness Narratives** with regard to Psychosis, together with the direct exploration of the relationship between the Psychotic crisis, hope and self-esteem.

2. The inclusion of attention to the relationships between hope, self-esteem and **Motivation**, with reference to one or more exercises specifically designed to address problems with motivation.

7.7.2 Process of Delivery of the Therapy Programme

Recommendations with regard to the process of delivering the Therapy Programme were more extensive.

1. Explicit and regular attention to discussion of the **therapeutic process**. This focus to include, considerations with regard to – (i) Issues of hope and self-esteem in the therapy process, (ii) Attitudes to progress and engagement with the Therapy, (iii) Attitudes of family and other support networks to the Therapy Programme and the persons 'applied' goals – experiences of support or resistance, (iv) Attitudes to reading (in general) and to the Handbook more specifically, and (v) The formal review of progress of the Therapy Programme at 4-session intervals, to include the graphical feedback of outcome scores to date.
2. Greater clarity with regard to the **Structure of the Programme**.
3. A **prioritising of 'pure' elements of the Programme over the 'applied'** – with regard to, both, the balance of time-investment and chronological ordering within the delivery of the Programme.
4. More explicit **attention to the place of the Participant Handbook** within the Therapy Programme, including setting the reading of an extract / chapter of the Handbook as a homework task on at least two occasions.
5. Two '**Booster sessions'** to be offered at 3- and 6-months following completion of the main body of the Therapy Programme.

A representation of the proposed structure for the next iteration of the Therapy Programme is presented in Appendix 5F. As stated previously, the primary purpose of the current research has been to generate recommendations for the improvement of the Therapy Programme, with, secondarily, attention to questions of efficacy that might justify the investment of time and resources required for that further development. This study has not been concerned with comparisons with other intervention programmes regarding questions of relative worth, although ‘proof of concept’ has been considered, in part, with reference to statements of efficacy associated with pre-existing therapies. It has been argued that this new intervention sits under the broad heading of CBT for Psychosis, which, itself, sits within the wider collective of Cognitive Behaviour Therapy. It has, however, also been argued that the level of specificity of the Therapy Programme with regard to the target complex of hopelessness and low self-esteem defines it as other than ‘just’ CBTp. Furthermore, the uniqueness of content distinguishes it from other definitive programmes within the school of CBTp (e.g. Social Recovery Therapy – Fowler et al, 2019; Fowler, Hodgekins and French, 2019; Hodgekins and Fowler, 2010). The recommendations for improvement identified above, in particular, the attention given to ‘illness narratives’ and ‘Staying Well’ booster sessions, do move the programme from a slightly more generic focus on ‘CBT for Hopelessness and Low Self-esteem’, to a more clearly targeted ‘CBT for Hopelessness and Low Self-esteem *in Early Psychosis*’. It is argued, however, that, although this strengthens the associated with CBTp, it does not undermine the assertion that this Therapy Programme is unique. In addition, neither the recommendation for a shift in the balance of structure and flexibility towards greater consistency in the chronological ordering of particular elements of the programme, nor the impetus for a clearer, more explicit explanatory narrative, should be interpreted as a move towards a ‘manualised’ approach. It does, though, support greater potential for implementation of the therapy within a group context.

7.7.3 Participant Handbook

The principal purpose of the Participant Handbook has been as a resource for the service-user participant. It was, also, utilised (secondarily) as a description of the intervention for the purpose of the audit of fidelity. Finally, it was employed as an aid to instruction or education in the process of engaging mental health professionals from the host service in the research agenda. Changing aspects of the content of the programme, therefore, requires that those changes are described and explained in the handbook for others to read. Separation of these multiple roles was advocated by the recommendation, expressed directly and independently by UH3 and MJ7, that the Handbook be re-written as two texts – one for participants and the other for professionals. Both participants noted that the separating out of the more complex concepts would make the Handbook more accessible to someone feeling fragile at the start of therapy. At follow-up, UH3, also, observed however, that it would be important not to '*patronise*' the participant by '*overly dumbing-down*' the material, and that some therapy-clients might value access to the more detailed version at a later point in the therapy-journey.

All of the recommendations detailed in the previous section might be equally included in a Participant or Therapist Handbook. The following recommendations specifically address the Handbook for participants. It was suggested that the Participant Handbook be written to a lower reading age, that it have a significantly fore-shortened discussion of the theories and roots of hope and self-esteem and that more academic sections be simplified. On the other hand, it was also recommended that additional chapters or sections be included, relating to illness narratives (with particular attention to bio-psycho-social understandings and the stress-vulnerability model), motivation and the significance of low self-esteem and hopelessness on the process of engaging in therapy. It was proposed that the Participant Handbook be written to reflect the structure of the delivery of the Therapy Programme, such that it would be easier to follow the two in parallel. In addition, participants recommended, directly or by implication, that the term 'self-esteem' be replaced with 'self-confidence' and the title of the book be moderated to de-emphasis the word 'psychosis'. Finally, it was argued that the Participant Handbook would be better served by having fewer worksheets, but for those retained to be utilised more actively and consistently through the process of therapy.

7.8 Processes of Co-Construction

The research has been organised within a paradigmatic framework which invites the researcher to explore the processes of co-construction alongside the complexity of experience. This has been endeavoured through self-reflective and transparent consideration of forces of influence in the feedback interviews, different stages of interpretative analysis, the collation of 'results' and the development of an overarching map within the thesis. Participants did not reflect on the process of the feedback interview. In particular they did not engage in conversations with the researcher about the co-constructive forces at work. Where reflections on construction have appeared in the critical analyses of the feedback interviews, they represent the researcher's observations on the interactions evidenced in the transcripts, with questions, concerns and thoughts about those factors that might have been influencing the development of the dialogue. As noted above, this section is concerned with raising to visibility key aspects of the co-constructive forces. Limitations with regard to words mean that just two intersecting areas of influence have been explicated.

1. The motivations of the participant, with particular reference to 'wellness' (or mental state) at the time of the feedback interview.
2. The Therapist as Researcher.

It is important to note that consideration of issues of co-construction relate, both, to the process of interpreting participants' observations or recommendations and to the critical evaluation of the design and conducting of the research. This section (and this chapter) is concerned with the first of those factors – the contextualising of participant reflections with regard to the dynamic process of the research interviews and the self-referential processes of the interpretative analyses of the transcripts there-of. The critical application of these observations to the evaluative review of the research design is progressed in Chapter 8.

7.8.1 Participant's 'state of mind' at the time of the feedback interview

Most of the reflections on construction that emerged through this process focussed on the role, contributions and person of the researcher - their style, questions and areas of attention. There were far fewer reflections on the ways in which the participants shaped the conversation beyond their observations regarding their experiences of the Therapy Programme and their recommendations for its improvement. There were some recurrent considerations of significance, including, in particular, factors that might have been influencing the participants (and, therefore, participants' stories) at the time of the interviews, as well as aspects of the participants' presentations that might have significantly impacted upon the progression of the interviews. In the feedback meetings, participants' 'states of mind' might have been, especially, influenced by (i) their attitudes towards the success or otherwise of the Therapy Programme, and (ii) their views regarding the ending of the therapy relationship. They might, of course, also, reflect issues with regard to other non-intersecting variables – a 'bad hair day' or 'getting out of bed the wrong side day' – which relate to, at best, tangential considerations. These were not, however, ascertainable in this study.

At the point of completion of the feedback interview MJ7 was beginning to progress an application to return to education. He had pursued a number of difficult conversations with regard to the process and risen above the set-backs of an institutional refusal to allow credit for work previously undertaken. His relations with his family or origin, with whom he lived, were much improved and he was exploring options for engaging more socially. He reported improvements in both hopefulness and self-esteem. FH2 had, also, experienced significant success in achieving her negotiated 'applied' goals of therapy, had been offered a permanent position at work, begun to resolve tensions with her family of origin, developed, what she felt was, a more balanced work-home life and had been doing much more with her partner. LJ7 had been able to commit to a new employment for a period of almost two months, was re-engaging with a social group, from whom she had been largely separate for more than a year, and was beginning to talk with her husband about 'trying for a baby'. Her hope and self-confidence had been very volatile, but had stabilised in the preceding weeks. UH3 was recovering from his third psychotic crisis, beginning to leave the house for the first time in several weeks, but generally disappointed with his situation.

These circumstances were fairly accurately represented in the outcome measures recorded by each at the end of therapy (as discussed earlier in the chapter). MJ7's scores showed substantial improvements, although they remained below even the clinical population mean. The scores of FH2, also, showed substantial improvement, meeting very high levels of clinical significance. LJ8's final scores on the formal measures were never provided, but her SADs scores showed an emerging stability, in the context of, what had been, a very volatile picture. The scores of UH3 had shown great improvement until his crisis, at which point they had plummeted. They were only just beginning to rally.

In their feedback interviews MJ7 and FH2 were, both, highly enthusiastic about the Therapy Programme and the therapist. MJ7 expressed considerable gratitude, especially for, what he deemed to have been, the therapist's '*going the extra distance*'. FH2 talked of her happiness at having found such a '*competent*' therapist. In the first part of the interview their observations were exclusively validating, though, primarily, concerned with generic aspects of therapy, rather than specific elements of the novel Therapy Programme. Neither offered any criticisms of the content or process even when asked directly. Recommendations for improvement were only made towards the end of the conversation. In both incidences that was initially in relation to the Participant Handbook and only subsequently extended to aspects of the broader Therapy Programme. In contrast, LJ8 presented as anxious and uncertain throughout the feedback interview, requiring extensive time to reflect on her worries about the future before and after the interview was conducted. That need for reassurance also intruded at times into the interview process. UH3 seemed frustrated throughout the meeting. For a large part of it, his answers were brief, without detail or apparent interest and he showed little effort in trying to recall particular thoughts or experiences. It was unclear, at first, if this reflected raised levels of medication, tiredness, dissatisfaction with his circumstances generally, or a sense of aggrievement with the

Therapy Programme and therapist. As the meeting progressed, however, his engagement with the conversation improved and it seemed more likely that his earlier responses had reflected psychological processes. Over the course of this interview there was evidence of both positivity and criticism, on occasion reflecting inconsistent responses towards the same considerations. His thoughts regarding improvement were, however, coherent, salient and well argued. The significance of these reflections on 'state of mind' during the interview have been linked to the position of the researcher as both therapist and interviewer. That tension is discussed in more detail in following section.

7.8.2 Therapist as researcher

In this research the same person played most of the roles - developer of the Therapy Programme, designer of the research, therapist, interviewer, analyst and author. That decision was influenced in part by questions of pragmatism, but mostly by a cost-benefit-analysis of the implications of different alternatives. It is postulated that that strategy will have had particular significance with regard to the observations made by participants and the researcher's own 'emergent' analytical interpretations. The relevance of that with regard to questions of the reliability and credibility of the recommendations progressed is discussed in some detail in Chapter 8. This section is primarily concerned with providing illustration of the constructive-context of the observations and recommendations reported in the preceding sections, with particular reference to the significance of the multiple layers of relationship between therapist-researcher and participant. Three areas of such consideration were identified. None was articulated directly in the feedback interviews and most of the relevant reflections were associated with a critical evaluation of the therapist-researcher's own contributions to the interview process. They related to -

1. The significance of the researcher's access to privileged knowledge of the participant's therapy-journey.

2. The effect of the therapy-relationship on the ‘story’ of the Therapy Programme that was co-constructed between researcher and participant.
3. The setting and maintenance of boundaries in the facilitation of the research-feedback interview.

One of the ways in which the strategy of therapist-as-researcher differs most significantly from an approach in which the roles are separated is the access that the researcher has to a lived story of the therapy journey that they and the participant have made together. That story of a shared journey sets the context within which participants’ research observations might be considered. It might offer depth and texture and provide a multi-ocular lens through which to interpret participants’ thoughts. That idea of a ‘shared history’ was openly acknowledged and explicitly utilised in each of the feedback interviews, in the thought-streaming of the critical interpretative analysis and in the bringing together of those ideas in this thesis. Throughout this, emphasis has been given to situations in which the therapist-researcher’s stories of the therapies have added clarity to participants’ observations or the interpretative reflections, or, vice versa, where participants’ observations and the resultant interpretations have illuminated an experience from therapy. It is important, however, to recognise that, in the progression of a therapy journey, the constructive forces at play will operate differently upon the experiences of the two protagonists. Howsoever much they discuss their experiences together, the therapist and service-user-participant will, never-the-less, take away different maps of the process. The contextual knowledge of the therapist-as-researcher, consequently, will reflect a different story of events, significances and experience from that which is brought by the participant. The employment, therefore, of those privileged knowledges adds depth and texture, but, also, introduces ideas that risk moving the investigation away from the essence of the participant’s experience, which is the central purpose of IPA methodology (Smith et al, 2009).

This disparity of ‘remembered stories’ was evidenced at several points in the feedback interview with UH3, where he felt it necessary to correct observations made by the researcher-therapist, and in that with MJ7 who attributed considerable importance to memories and understandings of the therapy process that were not shared by the therapist-researcher. It is likely that, where there is an existing relationship, the nature of that relationship will influence how words are interpreted or events remembered. In the circumstance of a post-therapy review, the shared experiences of undertaking the therapy together are likely to intersect with views regarding its efficacy to influence memories, observations and recommendations. Where the previous section suggested that participants 'state of mind' might influence how they remembered the Therapy Programme and what they might have wanted to say about it, the issue of the therapy-relationship raises questions as to what the participant might feel obligated, able or guided to say. Whilst it is possible that the presence of the therapist might have polarised the observations of the participant, heightening the dominant response to praise or criticise, a more likely scenario is that it would have affected the balance of reflections in slightly more insidious ways.

There was evidence in all interviews of participants' capacity to reflect on both strengths and weaknesses of the approach, although there was a tendency to restrict criticisms to specific areas. That applied whether participant's outcome scores suggested improvements in their wellbeing or (in UH3's case) not. There was some suggestion of ambivalence in places, which might have reflected uncertainty about what could be or might be expressed. There were points within the interviews where the participants appeared to temporarily back-away from a criticism. In these situations, a criticism appeared to be offered, but the observation was retracted when the therapist-researcher drew attention to it. There were no occasions when a similar process appeared to influence a positive statement

The final consideration with regard to the therapist as researcher concerns the issue of boundaries between therapy and research. In order to minimise any sense of discomfort in the research process, the feedback interviews were undertaken in the same venue and the same day and time slot as the therapy. The interview was recorded with the same equipment and was conducted using a questioning format, including a mix of convergent and divergent questions, that was not dissimilar from the process of therapy. This promoted seamlessness, but undermined the punctuation of the two as different. LJ8, in particular, struggled to see the research interview as separate from the therapy. Her previously un-acknowledged anxieties about the ending of the therapy relationship spilled over into the research interview. Her contributions on the day were strongly informed by the need to seek reassurance regarding her decisions at the time and prospects for the future. These needs intruded before, after and intermittently throughout the feedback interview. The situation was complicated by the therapist-researcher's experience of a tension between the need to contain the concerns in order to allow the research interview to progress, and to respond to the human need. Attempts to create separation and address one-at-a-time were unsuccessful.

7.9 Audit of fidelity

Chapter 6 described the importance and process of conducting an audit of fidelity of the therapy delivered within the research process. As noted, most therapy sessions (97) were video-recorded, with a 10% sample (10) being reviewed against the planned Therapy Programme. The audit tool addressed two considerations.

1. Consistency with established CBT practice – Part A.
2. Fidelity to the composition of the novel Therapy Programme – Part B.

Tables presenting a detailed summary of all of the audits are included in Appendix 5E. It can be seen that the auditor found, in each case, clear evidence of fidelity both to the CBT Approach and to the novel model. There is, however, an extremely high level of inclusivity in the auditor's evaluations of the components of CBT and the novel therapy presented in the tables. This observation might raise questions as to the validity of his conclusions. The audit tool required, however, that the auditor evidence their observations by reporting briefly on three of the aspects of Therapy which they had ticked on the check-list. In each case that qualitative evidence supported the judgement of fidelity.

7.10 Summary

This chapter has presented a synthesis of the results emerging from the completed outcome measures and the interpretative analyses of the feedback interviews, together with available information relating to the demographic characteristics of participants, the unique therapy-journey of each participant and the recommendations from the literature. Where it has not been possible to explicate in detail all the available themes and points, priority has been given to those that have spoken most clearly to the primary objective of the research agenda – the generation of clear recommendations for the improvement of the novel Therapy Programme. Attention to questions of ‘co-constructive’ processes has been included to allow the reader to consider the authenticity and credibility of the conclusions drawn. The review of the Audit of Fidelity indicates clearly that it was the Therapy Programme, as described in the Participant Handbook, that was subject to these investigations.

Chapter 8 – Discussion

8.1 Introduction

The study described in this thesis was concerned with experiences of hopelessness and compromised self-esteem in young people recently diagnosed with a psychotic illness. Negative evaluative attitudes towards self and the future are particularly endemic in this client group and, in that context, have been extensively implicated in the undermining of engagement, motivation, collaboration and effort with regard to treatment-regimes (Fannon et al, 2009; Freeman and Freeman, 2012; Warman and Lysaker, 2011). The study is located within the context of a wider research agenda, the overall aim of which is to develop a novel psychological Therapy Programme to address the needs of this particularly vulnerable group. In the majority of relevant research and theory, hope and self-esteem have been regarded, rightly, as independent constructs. Whilst some inter-relationship has been acknowledged (Schrank et al, 2015) attention has primarily focussed on their separate roles. This thesis has argued, uniquely, that the relationships between evaluative attitudes towards self and the future, for many if not most, will be intense, intimate and recursive. The project is, further, unique in that it has not been concerned with the serial or concurrent treatment of hope and self-esteem as separate entities. Instead, it has, for the purpose of the therapy, combined considerations of hope and self-esteem into a single complex, with an interlocking and reciprocating conceptualisation. In addition to influences from elsewhere, composite intervention strategies have been drawn from prior research associated with targeting each construct separately. In this Therapy Programme they have been fully-integrated within one coherent, paradigmatically consistent structure.

A preliminary version of the Therapy Programme was developed through extensive consultation with client- and carer-users of Early Psychosis Services, alongside mental health professionals, local to the research site, regionally and nationally. The purpose of this specific study was to progress the development of the Therapy Programme with reference to the observations of service users who had experienced it in practice. The objectives of the study, therefore, were to – (i) Pilot the Therapy Programme with a small group of service-user participants, (ii) Evaluate their experiences, and (iii) Refine the Therapy Programme, with a view to further research and exploration in clinical practice.

8.2 Methodology

The study was underpinned by the ontological-epistemological philosophic paradigm of critical realism (Bhaskar, 1998; Clark, Lissel and Davis, 2008) and organised within the methodological rigour of Interpretative Phenomenological Analysis (Smith, Flowers and Larkin, 2009). Conjointly these approaches offer a dual interest in considerations with regard to the complexity of human experience and the processes of co-construction by which those experiences are mapped or storied. The study employed a mixed-methods design (Teddlie and Tashakkori, 2009). The primary focus with regard to data capture and analysis was on the qualitative experiences of participant-service-users, as reflected in post-therapy feedback interviews. Participants were explicitly recruited to the study as collaborators in the business of improving the Therapy Programme through attention to both its strengths and weaknesses. Throughout the delivery of the Therapy Programmes and processes of the research multiple strategies were employed to promote participants' confidence in articulating such critiques. Access to quantitative data, relating to completed outcome measures, demographic characteristics of participants and the rates of recruitment to, and withdrawal from, the research and Therapy Programme, allowed additional triangulating layers of analysis. Only eight participants were recruited to the study, however, so questions of statistical significance were not considered. In the same way that the focus and composition of the Therapy Programme represents a unique conceptual-marriage, the linking of critical realism with IPA and mixed methods is believed to represent a unique research methodology.

8.3 Discussion

The aim of the research-study was to progress the development of the Therapy Programme. The primary objective of the study, therefore, was to generate a series of recommendations to that effect, which were rooted in, and made relevant by, the experiences of participant-service users who had engaged collaboratively with the programme. It is the central tenet of this discussion that the authenticity and richness of participatory experiences allow insights that might not be so readily achieved through a more theoretical undertaking. It is, also, worth noting that therapy is an interactional and dialogical process and that, consequently, participatory insights have been generated for and within the therapist-researcher as much as the participants.

It was noted in Chapter 2 that the aspirations for any new or developing Therapy Programme should include that it be experienced as accessible and engaging and be perceived to have value. There is, of course, little to be gained from investing time and effort in the development of a therapy programme that cannot deliver on its purpose. It is, equally, non-sensical to develop an effective programme that is experienced as so unappealing or off-putting that it struggles to recruit or engage service users in the process. This might appear to be obvious, but standards of service delivery defined, for instance, in NICE Guidelines for Psychosis (2002, 2009, 2014) measure compliance with regard to contacts and 'offers of treatment' rather than outcomes or uptake. These three ideals were expressed as a series of secondary research questions and were examined, principally, with reference to the available quantitative data. The qualitative feedback might, also, be considered as reflecting experiences of engagement along with subjective perceptions regarding value. The exploration of that material goes further, in fact, in considering the essence of participants' experiences there-of. It is important to acknowledge that the design of the study, in particular with regard to sample size and the lack of a control condition, has been such that any patterns observed and commented upon can only be regarded as interesting and, perhaps, suggestive of areas for further investigation.

8.3.1 Accessibility

Accessibility relates to a much broader set of dimensions than, merely, appeal, as measured through recruitment. It includes considerations with regard to availability, flexibility of delivery, cost and understandability. Within the contours of the research and the defined inclusion criteria issues relating to availability and understandability were largely managed. The Therapy Programme was offered free of charge at a time and a place to suit the person. It was delivered in a language that recruited participants were required to both read and speak and all written material associated with recruitment was reviewed for understandability (amongst other things) by service users, team members and the two involved ethics committees. Any variations in recruitment, consequently, might be more likely to be associated with appeal.

Exploration of this matter is complicated by the offer of therapy being tied closely to the requirements of involvement in the research. As noted, limited informal feedback suggested that some individuals, at least, were discouraged specifically by the research design elements – in particular the requirement for video-recording of the therapy. It might be said that for the service-user-subject video-recording involves exposure regarding both appearance and performance. Given that the issues of compromised self-esteem can manifest in discomfort with being the object of others' scrutiny it is unsurprising that that particular suggestion was not met with enthusiasm. The 'cost-benefit' considerations relating to that decision are presented in Chapter 7 (Section 7.2). Subsequent studies in the further development of the Therapy Programme might adopt an alternative measure of fidelity and different approach to clinical supervision. In the context of this study it is important merely to note that evaluations of percentage appeal are, consequently, flawed.

The second observation, regarding patterns of racial or cultural appeal, can, also, only be viewed tentatively given the extremely small sample numbers. This indicative 'finding' does, however, highlight the question of fit between a developing intervention and diversity with regard to race, culture, gender and gender identity, age, sexuality and other characteristics of difference. The ‘findings’ of the research with regard to accessibility might not lead to firm conclusions about the structure, content or delivery of the Therapy Programme. It is, however, significant that this consideration was not discussed in relation to any intervention study examined during the various stages of the literature review. It is the contention of this research that that oversight needs to be addressed. The very limited attention given to this question here should, therefore, be regarded as a starting-point. More focussed research into the matter will be included as the development of the programme continues.

8.3.2 Engagement

Of eight participants who were recruited to the research only five completed the Therapy Programme. If the aspiration of a developing Therapy Programme is that service users should as much as possible remain engaged to the end, then a 37.5% drop-out rate might be regarded as disappointing. Consideration of the sequelae associated with the decision by each non-completer-participant to withdraw from the programme offers the tentative possibility that family support (or, possibly, the absence of family resistance) and education leaving age were significant in determining commitment to the Programme. There was, also, some suggestion that withdrawals were telegraphed by changes in attendance patterns and were linked to a lack of evidenced early gains. The question of family context in relation to retention or outcomes has not been considered, or at least reported, in any of the intervention studies reviewed. The significance of family environment with regard to relapse and recovery in Early Psychosis has, however, been highlighted in response to decades of research (Hogarty, Anderson and Reiss, 1986; Oksuz et al, 2017; Vaughn and Leff, 1976). The Therapy Programme involved elements specifically designed to explore and address affiliative considerations, but was clearly framed as an individual, rather than, family therapy. This finding does, however, highlight the importance of attending to the service-user’s relational context as a central consideration when evaluating need, developing a conceptualisation and negotiating a package of care. Failure to do so not only misses the opportunity to access important external resources for support, but actually runs the risk of not recognising contra-indications to a recommended strategy. A relationally-unaware package, consequently, carries a greater potential for iatrogenic fall-out.

Similarly, education leaving age does not map directly onto considerations of intelligence or, even, reading age and the researcher's experience of the individuals concerned would not support the assumption that withdrawal was associated with issues of intelligence, conceptual capacity or engagement with the Participant Handbook. On the other hand, longer and more invested engagement with learning and greater familiarity with research might have encouraged participants to stay with the dual process. Several of the papers considered in the literature review described, what were effectively, procedures which were delivered invariantly and, thus, were largely indifferent to participants' unique characteristics (e.g., Duggelby et al, 2007; Hall and Tarrier, 2003; Korrelboom, 2007; Lecomte et al, 1999). Where, however, an intervention is delivered more flexibly, as with this Therapy Programme, exploration of service-user's intellectual or conceptual engagement with the material is essential in order to tailor the approach appropriately.

The recommendations arising with regard to this question of engagement have included increased attention to the narrative of therapy and the importance of exploring with greater regularity service users' attitudes and concerns regarding the process. They have, also, included suggestions for more detailed evaluation of the person's support structures, with the possibility that specific conjoint conversations might be scheduled to address questions as to how the person's improving hope and self-esteem might impact upon their relationships with others.

8.3.3 Findings relating to the Outcome Measures

The consideration of findings in relation to outcome measures speaks to three questions regarding the objectives of this research. The primary purpose with regard to the incorporation of that data within the study has been to provide triangulating information about each individual participant's experience of the therapy and the attitudes that they are likely to hold regarding the investment of their time in the process. It is important to bear in mind that a participant's reported scores over the course and at the end of a therapy process might not be paralleled in subjective qualitative reflections. It is, however, likely that, where reported changes in scores are high and, especially, when they are supported by evidence of goal-achievement, they will be reflected in a greater level of satisfaction with the Therapy Programme.

Secondly, it was anticipated that, for each individual, the trajectory of recorded scores over the period of the Therapy Programme might reflect associations with the introduction of particular elements in the menu of options that make up the programme. In the event, that expectation proved to be flawed. There was no obvious pattern of chronological linkage and, in fact, participants spoke during the therapy of delayed responses – connecting with earlier strategies only once other insights or changes had been achieved. Attention to those trajectories was, however, useful in considering factors relating to drop-out.

Finally, the evaluation of the findings in relation to the outcome scores speaks to the question of 'proof of concept'. The central argument for the development of the Therapy Programme was that – (i) Existing interventions were less effective than they might be, both, in achieving gains to the end of therapy and sustaining those gains over time, and (ii) A combined and complex approach might achieve levels of improvement in hope, self-esteem and wellbeing that would compare favourably, both, to the end of therapy and over time. Over the period in which participants engaged in therapy, three made gains in their recorded scores that collectively showed a mean improvement from baseline of 112.7% (hope), 86.6% (self-esteem) and 47.5% (wellbeing). Those scores were sustained and, in fact, improved upon at follow-up - 141.8% (hope), 108.8% (self-esteem) and 75.5% (wellbeing). The exception to this was the participant who experienced a psychotic crisis at university in the final stages of therapy, having achieved substantial gains earlier. He recorded improvements of only 4.5% (hope) and 3.2% (self-esteem) and a deterioration of 11.9%

(wellbeing) at the end of therapy. His scores had, though, also substantially progressed by follow-up - 63.6% (hope), 40.0% (self-esteem) and a 4.2% improvement in wellbeing. In comparison, Tables 4.6 and 4.7 show a maximum percentage gain from baseline in the reviewed hope-intervention studies of 53% (Klausner et al, 2000) which result was not followed-up, and 95.3% in one self-esteem single-case study, which reduced to 34.1% at 12-months follow-up (Chatterton et al, 2007). Three studies, (McManus, Waite and Shafran, 2009; Rigby and Waite, 2006; Whelan, Haywood and Galloway, 2007) evidenced gains continuing after the end of therapy. All were part of the ‘Fennell-Thread’. None produced results that come close to those recorded in this study (albeit with only four completer-participants).

It is an established understanding underpinning this research that patterns noticed can only be discussed with reference to ‘demi-regularity’ (Clark et al, 2008) and that, consequently, gains identified, numerically and verbally, over the same time-frame of therapy can only be said to be chronologically associated. Notwithstanding this philosophical perspective, in studies involving larger sample sizes and the incorporation of a control or comparison group within the design, statistical analysis of quantitative data might allow some discussion of causal attribution regarding accrued benefits with reference to a language of likelihood. The primary emphasis given to the gathering of qualitative data in this study, with the consequent necessity for a small sample size and no control group, means that no such conclusions can be reached or expressed with any authority regarding the data detailed above.

Such caution regarding consideration of the findings applies even more strongly to the follow-up quantitative data. Most of the hope- or self-esteem-targeting intervention-studies considered in the literature review, which followed-up participants post therapy, showed a substantial loss of pre-to-post therapy gains over the subsequent 3 to 9 months (see Chapter 4). The quantitative data collected at follow-up for this study indicates that those four participants who completed the Therapy Programme and remained involved with the research process did not experience a comparative reduction in the pre-to-post-therapy gains in hope, self-esteem and wellbeing. It is important to stress that this data can only be regarded as providing evidence of the reported existence of continued improved positivity towards self and the future, not the cause. The decision to follow-up participants two-years after the commencement of their therapy was designed to allow the gathering of further qualitative data subsequent to opportunities for them to progress life goals, enact life decisions and experience challenges and set-backs. Whilst that strategy was successful in capturing rich and textured qualitative data, the introduction of additional confounding variables, some obvious (the actual) and some less immediately visible (the real), has further undermined the credibility of the quantitative data. It might not be too strong, in fact, to state that the extended delay (in particular) makes the outcome data collected at follow-up effectively worthless when considered separately from the triangulating qualitative data. The limitations arising from these design decisions are discussed in more detail in Section 8.4 below (Critique of the Research Design). The quantitative data, examined in isolation, cannot be said to provide evidence for the efficacy of the intervention or to make predictions with regard to its generalizability to other clients and client groups. It might not unreasonably be argued, however, that the degree of experienced changes captured by the outcome measures and reported above are interesting enough to support the position that further exploration of the Therapy Programme might be justified. This might be considered ‘proof of concept’.

Finally, with regard to the question of subjective perceptions of value, the qualitative reflections of participants at follow-up appeared to suggest that their involvement within the Therapy Programme was associated with gains in hopefulness, self-esteem and wellbeing. In particular, it was suggested that sustained changes were consequent to elements in the programme that specifically encouraged the participant-service-user to recognise themselves as responsible for their own future wellbeing, that promoted methodical attention to planning against relapses of confidence in self and the future, and which emphasised the Participant Handbook as a reference resource. There are, however, two cautionary points to observe with regard to the above. Firstly, the analysis of co-constructive processes within the dynamic of the post-therapy feedback interviews raises questions concerning the validity of participant observations. There is strong evidence in participants' responses, of bias towards gratitude, generosity and social appropriateness, associated with the perceived 'insider' positionality of the researcher. Secondly, in addition to the inflexibility of previous interventions noted above, the majority of studies reviewed offered therapy within a group format (e.g., Barras et al, 2009; Brown et al, 2005; Cheavens et al, 2006; Morton et al, 2011). It is possible that any advanced benefits perceived by participants to be associated with the new Therapy Programme might be attributable to its person-centred approach (conceptually-driven and individually-delivered) more than its unique content. Future research will need to examine the relative importance of these different factors.

8.3.4 Participants' Experiences of the Therapy Programme

The principle thrust of the research design was the gathering of participants' lived experiences of the Therapy Programme and the distillation of those observations into focussed recommendations for its improvement. These experiences might be said to primarily reflect the individual's engagement with the Programme. Participants' observations touched upon a wide breadth of areas. Limitations of space have required that the previous chapter and this have considered five only. In each case the subject has been chosen for attention because participants' observations and the emergent critical interpretative reflections offered clear ideas for improving the programme.

The conceptual delineation of 'pure' and 'applied' was developed as a categorical device in the analysis of intervention studies during the undertaking of the literature review. The terms were not verbalised by participants directly, but the associated themes were implicated in a great deal of their reflections. 'Pure' elements of the Therapy Programme were concerned with the specific deconstruction of the experiences of hope or self-esteem and were, primarily, targeted towards changes in those attitudes that might give rise to (or allow) subsequent changes in illness-management, social integration and occupational functioning. They were generally founded in cognitive-change and were process-orientated.

‘Applied’ elements were concerned much more with the operationalising of truly-meaningful ‘life-goals’. They were, if not exclusively, strongly biased towards the behavioural and very content-specific. A clear critique arising within the literature review was that interventions which were overly biased towards the ‘pure’ might have suffered from not being tethered sufficiently to meaningful, life-sustaining goals (e.g, Hall and Tarrier, 2003) and those that were too ‘applied’ might have been experienced as too narrow or ephemeral (e.g. Cheavens et al, 2006). In this study, participants expressed or implied the views that the achievement of cognitive re-evaluations and behavioural wins were both of huge value and, therefore, both essential to the efficacy of the approach. There was a suggestion that ‘applied’ gains were more immediately rewarding and, consequently, engaging, but of questionable sustainability in the absence of an underpinning cognitive-shift. Although some participants had actively manoeuvred for a priority attention to the ‘applied’ within their uniquely-tailored Therapy Programme, the consensus view was that robust and earlier attention to the ‘pure’ was more likely to achieve a balancing of short and long-term engagement.

The significance of therapeutic attention to participants’ illness narratives is well established within the general field of Early Psychosis (Yanos, Roe and Lysaker, 2010). The relevance of these understandings specifically to the negative evaluations of self and the future of those so diagnosed had been recognised prior to the research (Knight, Wykes and Haywood, 2006), but not accorded a position of centrality. The research was undertaken within a specialist service that publicly prides itself on its open-minded and collaborative approach to this issue as a standard aspect of Treatment as Usual. In response to consultation feedback, discussion of these considerations was, consequently, removed from the Participant Handbook on the grounds of redundancy and there was no specific plan for their exploration within the Therapy Programme. In every case, however, this issue was a significant focus of the therapy, both in the amount of time that it took-up, and, more importantly, its impact on the therapeutic progression. One participant specifically observed at follow-up that movement would not have been possible (‘pure’ or ‘applied’) without first addressing the oppressive paralysis of his previous understandings. It is of note that consideration of participants’ illness narratives was the primary mechanism of content-specificity in the delivery of the Therapy Programme to *Early Psychosis Service users*. Without that attention the Therapy Programme might have been viewed as a more generically-orientated intervention. This much more invested perspective is supported strongly by the research strands associated with Yanos, Roe and Lysaker (2010, 2011) and McCay and colleagues (2006, 2007), which were identified in a post-therapy search of the literature. It was absent, however, from the original Lecomte et al study (1999) and that by Hall and Tarrier (2003), even though they were also concerned with participants who had been the subject of disabling and pejorative illness labels. The recommended new structure for the Therapy Programme (Appendix 5F) locates this aspect of intervention as a key early process.

The literature review critically-evaluated some interventions as having been delivered with too much rigidity or invariance, and insufficient attention to the unique needs of the individual client (e.g. Hall and Tarrier, 2003; Morton et al, 2011). This Therapy Programme was designed, in direct contrast, to be delivered flexibly, with a loosely recommended core structure and a menu of available strategies and techniques to be used in line with the person's collaboratively-negotiated unique problem-formulation. The findings of the study suggest that this commitment to avoiding rigidity was experienced as having been taken slightly too far. Participant observations reflected upon the relative merits of more or less structure and clarity and the place of 'prescribed action' within a framework of democratic collaboration. It is of note that that perspective of collaboration was particularly strongly emphasised in light of the research agenda that defined participants as colleagues. Participants' challenged the hegemony of non-directive collaboration in favour of a recognition of the need, at times, for the therapist to take a more authoritative position in prescribing action. The interpretative reflections envisaged this as a collaboratively-negotiated agreement to, temporarily, delegate power to the therapist. Along-with that view participants moved for a more tangible core skeleton that might provide predictability and clarity of direction. It was suggested that the Participant Handbook would be singularly improved by the importation of such a structure. The researcher's reflections on flexibility and structure, also, connected with developmental-considerations with regard to fidelity and generalisability. The confirmation of high fidelity to the written Therapy Programme not-with-standing, the commitment to flexibility was manifest in four very different Therapy packages. Although the therapist-researcher would argue that this variance was consistent with a ‘case-formulation-driven-approach’ (Persons, 2005), the level of variance adds further questions regarding the validity of extrapolating recommendations for repetition or generalisation.

In the process of facilitating or delivering therapy it is always advisable to give periodic reflective consideration to the dynamics within the therapy room. Where a client struggles with issues that are associated with relational unease and pessimistic expectations of everything that they try that attention becomes paramount. Participants overtly identified, implied and made manifest in their actions (both in the course of the Therapy Programme and the research process) a number of dimensions reflecting their attitudes towards themselves and their future. The discussion picked up on those that implicated a need to please and to be liked, a sensitivity to criticism, the risk of negative comparisons with the therapist, a worry about losing more when trying to win and the inspiration of hope in the beginning of a therapy journey. The last included the potential undermining of self if too much of that hope was invested in the personhood of the therapist rather than the process of the Therapy Programme. These ideas are not new (Fennell, 2016). It is of enormous significance, however, that, although several articles considered the potential for a nurse or therapist to use ‘themselves’ to model and inspire hope (Miller, 1986; Nowotney, 1986; Cutcliff, 2004), none of the intervention studies reviewed discussed these themes in relation to their delivery or outcomes. It is particularly to be noted that the most natural therapeutic devices for engaging hope and faith in the process - therapist competence, confidence and encouragement - also, potentially pose the greatest risk to undermining client self-confidence in the room. Attention to these two normally-discreet constructs as a combined and reciprocating complex highlights the need to consider the broader consequences of such actions. These approaches are not dismissed, but greater reflection on their relevance to the person’s unique conceptualisation is strongly recommended.

8.3.5 Participant Handbook

A unique and central resource in the delivery of the Therapy Programmes was the Participant Handbook. In the original process of writing the Handbook there was some debate as to whether it might most usefully be produced as a guide to the professional or as a resource for the participant. This dilemma remained a live consideration throughout the early stages of its creation and was reflected in some inconsistency of style and content in the completed first draft. Following a process of local consultation, with service users, carers and professionals, the firm decision was made to focus on its function as an adjunctive resource for the therapy, as reported in Chapter 5 and discussed throughout this thesis. It was postulated that a handbook for the participant, if written in sufficient depth, might be used, secondarily, as a framework against which to evaluate therapeutic fidelity and as a basis for engaging with the wider professional team of the host mental health service. It is important to note, however, that these associative considerations were deemed to be significantly less important to the progression of the research. As a consequence, those parts of the handbook adjudged through the consultative process to be most strongly organised to 'speak to' the professional were extensively rewritten.

Participants' observations regarding the handbook were quite mixed. Some of those concerns expressed simply reflected a clumsiness in the style of the author. Most might be attributed to confusions arising from the initial duality of focus along with the subsequent secondary purposes reported above. In general, participants were extremely positive about the design of the handbook, which was described as immediately and viscerally engaging. Those elements of the text written more clearly for the participant, illustrative examples, worksheets and exercises, were experienced as inspirational. Participants noted, however, that the book was simply too big, too complex in places and too off-putting. They expressed particular unease with those sections that appeared still to be more geared to the professional and, especially, those that engaged with considerations of evidentiary justification. It was specifically observed that this form was experienced as most over-whelming at the beginning of each person's therapy journey, when they were trying to embrace hopefulness for the future, whilst remaining essentially unconfident in themselves. The Handbook will remain a central consideration in the progression of the Therapy Programme, but participants' guidance will be heeded and their specific recommendations will be followed. In particular, the handbook will be reproduced as two versions with very distinct purposes – to reflect the original debate noted above.

Both handbooks will include details of the content and process of delivery of the Therapy Programme, along with a clear recommended structure or plan for implementation. Both with include additional sections which pick up on the interconnections between hope and self-esteem, narratives of illness and motivation to progress and sustain difficult life-changes. The Handbook for Professionals will retain an expanded discussion of comparative research and the evidentiary support for the development of the new intervention. In that book, the style will be more academic, and with more assumptions of shared language. The worksheets will remain in the appendices of the book, but will be reviewed for relevance, and amended for more simple reproduction and clinical utility. The Handbook for Service Users, on the other hand, will be deliberately reduced in size and depth of discussion. Academic and evidence-based sections will be removed or rewritten. More service-user stories will be included, learning from the therapist's experiences of delivering the Therapy Programme and picking up, in particular, on understandings about psychosis, self-stigma and motivation. The language will be moderated to a lower reading age, calculated with regard to syllables per word and words per sentence. Specificity with regard to reading age will be determined through further consultation with local service users. The work-sheets will be included within the text rather than in the appendices, with encouragement for the reader to consider relevance to self and guidance for them to complete the sheets as they progress through the book. It is still intended that this handbook will be for use as an adjunctive resource to a therapist-lead intervention, but with the modifications necessary to support greater accessibility for self-guided learning. Service-users wanting more detailed information will be given access to both texts.

8.3.6 Recommendations

The principle objectives of the study involved the elicitation or creation of direct and specific recommendations for the improvement of the Therapy Programme. Those recommendations were reported in the previous chapter and that detail will not be rehearsed again here. It is important to note that, although there has been reference to consensus reflections and recommendations, participants were disparate individuals, offering, at times, confused or conflicting ideas – both within their own stories and across the group. It is the responsibility of the therapist-researcher to decide how to listen and respond to that picture. Those decisions have reflected, and will continue to reflect, the biases of his own aspirations, pre-expectations and personal experiences of the Therapy Programmes facilitated. Recognition of those biases – the forces of co-construction in the creation of a map – has been a central consideration of the research, informed by the underpinning paradigm of critical realism.

8.3.7 Co-constructive Forces

Co-constructive forces might be said to operate at all levels and throughout the broad process of undertaking the research – from the first contact with potential participants, through recruitment, the delivery of the therapy, to the conducting of the feedback interviews, the analysis of emergent data and articulation of the research story in the writing up of the thesis (Burr, 1995). In all of those processes, construction reflects a dynamic between the people involved, most particularly the therapist and participant-service-users, contextualised by the expectations of research, therapy and organisation. It is not possible to encapsulate all of the stratified layers of involved influence. As a key assurance strategy, the research attempted to 'bracket-off' something of the researcher's thoughts prior to their undertaking the first feedback interview. The tables presented in Chapter 6 illustrate something of the convergence and divergence with regard to issues raised. They don't reflect the influence of the therapist-researcher in the conducting of the feedback interviews. The critical interpretation of the feedback interviews paid equal attention to the utterances of the therapist-researcher as to the words of participants. As noted previously, in the exploration of findings, however, the author-researcher elected to focus on the interweaving strands of the participant's 'state of mind' at the time of the feedback interview and the significance of the therapist as interviewer. Participants expressed considerably more positives than negatives – in spite of clear messages that improvement of the programme required the identification of flaws. It has been suggested that this bias might reflect a combination of gratitude consequent to the perceived successes of the Therapy Programme (not-with-standing the cautionary note with regard to causal attributions) and a discomfort with the expression of criticism. It is hypothesised that some aspects of dynamic influence, described above in relation to the enactment of hope and self-esteem in the process of doing therapy, might equally play out in the process of doing research.

8.4 Critique of the Research Design

It has been emphasised throughout this thesis that the priority focus on the study discussed was on the gathering of qualitative data – participants' observations concerning their experiences of involvement with the Therapy Programme and their recommendations for its improvement. As noted in Chapter 5, however, CBT is a therapeutic approach that makes extensive use of outcome measures and other numeric instruments to assess need, guide planning, fine-tune intervention strategies and evaluate progress. The utilization of such 'therapy-generated' quantitative data is routine in the evaluation of CBT-based intervention programmes – as evidenced by the hope- and self-esteem-targeting intervention research reviewed in Chapter 4. The study was, therefore, shaped to take advantage of the outcome data generated by the therapy through the use of a mixed methods design. Given the primacy of the qualitative agenda, a 'QUAL quan' approach was adopted (as defined by the taxonomy of Tashakkori and Teddlie, 1998). The following discussion of the limitations of the design and undertaking of the research considers these two elements separately, as well as touching upon the process by which the quantitative data was integrated within the qualitative agenda at the stage of data collection. The critique of those elements of the research design concerned with the quantitative data pays particular attention to the small sample size, the lack of inclusion of a control or comparison group and the extended delay to follow-up. It, also, addresses the potential significance of employing unvalidated subjective measures to map changes in hope and self-esteem on a session-by-session basis, albeit, in addition to the use of established measures. These design features are considered with reference to the validity of the data gathered and the credibility of any conclusions that might be drawn concerning the relationship between involvement in the therapy and changes recorded in the outcome measures. The evaluation of the qualitative components of the research design is principally concerned with the implications of the 'insider' positionality of the researcher-therapist (Dhillon and Thomas, 2019) and, in particular, the design decision for him to undertake the feedback interviews. The critique concludes with reflections on the potential significance of the omission of any formal evaluation framework as a meta-methodology to provide overarching guidance for the research-design within the context of a planned multi-study research agenda and as a mechanism to reach out towards intersecting research programmes and teams.

8.4.1 Limitations relating to the capture and analysis of Quantitative data – small sample size, lack of a comparison group, use in research of unvalidated instruments and the extended delay to follow-up

The implications of sample size, lack of a control condition and the extended delay to follow-up have been noted on a number of occasions throughout this thesis. This section collates those intersecting points with the purpose of presenting a concerted perspective on the utility, validity and generalizability of the quantitative outcome data. A small sample size was selected to address the research-priority of gathering qualitative data relating to participants' experiences of the programme and their recommendations for change. A sample size of 8 was chosen in order to (i) make available sufficient qualitative data for the purpose and depth of the study, but, following the advice of Smith and colleagues, 2009, not so much as to overwhelm the process of analysis, (ii) gather sufficient quantitative data to be interesting and meaningful enough to make the case for ‘proof of concept’, and (iii) to achieve the above whilst, also, accommodating the possibility of some participants withdrawing from the therapy or study. It was never anticipated or required that the sample size be sufficiently large enough to support meaningful statistical analysis, but it was felt that the outcomes of 8 participants examined with reference to individual clinical significance might have had some validity. In the event, the rate of attrition - 3 participants discontinuing the therapy and a fourth declining to complete the research - was higher than the worst-case scenario predicated on the experiences of other studies reviewed (see Chapter 4). Although there was still sufficient qualitative data generated to meet the research requirements for the critical evaluation and fine-tuning of the approach, the already-limited value of the quantitative data was much reduced.

Secondly, as noted, the study did not incorporate a control or comparison group. The inclusion of a control condition allows the researcher to compare the experiences of those who engage with an intervention with those who do not. In the context of this study, the comparison might have considered changes in hope, self-esteem and wellbeing over a defined period, which, for the intervention group, would have involved the delivery of the target therapy. The failure of the study design to include any such data has meant that all references to changes identified over the period in which the Therapy Programme was delivered have had to be regarded with considerable caution. Care has been taken to ensure that this lack of any credible certainty regarding associations has been acknowledged throughout the thesis. Nevertheless, the quality of conclusions relating to outcomes has been reduced by this deficit.

Thirdly, participants were followed-up two-years (approximately) from the commencement of their therapy. Given the variance in the time that it took for each to complete the programme this amounted to a range of 14 to 20 months from the end of their engagement with the therapy and the undertaking of their feedback interview. No other data was collected over this period. As with all features of the study design, the priority purpose of this decision was to capture rich and textured qualitative feedback. The delay was intended to give sufficient time for any benefits accruing from the Therapy Programme to be tested in relation to participants’ experiences of the progression of life goals and enactment of life decisions, and consequent challenges and set-backs. It was, also, felt that an extended delay, away from the therapy and therapist, might allow participants to gain a measure of ‘objective perspective’ with regard to their experiences of involvement with the programme. It is argued that this strategy was successful in achieving those goals. The extended delay, with the ‘welcomed’ changes and challenges to participants’ lives, however, increased the possibility of the introduction of innumerable additional confounding variables, the consequence of which has been to further undermine considerations regarding causal attribution. It is acknowledged fully that this particular design-decision was significantly flawed. The approach resulted in the gathering of quantitative data that added no value to the research. The qualitative agenda would have been equally well addressed by a much-reduced follow-up period. Alternatively, the research would have benefitted from a more exclusive focus on qualitative feedback alone.

Finally, in this section, intervention studies tend to give primacy to outcome measures that have been evaluated extensively, have shown evidence of internal consistency and subject-validity, and for which relevant normative data is available (see Chapter 4). These qualities or characteristics afford professional credibility. Snyder’s Adult Dispositional Hope Scale (SADHS – Snyder et al 1991), Robson’s Self-Concept Questionnaire (RSCQ – Robson, 1989) and the CORE-OM (Barkham et al, 1998) meet those criteria. Subjective measures of distress (SUDs) are, as the name suggests, organised with reference to the idiosyncratic experiences and interpretations of the individual, tend to be simpler in nature and have no comparative validity. They have an established utility within clinical practice, as they offer a snapshot of service-user experience, which can be gathered quickly and immediately without the time needed to complete a more extended assessment within the session or the risk of a participant failing to complete a measure taken home. They are, however, rarely employed as a central device in research as there is no basis from which the scores of one-person might be directly compared with those of another. Sitting alongside the more formal instruments listed above, the SUD ratings were not used in isolation in this study.

Nevertheless, they were employed to clinical benefit within the delivery of the Therapy Programme and have been incorporated within this thesis to illustrate the pattern of change of each participant-service-user's perceived hope and self-esteem. Where the trajectories of different participants have been presented simultaneously the purpose has been to pick up on the shape of change rather than the degree. No analyses of this data have been offered with regard to either statistical or clinical significance. The SUD scores are, however, unvalidated, are subjective not just to the person, but also the moment, cannot be directly compared and can be misleading. Consequently, although useful as a 'mapping' tool, the data arising in relation to these scales has to be regarded with particular caution.

The gains in scores for hope, self-esteem and wellbeing, from pre-to-post therapy, were substantial for 3 of the 4 completer-participants. Those from baseline to follow-up were even greater, and included the fourth completer. In the context of the study-design employed, with a small sample size, high attrition rate, lack of any control condition or information, an extended delay to follow-up and the reliance, in part, on unvalidated and subjective measures (and with all of the consequences noted above), those results might be said, at best, to be 'interesting'. It might be argued that that the 'corroborating evidence' of the triangulated qualitative data presented in Section 7.5 could be regarded as 'suggestive of significance', although that data has its own issues of credibility to address (see below). It is important to remind the reader that the study design did not prioritise the quantitative evaluation of the outcome. The design met its principle objectives, both qualitatively, in generating recommendations for improving the programme, and quantitively, in generating numeric data of sufficient 'interest' to support 'proof of concept'. It might be regarded as ungracious should the study design be adjudged to have failed for not achieving goals that it did not set out to deliver. Nevertheless, in the face of such substantial gains in the outcome data collected the inability to draw strong conclusions in support of the value of the programme is disappointing.

It has been noted on several occasions that this study represented just one step in the MRC guidance (Craig et al, 2008) for the development of a novel, complex intervention. Further small-scale studies are planned, to progress exploration of implemented changes to the approach and to test out variables of the Therapy Programme relating to developer effects, the development of a structure for therapist-training (including gateway knowledge, skills and qualifications for those delivering the programme) and attention to participant age. It is proposed that these future studies would benefit from a number of modifications to design, learning from the points identified above. With regard to sample size, these planned studies will continue to prioritise the gathering of qualitative data and participant numbers, of necessity, will remain limited. It is, however, suggested that they be organised with reference to a ‘minimum number of completions’ rather than a ‘fixed number of commencements’. That intent might be achieved either by a strategy to recruit a substantially greater number of participants than required for data collection at completion or the ongoing recruitment of participants until sufficient numbers have completed a course of therapy.

In addition, although the inclusion of specific, time-and-resource-balanced control groups might be a solution, such a process could be considered to be disproportionate within the context of small-scale pilot investigations. An alternative strategy might be to establish a comparative norm for the trajectory of service users’ experiences of hope and self-esteem, in response to TAU, as they progress through the period of support within the host EIP Service. Given the evidence arising from the various literature reviews undertaken for this research, along with the, albeit more limited, evidence arising directly from the study itself, the host service has engaged with an argument that the hope- and self-esteem-experiences of service users might be regarded as aspects of need, barometers of wellbeing and indices of change. On that basis discussions are advanced for the inclusion of measures of hope (SADHS – Snyder et al, 1991) and self-esteem (RSCQ – Robson, 1989) within the battery of clinical assessments utilised routinely within the service. This service investment might be regarded as a first measure of the ‘adoption’ of the intervention and associated research (Glasgow, Vogt and Boles, 1999). Subject to further discussions regarding questions of consent in clinical practice, research, audit and service evaluation, part of that progressively accruing data might be utilised to provide the requisite comparative norms for the next stages of the development of the intervention. If the intervention progresses to stage 4 of development (as defined by the MRC) matching control conditions will be required. It is important to acknowledge that service structures, resources and deliverables are in constant flux, subject to changing circumstances with regard to newly emerging research, shifting policy drivers and the economic pressures on the host organisation. As a consequence, TAU might also be regarded as a changeable feast – not merely with regard to differences between clients, but differences between the range of packages offered to clients over a period of time. Consequently any 'normative data' determined within a single such analysis will have a limited time frame with regard to 'being in-date' before it loses its credibility as a reasonable comparator for ongoing research. It will be important, therefore, to either plan the concurrent gathering of normative data alongside outcome data from the next stages of developing the intervention or to make the gathering of such normative data a longer-term service commitment.

Finally, with regard to the evaluation of findings relating to the outcome measures, it is acknowledged that very small sample sizes will limit any capacity for the pursuit of meaningful statistical significance. It is suggested, however, that a continued focus on individual clinical significance, combined with the gradual aggregation of outcome results accruing from multiple small studies, might begin, over time, to generate a more credible basis of evidence. That agenda will be furthered by the incorporation of brief, but validated, assessment of session-by-session change and a strategy for more regular and less delayed follow-up of quantitative data.

8.4.2 Limitations relating to the gathering and analysis of qualitative data – the strategy of therapist-as-research-interviewer

Considerations regarding the limitations of the study in relation to the qualitative elements of the design are centred on questions concerning the processes of co-construction associated with the facilitation and analysis of the post-therapy feedback interviews. It was noted in Chapter 6 that the 'raising to visibility' of aspects of the complex processes of co-

construction had a dual purpose. At one level this represented a hermeneutic engagement with the research as a cartographic exercise – producing maps not facts (Korzybski, 1948). That level of reflection was concerned with seeking understanding through divergent exploration. The second level of consideration reflects a more convergent focussing down on evaluative examination of the research design. That critique asks if identified or hypothesised biases might have undermined the credibility of the research findings.

It was noted in Chapter 6 that, in developing the study-design, the decisions were made to access participants' experiences, observations and recommendations (qualitative data) through the format of semi-structured interviews and to process the emergent data using IPA's strategy of interpretative reflective analysis (Smith et al, 2009). Having determined this approach a decision needed to be made as to who might undertake these two roles. Two alternatives were considered – that these functions be met (one or both) by the therapist-researcher or by a research colleague, not otherwise involved in the study. The development of the study-design included a commitment to coherence across the integrated structure of philosophy, methodology and the pragmatics of the method employed. Critical realism (Bhaskar, 1975, 1993, 1998; Bhaskar and Danermark, 2006; Clark, Lissel and Davis, 2008; Walters and Young, 2010) and IPA (Smith et al, 2009), both, advocate the dual perspectives of seeking to explore or discover 'what is', whilst embracing and raising to visibility the processes of construction that shape the way that 'what is' is perceived and storied. Neither critical realism nor IPA offer direct or specific guidance with regard to 'who should best undertake the feedback interviews and analyses in practitioner-led, action research?' Furthermore, it is argued, both were adjudged to equally support either strategy-option on the grounds of philosophical or methodological coherence. Determination of the most useful approach, therefore, was progressed with reference to pragmatic considerations, and through the undertaking of a cost-benefit analysis.

Attention to matters of pragmatism needs to acknowledge the significance of the academic context of the study, in relation to which, the absence of a research-grant imposed limitations in terms of access to resources and created a reliance on the generosity of others. It is, also, important to acknowledge the influence of researcher-allegiance to the research design and the potential discomfort associated with delegation. Although these points were not regarded as particularly significant at the time that the study-strategy was being developed both would have supported an argument for these roles to be undertaken by the therapist-researcher. It is not unreasonable to suggest that they might have contributed to the decision-outcome. It is, nevertheless, important to stress that the predominant determinants with regard to this decision-process related to the potential implications, for good or bad, of the 'insider-positionality (Dhillon and Thomas, 2019) of the therapist as researcher. As explained in Chapter 6, following a detailed cost-benefit analysis with reference to the identified benefits and problems of insider- and outsider-positionality, the decision was made for the researcher-therapist to undertake both tasks.

Dwyer and Buckle (2009, p59) note that concerns with researcher-bias in 'insider-positioned' research can be reduced with 'disciplined bracketing and detailed reflection on the subjective process', as well as a 'close awareness of one's own personal biases and perspectives' (referenced in Nakata, 2015, p179). Relevant adjunctive strategies employed in this study included the undertaking of a 'researcher-interview' prior to the first of the feedback interviews and extensive self-reflection across the analytic process through the multi-layering of observations of each transcript and the sharing of attention to the words of the researcher alongside those of the participant. In addition, check-back letters were sent to all participants to invite feedback on the researcher's interpretations and the follow-up included an invitation for further reflection on both the experience of the therapy and the observations arising from the research. These mechanisms were employed, both, for the purpose of reducing researcher-biases, and to raise them to visibility, to allow the reader to make their own evaluations of credibility. Finally, to support clarity with regard to the focus of the discussion an audit of Fidelity was progressed.

As noted in Chapter 6, however, the process of each semi-structured, feedback interview was, also, informed by the biases arising from participants regarding their perceptions or constructions of their relationships with the therapist and Therapy Programme. At the stage of designing the research, two potential issues were anticipated - (i) that the paralleling of therapy and research process might result in a blurring of distinctions between the two, and (ii) that participants might experience strong emotions, with regard to the therapist and therapy, whether of gratitude or frustration, that might impact on their capacity to provide 'honest' and balanced feedback. The second of these risks was regarded as of particular importance. The fundamental premise underpinning the purpose of the study was that there would be issues with regard to the content or delivery of the first iteration of the Therapy Programme that could be improved upon. It was central to the study design that participants be able to tell the 'truth' (Bonner and Tolhurst, 2002) regarding their experiences of the intervention and their ideas concerning its necessary revision. In addressing this consideration, it was not deemed possible or appropriate to anticipate which participants might find it more difficult to express critical thoughts to the therapist-as-interviewer, to assess this directly or to offer individuals the choice.

Dhillon and Thomas (2019) have proposed that insider research might be progressed effectively by 'engaging' individuals in the process, rather than inviting them to, simply, participate. Nakata (2015) has suggested that this involves explicitly defining them as 'cooperative generators of data' (p177). In this study, participants were actively and transparently recruited to a project as 'participant-collaborators' in the task of improving the Therapy Programme. Acknowledging that some individuals might agree to 'sign-up' to such an undertaking without a complete understanding of what was entailed, this purpose was, also, discussed periodically throughout each participant's course of therapy. Furthermore, competence and preparedness in expressing critical observations about the programme were modelled and practiced during the therapy with regard to the shaping of therapy-direction and under the auspices of 'developing confidence'. 'Seamlessness' between therapy and research was pursued through participant-determination of venue, date and time for both processes. Cognitive-separation was encouraged through frank, open discussion of the purpose and style of the feedback interview, together with the incorporation of a detailed critical analysis of outcome data as the starting point of that conversation. This second element, also, ensured the integration of quantitative data into the process of collecting qualitative information.

With regard to the outcomes of this study, it is the contention of the researcher-author that the relational forces discussed above were likely to have encouraged a greater focus on positive feedback, but that critical and meaningful recommendations for the improvement of the Therapy Programme were still forthcoming. On that basis, the research is deemed to have met its objectives. It is, also, postulated that the strategy of therapist-as-researcher was, as planned, successful in harnessing the benefits of access to privileged information, not merely with regard to the purpose and form of the intervention, but also the unique journeys of each participant's course of therapy. In the detailed, layered analyses of the interview transcripts there was no evidence to indicate that the interviewer had disattended to particular observations or contributions by the participants or that he had diverted significantly from the interview-plan. There is, in fact, clear evidence of extensive efforts by the therapist-researcher to encourage participants to identify aspects of the programme with which they were less enamoured or that they felt might be improved upon. The same cannot be said with regard to the possibility of biased interpretations. Although no such instances were identified in the interpretative analyses, it might not unreasonably be argued that the decision to use the same person to conduct each step in the process might have allowed particular interpretative biases to be replicated across the breadth of the research, included the stratified layers of meta-analysis.

At the same time, it is also important to note that the feedback interviews of FH2 and MJ7 were clearly influenced by overtly acknowledged feelings of gratitude and appreciation towards, both, the Therapy Programme and the person of the therapist-researcher. In addition, the interview with UH3 appeared to reflect a frustration with the events of his relapse, which, from his somewhat confrontational stance allied with self-critical statements, suggested a shared-blaming for these events on the therapy, therapist and himself. Further, LJ8 was overtly anxious about the end of the therapy and clearly struggled to separate therapy process from research process. She interrupted on several occasions to seek reassurance about the future and to endeavour to engage the therapist-researcher in 'therapy' dialogue. Her explicit request for further sessions might be regarded, both, as a validation of her engagement with the therapy (or therapist), but, also, an indictment of its achievements with regard to the goal of supporting her to becoming more self-determining 'going forward'. In addition, her active attempt to gain the reward of further sessions undermines the credibility of her positive affirmations of the Therapy Programme. Finally, two participants commented at follow-up that the research-interview had been experienced as a 'booster' session to the therapy – reminding them how to continue to use the therapy processes going forward. This strongly suggests a lack of effective conceptual separation between therapy and research.

There were other aspects of the qualitative-elements of the design that might, also, be said to have been less successful than desired. The decision to shape the feedback interview in relation to an open and transparent acknowledgement of 'therapy gains' proved to be troubling. The exercise created a therapist-dominated experience of the early part of these meetings. The impact is unclear. Whilst creating a context to the conversation that was clearly distinct from those progressed in the therapy, it, also, appeared to undermine somewhat the collaborative ethos of the interview conversation. It is suggested that those impacts were unlikely to have been an asset to the research-process. Furthermore, two of the key assurance strategies failed to deliver as much as was hoped for. The Participant Check-Back letters went unanswered and thought needs to be given as to how their purpose might be better negotiated. The researcher-interview generated a wealth of information, but little of it targeted towards its design purpose. That particular observation reflects a tension around delegation of responsibility and control to someone else. Future research will need to consider ways of promoting greater shared ownership amongst involved professionals.

In summary, two options were considered with regard to the facilitation of the feedback interview. Neither was deemed to be without flaws. The strategy of therapist-as-interviewer was considered to offer the greater benefits and was, consequently, adopted. Adjunctive strategies were implemented to address the potential predicted pitfalls. The evidence suggests that this combination of strategies was somewhat successful in containing and highlighting researcher-bias, but, at best, only partially successful in creating a context in which participants might offer ‘truthful’ reflections on their experiences, without the intrusion of considerations with regard to the ‘outcomes’ of their words. It is not, of course, possible to define the exact nature of the way in which observations and recommendations were shaped, only to note that there was evidence that they were likely to have been influenced. Similarly, it cannot be shown that the alternative strategy, the recruitment of an independent interviewer, would have been more effective in generating rich, detailed and, above all, ‘honest’ feedback. If, however, as Gergen notes (2011, 2015) the progression of any interview is shaped uniquely by those individuals involved in its enactment, then it is possible to say that the involvement of a different interviewer would have resulted in different conversations. Those conversations might not have been more productive with regards to the generation of critical evaluations and recommendations for improvement. The critique of the research design is left, however, with the significant possibility that it might have done.

It is important to recognise that the research design, in its own way, has been as unique as the new Therapy Programme. As such, it might, also, benefit from the exploration of different strategies. Future studies, using a similar structure, might consider recruiting an independent interviewer and, even possibly, the conjoint interviewing of therapist and participant as a collaborating system. Alternatively, any gathering of qualitative data might make use of questionnaires. On this occasion, the interview process was considered preferential on the grounds that semi-structured interviews might promote more opportunity for the researcher to connect uniquely, flexibly and in fine detail with each participant’s narrative, as well as reducing the risk of uncompleted or unreturned assessments at an un-remediable point in the research process. Questionnaires might, on the other hand, have been more successful in drawing a distinction between therapy and research, and creating a degree of separation from the person of the therapist. Such variations in the future might be considered with regard to the different maps that they have the potential to generate, rather than the right path to truth.

8.4.3 Limitations arising from the lack of a formal evaluation framework within the study-design

It is possible that some of the limitations identified in the previous sections might have been moderated by the employment of a structured evaluation framework. Evaluation Frameworks, in the context of research, have been described as ‘over-arching’ (Piggot-Irvine and Zornes, 2016) and ‘umbrella processes’, or as ‘meta-methodologies’ (Dick, Sankaran, Shaw, Kelly, Shaw et al, 2015, p38). They were developed, in the first instance, as a response to perceived failures regarding the adoption into practice of policies and interventions that appeared to have significant evidentiary support (Gaglio, Shoup and Glasgow, 2013; Glasgow, Vogt and Boles, 1999). The problems with take-up of ‘effective’ approaches have been attributed to the difficulty of establishing ‘linear causal relationships between interventions and impacts’ and the associated ‘lack of evidence and oversimplification of approaches in impact assessment of policy interventions’ (Kalpazidou Schmidt and Graversen, 2020, p1). Glasgow and colleagues suggested that much of this was associated with a tendency in research to be overly focused on ‘eliminating confounding variables’ and not enough on exploring wider measures of significance (p1322). They identified problems with insufficient reporting of demographic differences between participants and non-participants, recruitment methods or rates of attrition by participant characteristics. They noted issues of inattention to the broader effects of the programme and, in particular, the settings to which the intervention had been applied. They pointed specifically to questions of percentage-application in terms of the investigation of an intervention across the breadth of the relevant possible contexts. They highlighted gaps in the inclusion of data relating to characteristics of staff participants, adaptations made to the programme during and subsequent to the study, as well as the presence of broader or unintended outcomes. It has been suggested that all of these limitations might be regarded as relating to the challenges of addressing ‘Real World’ problems through the translation of outcome recommendations arising from oversimplified research conducted in situations of optimal-efficacy, with ‘perfect’ contexts and enthusiastic participants, and in the absence of any comprehensive implementation framework in their design, undertaking, evaluation or application (Carr, Loucks and Bloschl, 2018; Gaglio et al, 2013; Kalpazidou Schmidt and Graversen, 2020).

There are numerous established formal evaluation frameworks. All might be said to address three intersecting considerations – (i) the comprehensive, coherent and effective undertaking of each single piece of research, (ii) the coordination and integration of multiple studies, whether within a multi-faceted, complex research agenda by a single team or collective of researchers, or across diverse teams, from different disciplines, organisations and countries, and (iii) the adoption of those interventions across appropriate contexts and in the service of relevant individuals or groups. In typological discussions, they have been organised either with regard to their application or orientation.

In terms of application, four positions appear to have been identified. Some frameworks have been designed to be comprehensive, methodical and generic, such that they might apply in any situation – for instance, RE-AIM (Baba, Martins Oliveira, Ferreira Silva, Vieira, Cerri et al, 2017; Gaglio et al, 2013; Glasgow et al, 1999; Holtrop, Rabin, and Glasgow, 2018; Shoup, Gaglio, and Glasgow, 2015). Others offer a structure of generic and consistent processes that can be utilised to organise a bespoke package of strategies and instruments, consistent with the underpinning philosophy of the intervention under consideration and in relation to uniquely identified questions or parameters of interest – such as the Evaluation Framework for Action Research (EvAR – Dick et al, 2015; Piggot-Irvine and Zornes, 2016). There are frameworks designed for very specific political, strategic and / or health agendas, for instance EFFORTI which seeks to address gender inequality in science, research and innovation (Kalpazidou Schmidt and Graversen, 2020; Marra, 2020). Finally, there are those developed to highlight formative stages in the progression of a complex, extensive research agenda, for instance Rapid Cycling Evaluation (RCE - Skillman, Cross-Barnet, Friedman Singer, Rotondo, Ruiz and Moiduddin, 2019). RCE offers multiple assessments of competence over time, which introduces the opportunity for readjustment of the process and direction within the flow of a single study.

Kalpazidou Schmidt and Graversen (2020) have suggested that frameworks might, also, be described as (i) impact-orientated – focusing primarily on the direction, level, consistency and worth of any changes rather than the theories, methods or processes by which such changes are achieved, (ii) method-orientated – organised primarily with reference to the specific research-methods progressed, or (iii) theory-driven (theory-orientated) - ‘where assessed variables are selected according to a theory that formulates implicit or explicit assumptions about the interventions and the factors expected to be important to achieve impact’ (Chen, 2012 – cited in Kalpazidou Schmidt and Graversen, 2020, p3).

The building-in of an evaluation framework as a meta-methodology at the planning stage in research-design has been associated with a number of purposes and benefits. These have included guiding, both, the development and evaluation of an intervention, increasing scientific quality, improving comprehensiveness, internal and external validity, increasing coherence, and providing the structures for a standardization of experience (Car et al, 2018; Glasgow et al, 1999; Marra, 2020). Skillman et al (2019) have suggested that evaluation frameworks have the potential to promote consistency and rigour in the organisation of data from multiple connected studies, to generate insights into processes of implementation and outcome, and to draw attention to considerations relating to programme impact, implementation successes, sustainability and replicability. Car et al (2018) have stressed the significance of evaluation frameworks in bringing together knowledge and understandings from different disciplines, transferring information between collaborators and promoting a sharing of identity, values and understandings. Holtrop and colleagues have added that they can enhance the capacity of groups and organisations to own and sustain change (2019). Finally, Gaglio et al (2013) have noted that, in the USA, the identification of an established evaluation framework appears to be associated with greater success in applications for grant funding.

The study reported in this thesis did not include the adoption of an established evaluation framework. The research was of small-scale, with few participants and modest aspirations, and it might be argued that, in that circumstance, the utilisation of a meta-methodology would have been disproportionate. The investigation sits, however, within a planned agenda for multiple studies associated with the progressive fine-tuning, evaluation and implementation of the novel Therapy Programme under consideration. Furthermore, the development of that programme is contextualised by the daunting needs of the target service user population both individually and collectively across the country. That locates the intervention within the wider caucus of emergent novel therapies being progressed in the UK and elsewhere to address the same concerns. Including an evaluation framework might have benefitted this study with regard to each of these three layers.

It is unlikely that the utilisation of any evaluation framework would have justified a sample group large enough to support meaningful statistical analysis. Neither would it have been likely to argue for the incorporation of a control group for what was intended primarily as an exercise in gathering qualitative data regarding participants' experiences of receiving an intervention. On the other hand, the greater clarity of operating to an established 'meta'-protocol might have contributed to broader reflection on the potential consequences of, and effective response to, participant drop-out and might have led to an earlier commitment to more routinely gathering data on hope and self-esteem within the broader pool of those supported by the host EIP Service. It might, further, have helped with predictions of credibility, and, therefore, external validity, regarding the use of subjective measures, the extended time to follow-up and, most significantly, the role of therapist as interviewer.

The potential role of an evaluation framework in the coordination of multiple linked-studies is more striking. As noted throughout the thesis, the research under consideration is part of a more extended process in the development of a complex intervention – a process guided by the recommendations of the MRC (Craig et al, 2008). A number of studies are likely to be necessitated, progressing from smaller and more local consideration of successive iterations of the intervention and exploration of its application in relation to variables in participant characteristics, and progressing (hopefully) to larger investigations, across different sites and extending significantly beyond the person of the therapist. These aspirations speak to challenges of coordination across studies, integration of emergent data, and the need for attention to issues of service user 'reach' and professional 'adoption' (Glasgow et al, 1999).

It is argued that an early awareness of the significant potential value of an over-arching methodology to the larger agenda, might have supported the employment of an evaluation framework from the beginning. Not least within that consideration is the prospect that the larger studies planned for ‘further down the line’ will require effective application for grant funding.

Finally, evaluation frameworks contribute a standardisation of structure to a research endeavour that enables comparison and, potentially, integration with other intersecting studies. This promotes a clarity of presentation, which allows the research to be explored in relation to its own purposes, whilst, also, encouraging an appreciation of its connections to and variances from intersecting research. Any evaluation framework might award these qualities to a study, but the strategic adoption of a framework already employed within the field might have offered more direct opportunity for making connections, promoting a mutuality of ‘reaching-out’ and encouraging collaboration, cross-fertilization and support.

8.5 The Researcher’s Learning Journey

The research was undertaken within the context of an academic training. It was noted earlier that that imposes dual requirements for learning – in relation, both, to the subject of the study and the progression of the student as a researcher. The challenge for me has been much more in the delivery than the design of the study. There are two particular threads that I would like to touch on with regard to this.

The first is the issue of research paradigm. I have emphasised the significance of that throughout the authoring of the thesis. It might be thought that I have over-stated its importance. I do believe that it is easier to say less when travelling within the flow of established orthodoxies and that, by definition, it is more important to be clear when the perspective adopted swims against the current. That challenge has been particularly magnified in this context. My professional engagement with such concerns has passed through three stages – from my early indoctrination into positivist understandings, through the challenges of engaging with the social constructionist, to the balancing act that is reflected in critical realism. It is easier to take a stand against one's old allegiances when the position is of contradiction. I had thought that, intellectually, I had made the transition until my own interview by an experienced social-constructionist colleague. That interview might not have answered its intended purposes, but it did generate for me a wealth of questions and challenges about how to remain engaged with, both, knowing and not knowing. These concerns were reflected extensively in my critical interpretations of feedback interviews and the various stages of the construction of this research story. I do not believe that I have reached the peak in the development of my understandings, but am confident that I am travelling on the right path.

The second concerns the emergent data. I elected to employ a modified form of IPA, utilising a thought-streaming approach to the generation of critical reflections. I believe that this process allowed the inclusion of lateral considerations that significantly enabled the interpretative process. At the same time, it gave rise to the most incredible volume of information – overwhelmingly so. The greatest challenge in writing this thesis has, consequently, been concerned with trying to engage with that ocean of material without drowning in it. Whilst I remain committed to the value attendant upon this strategy, future studies will require additional measures of containment. It is interesting that there has been a parallel conclusion regarding, both, Therapy Programme and Research Design – that they have been experienced as inspirational, exciting and creative, but, also, in need of considerably greater imposed structure.

Chapter 9 – Conclusions

It has been noted throughout that this study has been part of a wider agenda to develop a complex, multi-faceted psychological intervention to address hopelessness and low self-esteem as experienced by young people recently diagnosed with First Episode Psychosis. The Therapy Programme is unique in its attention to the development of a conceptually and strategically coherent integration of understandings and approaches associated with the two central constructs. The primary objective of this study, a small part of the greater whole, was to progress the fine-tuning of the approach with reference to the lived experiences of study participants. The study has been adjudged to have been successful in achieving those goals.

It is, of course, important to keep in mind that the recommendations that have been generated are part of a live and ongoing process. There were a number of iterations of the Therapy Programme as it progressed through stages of construction and consultation prior to the research. The Therapy Programme that was examined simply reflected the most current version at that point. Recommendations from the research will result in the production of a new version of the approach, along with a modified Participant Handbook. That new version will, then, be subject to further research and re-visionings. Recognising this flow of development creates a context in relation to which the emergent recommendations might be thought of in terms of *a* ‘tentative next step’ rather than as *the* ‘definitive solution’.

Access to outcome data from the Therapy Programme, along-with other quantitative material, has, also, allowed the study to consider questions with regard to ‘proof of concept’. Given, in particular, the very small number of research-completers and the lack of a control condition (or access to normative data for the service user population) any conclusions with regard to numerical data have to be treated with considerable caution. The gains in hope, self-esteem and wellbeing, as recorded by the relevant instruments, are substantial. Average gains at the end of the therapy-period compared favourably with those associated with the pre-existing intervention literature reviewed in Chapter 4. The sustained and progressed gains to follow-up surpass anything previously reported. Causal association cannot, as stated, be proven, and the value of the approach remains unclear. The results are, however, interesting and worthy of note. It is too early to talk about generalisation to other clients or client groups. That position cannot be regarded as evidenced given the limitations of the research design. It is, however, argued that the identified changes alongside the subjective reflections of participants are ‘interesting’ enough to support the argument for proof on concept and to justify further exploration of the intervention.

Nevertheless, as noted, it is not finished. The research has highlighted a number of gaps in the literature – not least the absence of any comprehensive analysis of the patterns of relationship between the two constructs of Hope and Self-esteem. It has, also, indicated a number of avenues for further exploration. The ideal is to move towards a more extensive investigation of outcomes. Prior to that stage, however, there is an identified need for more exploratory research, with small groups, considering questions with regard to participant age, gender and ethnicity, as well as the examination of ‘developer-effects’ through the recruitment of other therapists. Finally, to extend the relevance of the study it is important that these ideas are shared with others. Any dissemination strategy will involve threads relating to the written and spoken word. The development of the Therapy Programme, progress of the research and outcomes achieved have been explored in team-training sessions locally and at conferences regionally and nationally. The ideas have been presented in clinical-training courses for professionals at the University of Derby and for Amica. Further presentations are planned, with an emphasis on the fields of Cognitive-Behavioural Therapy and Psychological Approaches to Working with Psychosis. Articles are, also, planned, though have not been progressed as yet. It will be, equally, important to present the unique research design as the unique Therapy Programme and papers will be targeted accordingly. The thesis has already identified plans with regard to the Participant Handbook. It is of note that very few of the researchers involved with the intervention studies reviewed have made their treatment protocols available, even when approached directly. Kees

Korrelboom was an exception to that rule. It is important that the two new versions of the Handbook are made available as soon as possible to encourage greater connection with the material as it is shared with others.

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Appendices

Appendix 1

Ethical Approvals to Commence the Research

A. University of Derby
B. NRES East Midlands

Appendix 1A - Ethical Approval – University of Derby

Letter dated 22nd May 2012

UNIVERSITY of DERBY

Approval Letter

Date: 22nd May 2012

Name: Daniel Pearson

Dear Daniel,

Re: Application for ethical approval for study 'Hopelessness and Compromised Self Esteem in Early Psychosis: Developing a Cognitive-Behavioural Therapy-based intervention Protocol'

Thank you for submitting your application for the above mentioned study which was considered by the Nursing and Allied Health Professionals Research Ethics Committee on 11th May 2012.

Your study has been **approved** and you are able to proceed. The committee also advises that it may be beneficial if you initiate the required NHS approval process now in preparation for stage two of your study.

Please note, if any change to the study described in the application or to the supporting documentation is necessary, you are required to make a resubmission to the Nursing and Allied Health Professionals Research Ethics Committee

Yours Sincerely

Joint Chair

Nursing and Allied Health Professionals Research Ethics Committee

Appendix 1B - Ethical Approval – NRES Committee East Midlands

Letter dated 8th January 2014

Health Research Authority

NRES Committee East Midlands - Nottingham 1
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839525

08 January 2014

Mr Daniel James Pearson
PIER Early Psychosis Service
Swithland House, 352 London Rd
Leicester
LE2 2PL

Dear Mr Pearson

Study title:	**Developing a Cognitive-Behavioural Therapy Treatment Programme designed to promote Hopefulness and Self-Belief in Mental Health Service Users recently diagnosed with a Psychotic Illness: A Pilot Study to explore the acceptability of the approach to potential recipients.**
REC reference:	**13/EM/0378**
IRAS project ID:	**128804**

Thank you for your letter of 31 January 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair and Vice-Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Miss Helen Wakefield, at nrescommittee.eastmidlands-nottingham1@nhs.net

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

The Committee has not yet been notified of the outcome of any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as one Research Ethics Committee has notified the outcome of a SSA. In the meantime no study procedures should be initiated at non-NHS sites.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

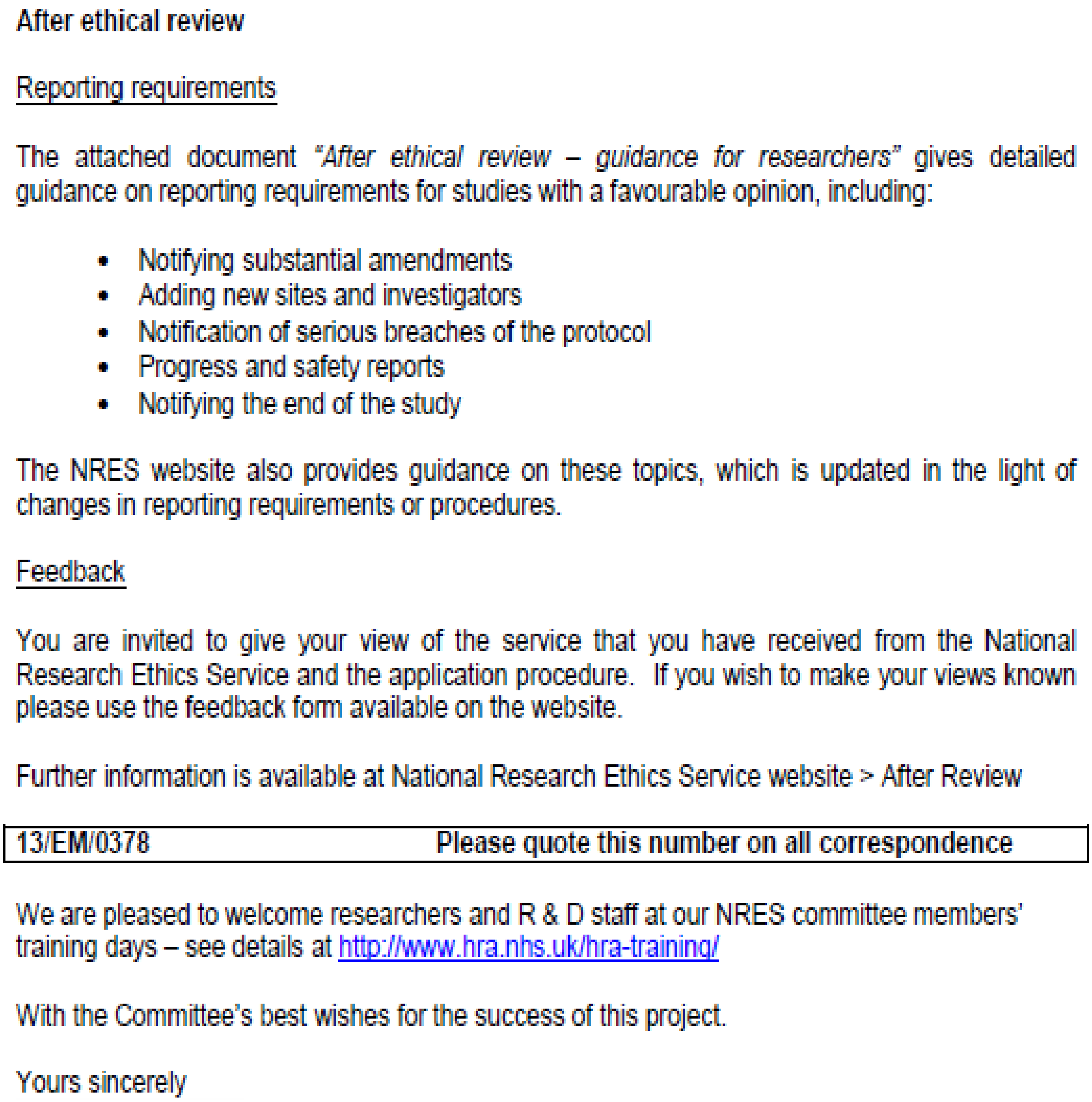
Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering Letter		24 September 2013
Evidence of insurance or indemnity		25 September 2013
Interview Schedules/Topic Guides		25 September 2013
Investigator CV	Daniel James Pearson	25 September 2013
Investigator CV	Michael Townend	25 September 2013
Investigator CV	Wend Wood	25 September 2013
Investigator CV	Trevor McDougall	
Investigator CV	Sam Abbott	
Other: Treament Manual		
Other: Fidelity Audit Tool	1	17 September 2013
Other: Treatment Programme	1	17 September 2013
Other: Algorithm of Recruitment Process (flow chart)	2	19 December 2013
Participant Consent Form	1	17 September 2013
Participant Consent Form: Independant Interviewer	1	17 September 2013
Participant Information Sheet	2	19 December 2013
Participant Information Sheet: Introductory Sheet	2	19 December 2013
Protocol	1	17 September 2013
Questionnaire: Snyders Adult Dispositional Hope Scale		
Questionnaire: Robson's Self-Consept Questionnaire		
Questionnaire: CORE Outcome Measure		
REC application	128804/501473/1/120	25 September 2013
Referees or other scientific critique report	Letter of approval from University Ethics Committee	23 July 2013
Response to Request for Further Information	Email	31 January 2013
Summary/Synopsis	1	17 September 2013

Statement of compliance

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



After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/EM/0378 Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely

Appendix 2 – Literature Review

(Relating to Chapter 4)

A. PRISMA Checklist
B. Example Wiring Diagrams
C. Tables of Outcome Results for Hope- and Self-Esteem-Targeting Intervention Studies

Appendix 2A – PRISMA Checklist

Adapted from - Moher, D., Liberati, A., Tetzlaff, J. and Altman, D.G. (2009)

Section / Topic	No	Checklist Item
Title		
Title	1	Identify the report as a systematic review, meta-analysis, or both.
Abstract		
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.
Introduction		
Rationale	3	Describe the rationale for the review in the context of what is already known.
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).
Methods		
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.

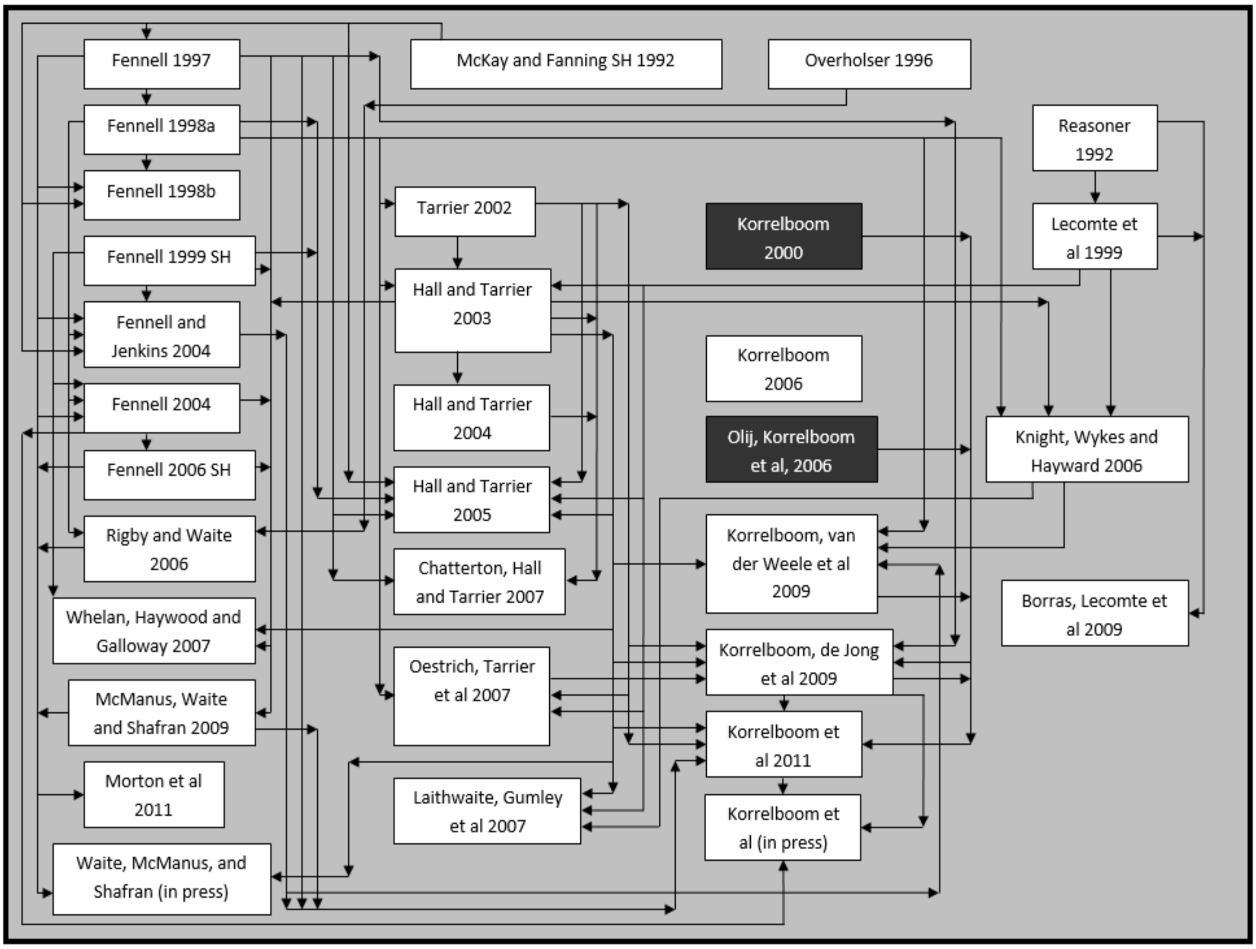
Section / Topic	No	Checklist
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.
Results		
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).
Discussion		
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.
Funding		
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.

Appendix 2B – Wiring Diagrams

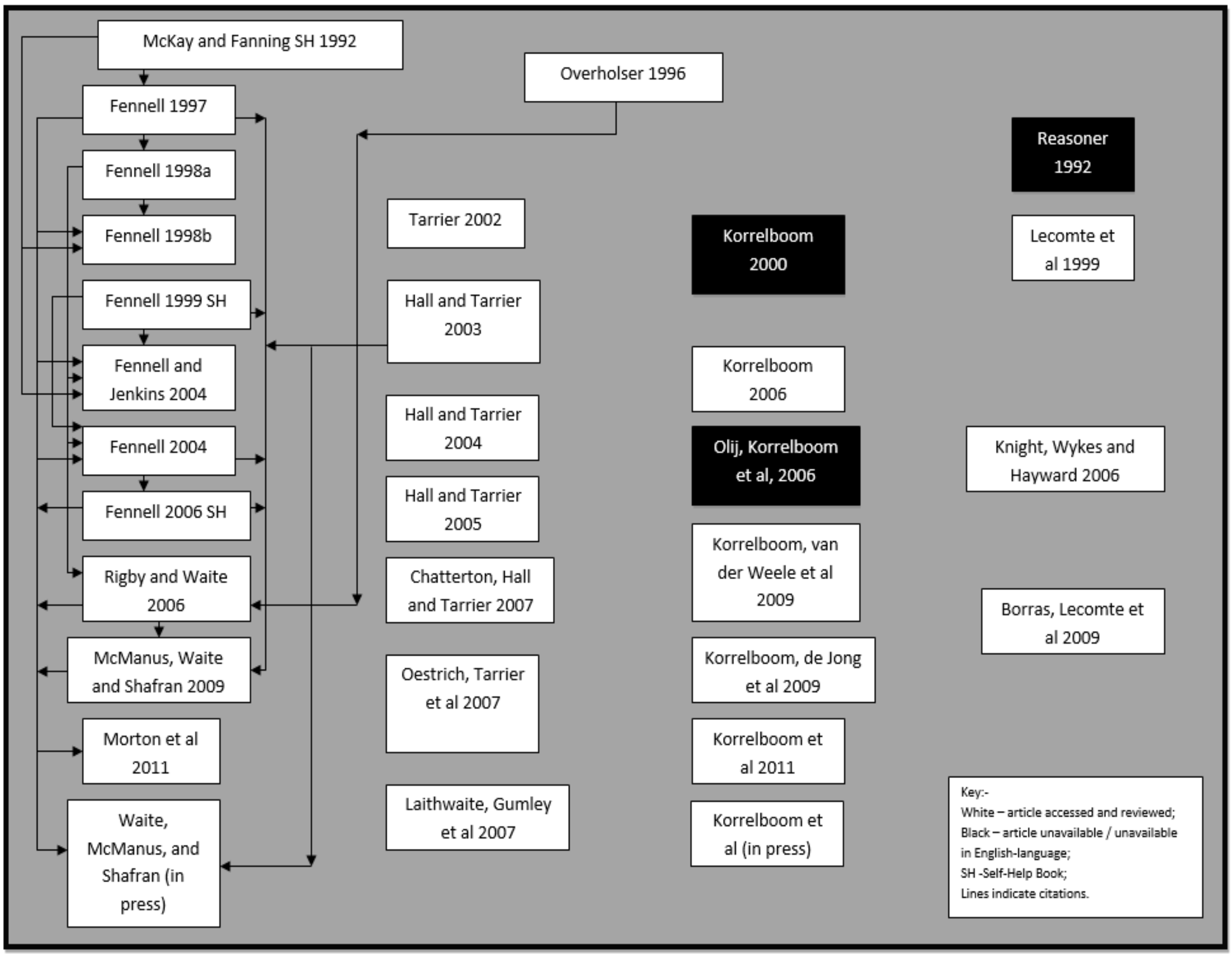
The Wiring Diagrams were created as a part of the first review of literature relating to Self-Esteem-Targeting Interventions. Several authors had commented on the paucity of intervention studies in the field, identifying on average just 4 prior studies. The exercise was intended to highlight the interconnectedness of the 4 main intervention threads identified. All of the studies identified at the time are listed. Lines represent citations.

In the event the diagrams became a statement about the lack of mutuality of awareness and cross-fertilisation of ideas. The diagrams are complex and were difficult to produce. They were not updated in the light of studies identified in the second literature review. Neither were they paralleled with regard to the Hope-targeting intervention studies.

- Wiring Diagram showing relationships between all articles and all research threads.
- Wiring Diagram showing citations acknowledged by articles / authors in the Fennell Research Thread.
- Wiring Diagram showing papers that cite articles / authors in the Fennell Research Thread.
- Wiring Diagram showing citations acknowledged by articles / authors in the Hall / Tarrier Research Thread.
- Wiring Diagram showing papers that cite articles / authors in the Hall / Tarrier Research Thread.
- Wiring Diagram showing citations acknowledged by articles / authors in the Korrelboom Research Thread.
- Wiring Diagram showing papers that cite articles / authors in the Korrelboom Research Thread.
- Wiring Diagram showing citations acknowledged by articles / authors in the Lecomte Research Thread.
- Wiring Diagram showing papers that cite articles / authors in the Lecomte Research Thread.



Wiring Diagram showing relationships between all articles and all research threads



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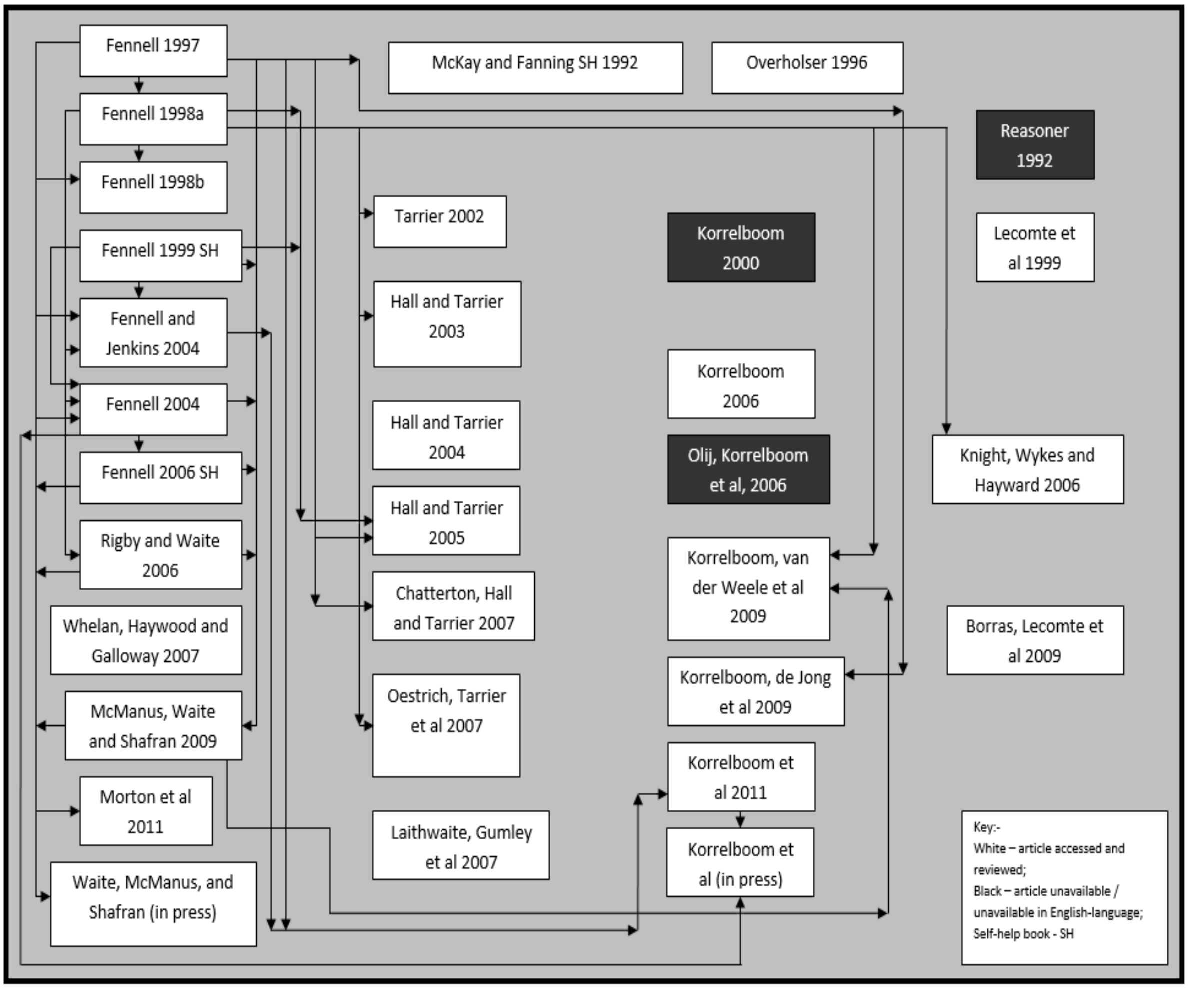
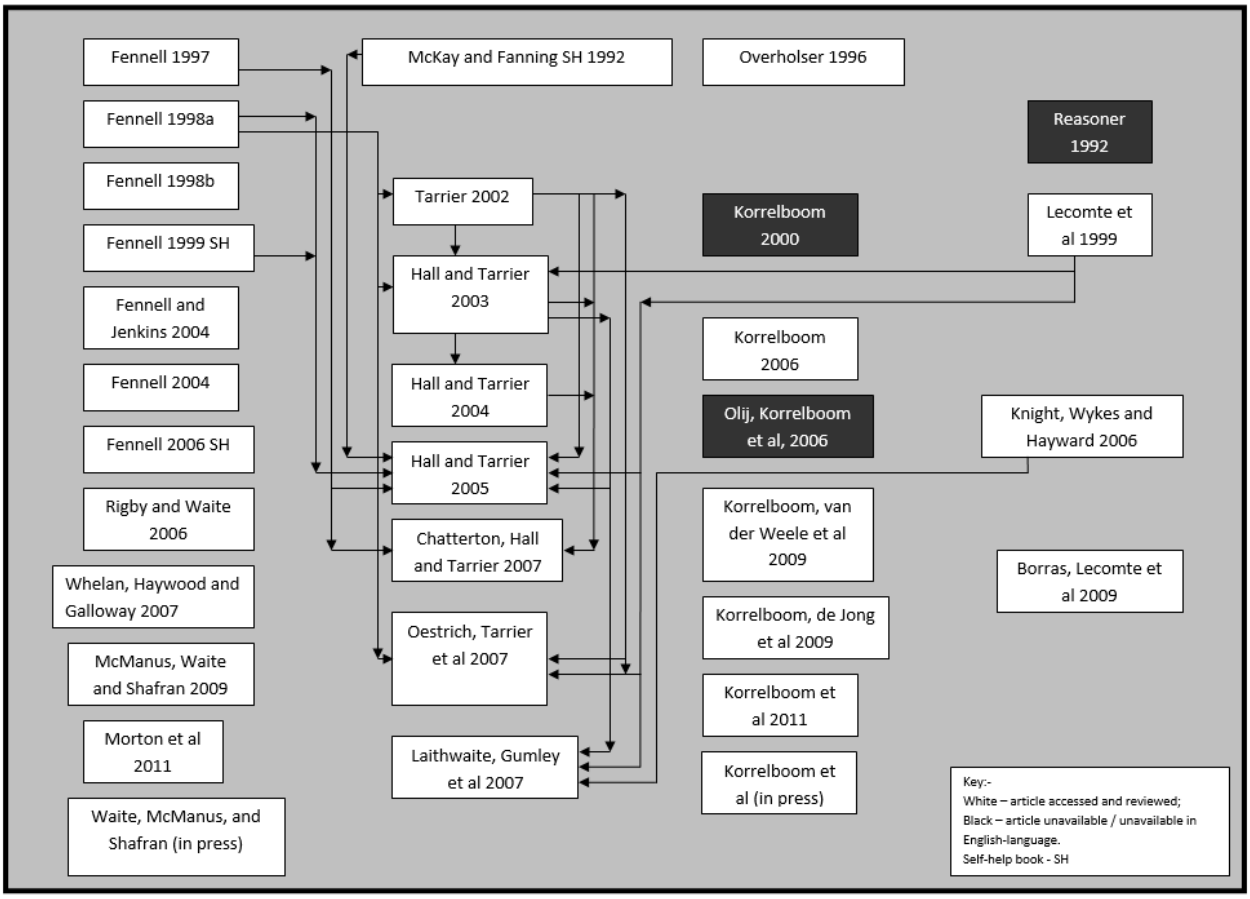
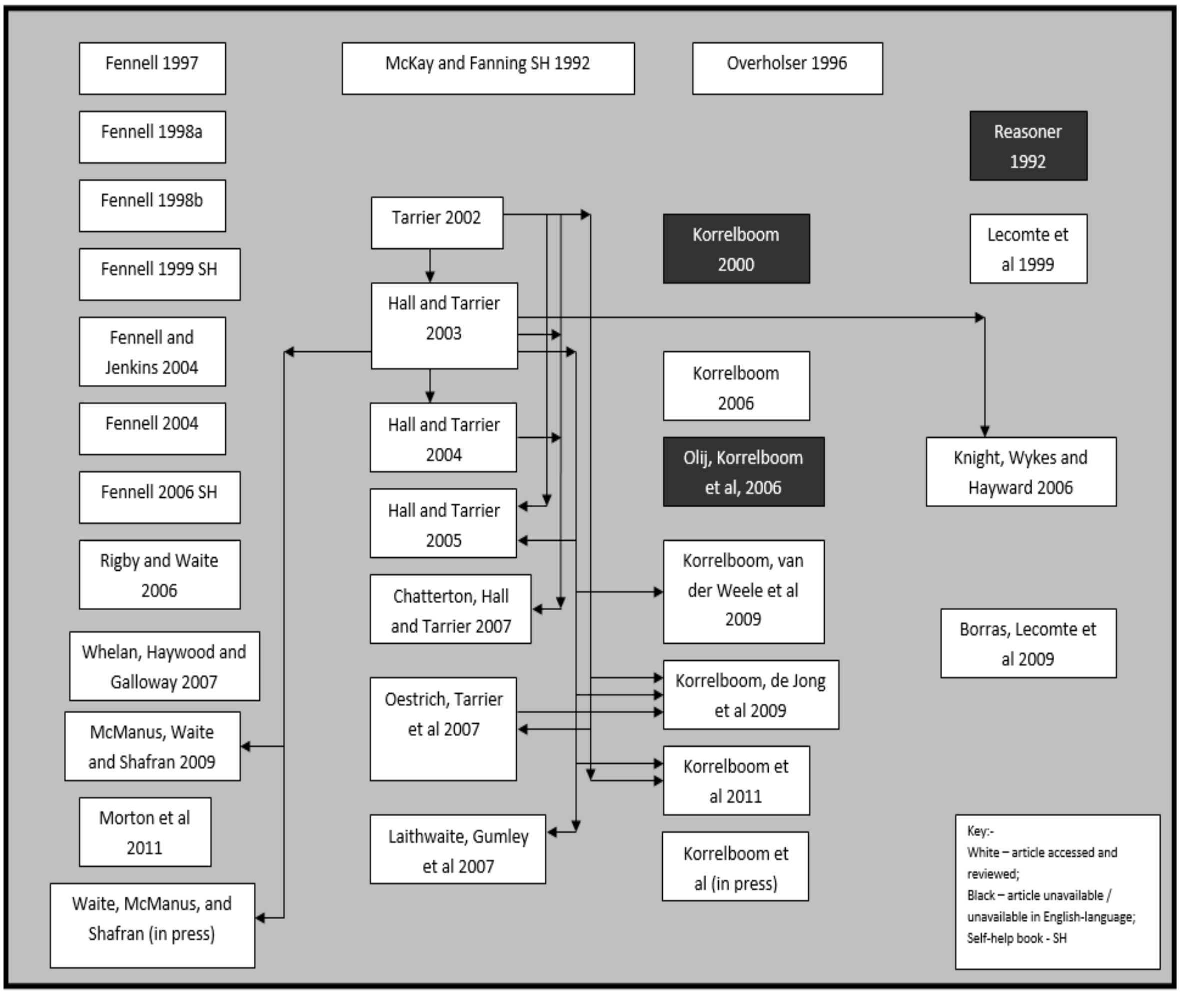


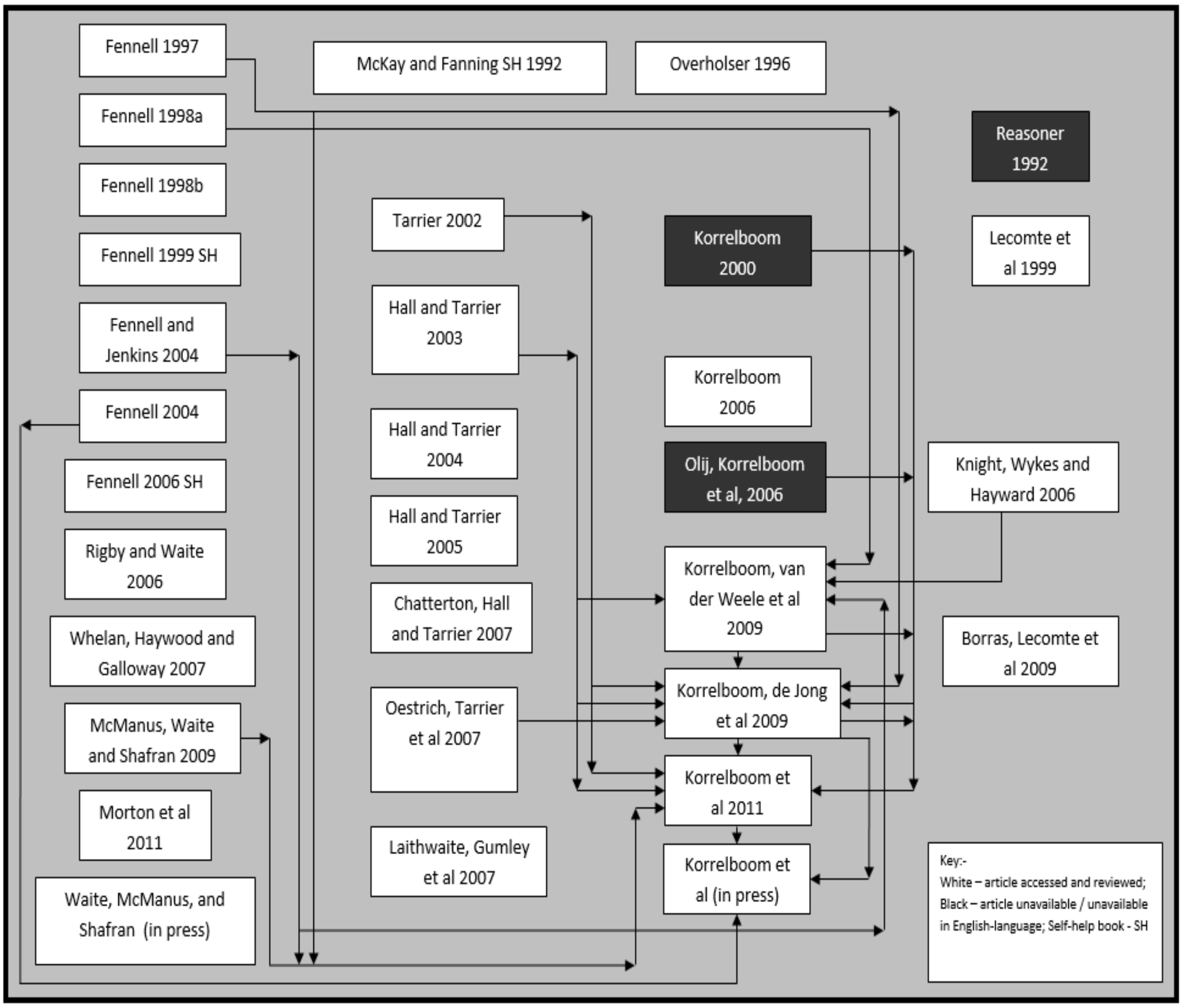
Wiring Diagram showing papers that cite articles / authors in the Fennell Research Thread



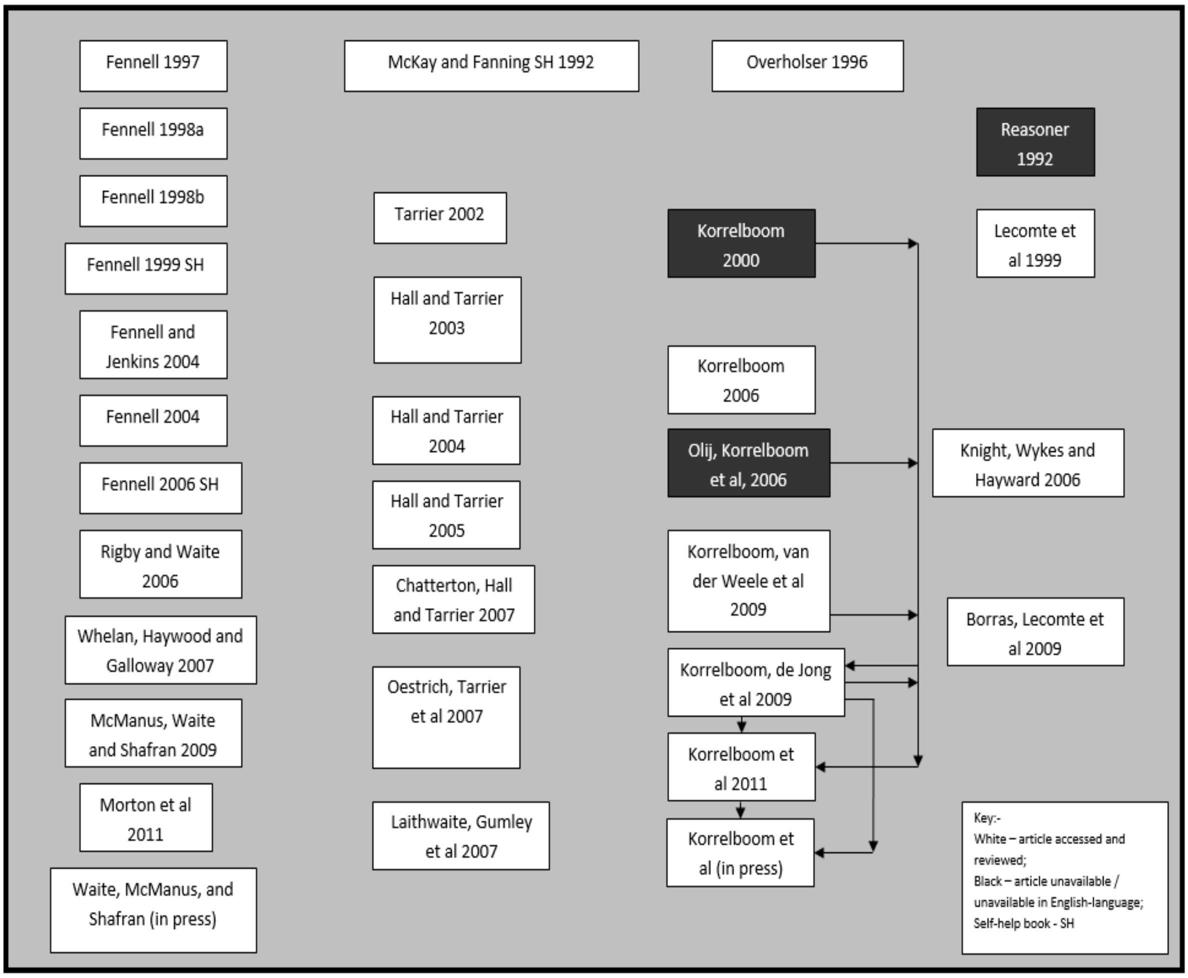
Wiring Diagram showing citations acknowledged by articles / authors in the Hall / Tarrier Research Thread



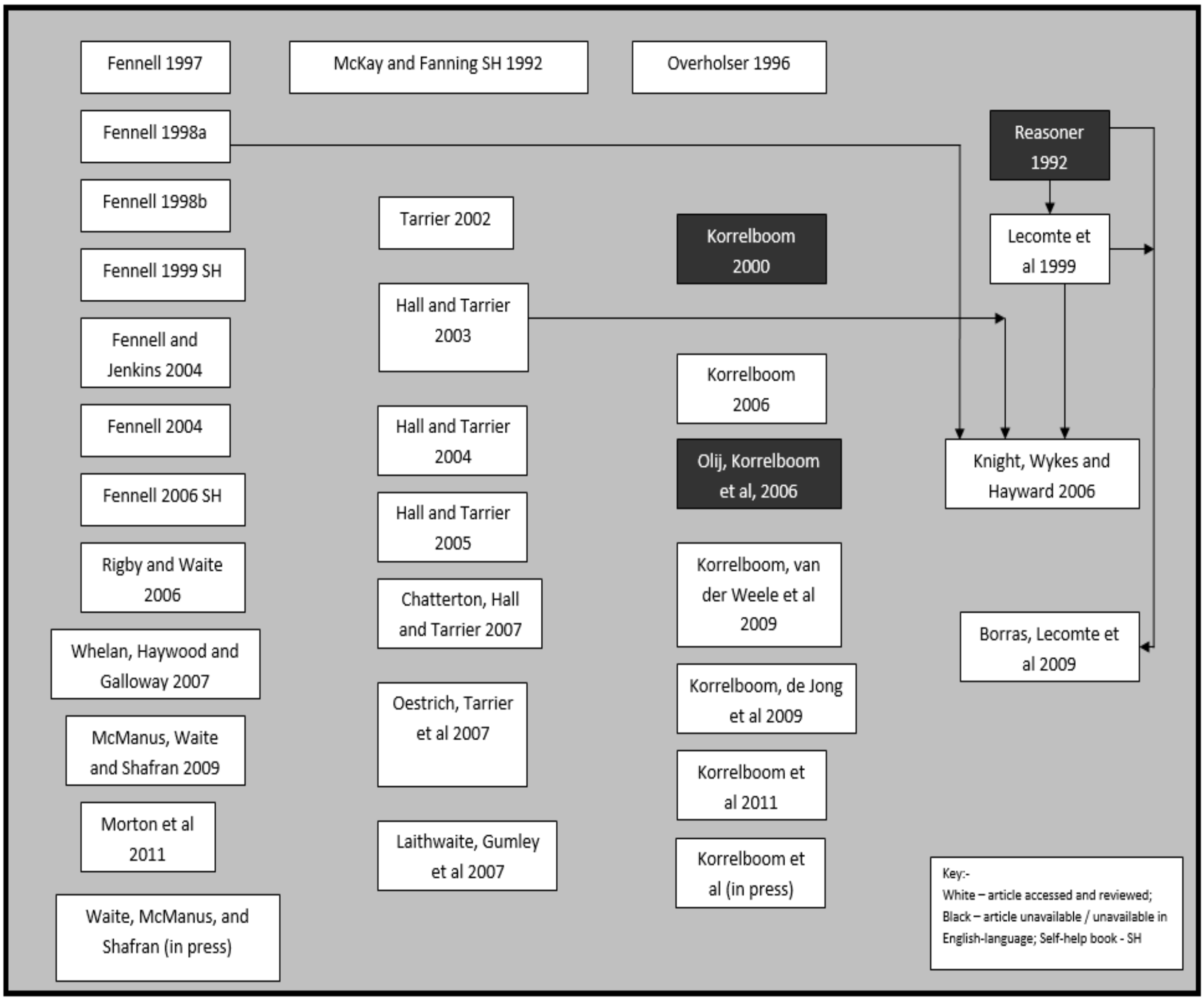
Wiring Diagram showing papers that cite articles / authors in the Hall / Tarrier Research Thread



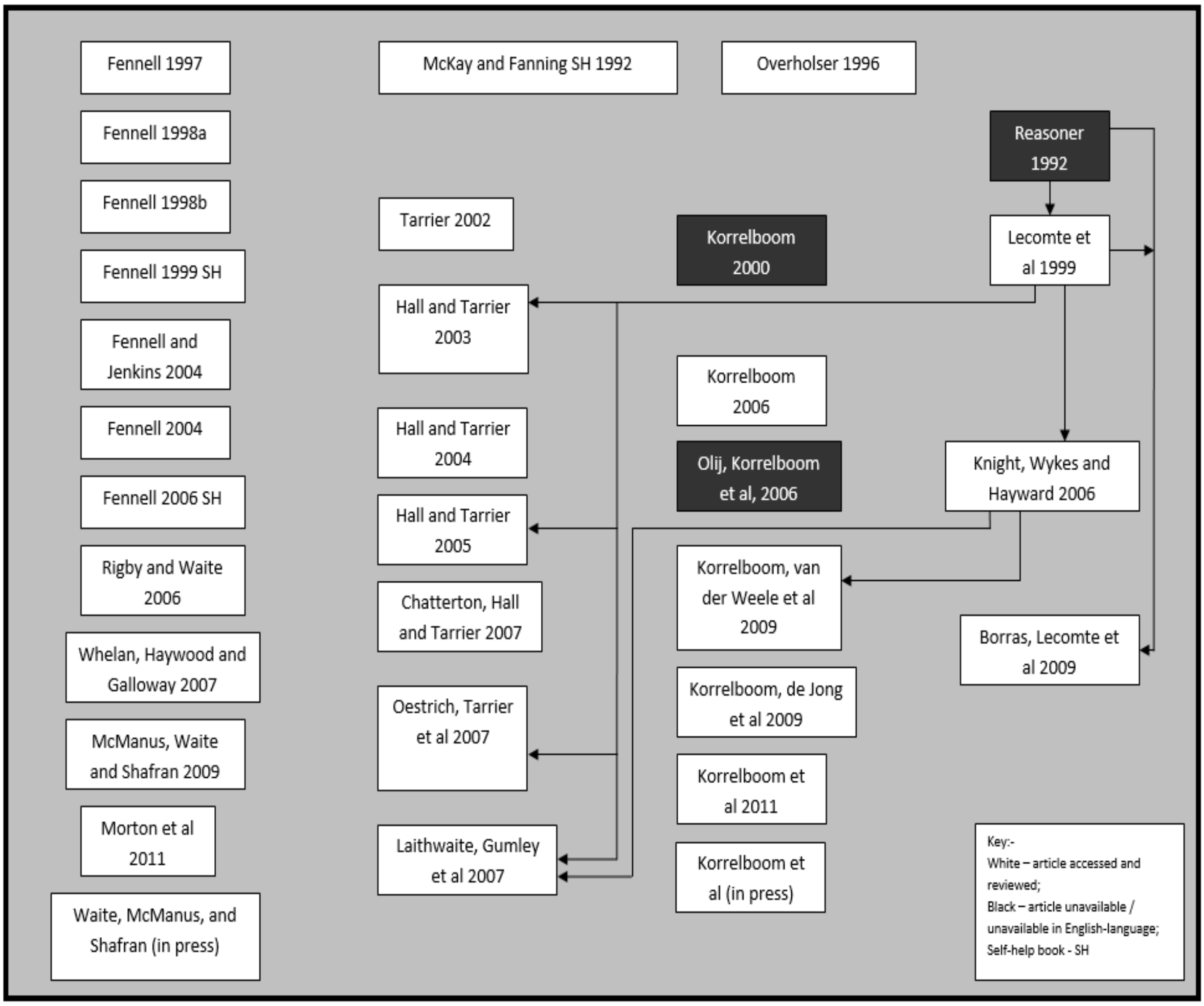
Wiring Diagram showing citations acknowledged by articles / authors in the Korrelboom Research Thread



Wiring Diagram showing papers that cite articles / authors in the Korrelboom Research Thread



Wiring Diagram showing citations acknowledged by articles / authors in the Lecomte Research Thread



Wiring Diagram showing papers that cite articles / authors in the Lecomte Research Thread

Appendix 2C – Outcomes of Hope- and Self-Esteem-Targeting Intervention Studies by Thread

- Hope-Targeting Studies
- Self-Esteem-Targeting Studies

Appendix 2B(i) – Hope-Targeting Studies

- *Snyder-Cheavens Research Thread*
- *Nowotny-Rustoen Research Thread*
- *Herth Research Thread*
- *Duggleby Research Thread*
- *Schrank Research Thread*

Snyder-Cheavens Research Thread - Aggregated Outcome Data

Study	Participant Numbers (Intervention Group only)	Intervention Cost (Hours)	Self-Esteem Outcome Measure	Baseline	Evaluation Point	Numerical Change	Percentage Change from Baseline	Percentage change across the Range of the Measure
Klausner et al (2000)	10	11 hrs (11 x 1 hr Group)	SSHS – Total	**22.8**	End of Therapy	**8.9**	**39.0%**	**24.7%**
			SSHS – Agency	**8.6**		**6.65**	**77.3%**	**36.9%**
			SSHS – Pathways	**14.2**		**2.25**	**15.8%**	**15.8%**
			MAI – Hope	**27.75**	End of Therapy	**9.35**	**33.7%**	
			MAI – Hopelessness	**5.26**		**3.01**	**57.2%**	
Cheavens et al (2006)	32 Divided into immediate and delayed starts	16 hrs (8 x 2hr Group)	**Immediate Start**					
			SSHS – Total	**24.56**	End of Therapy	**9.22**	**37.5%**	**25.6%**
			SSHS – Agency	**9.89**		**5.89**	**59.5%**	**32.7%**
			SSHS - Pathways	**14.67**		**3.33**	**22.7%**	**22.7%**
			Delayed Start					
			SSHS – Total	**26.79**		**3.71**	**13.8%**	**10.3%**
			SSHS – Agency	**12.07**	End of Therapy	**2.07**	**17.1%**	**11.5%**
			SSHS – Pathways	**14.71**		**1.65**	**11.2%**	**9.2%**
Feldman and Dreher (2012)	32 (Non-clinical population)	90 mins (1 x 90 mins Group)	GSHS – Agency Range 6-48	**18.42**	End of Therapy	**1.85**	**10.0%**	**8.81%**
					1-Month Follow-up	**-0.63**	**-3.4%**	**-3.0%**
			GSHP – Pathways Range 3-24	**18.64**	End of Therapy	**2.17**	**11.6%**	**10.3%**
					1-Month Follow-up	**0.54**	**2.9%**	**2.6%**
Thornton et al (2014)			SSHS Total	**33.16**	End of Therapy	**3.67**	**11.1%**	**10.2%**
			SSHS – Agency	**16.13**		**1.41**	**8.7%**	**7.8%**
			SSHS – Pathways	**17.03**		**2.26**	**13.3%**	**12.6%**

Nowotny-Rustoen Research Thread - Aggregated Outcome Data

Study	Participant Numbers	Intervention Resource Investment (Hours)	Measure of Hope	Baseline	Evaluation Point	Numerical Change	Percentage Change from Baseline	Percentage change across the Range of the Measure
Rustoen, Wiklund, Hanestad and Moum (1998)	465	16	Nowotny Hope Scale (NHS) Range 29-116	**89.3**	End of Therapy 6-month Follow-up	**1.2** **0.0**	**1.3%** **0.0%**	**1.4%** **0.0%**
Rustoen, Cooper and Miaskowski (2011)	194/5	16	Hearth Hope Index (HHI) Range 12-48	**36.1**	End of Therapy 3-Month Follow-up 12-Month Follow-up	**0.5** **0.1** **0.3**	**1.4%** **0.0%** **0.8%**	**1.4%** **0.0%** **0.8%**

Herth Research Thread - Aggregated Outcome Data

Study	Participant Numbers	Intervention Resource Investment (Hours)	Measure of Hope	Baseline	Evaluation Point	Numerical Change	Percentage Change from Baseline	Percentage change across the Range of the Measure
Herth (2000, 2001)	38	8 x 2 hrs (Group Therapy)	Herth Hope Index (1992) Range of 12-48	**34.3**	End of Therapy 3-Month Follow-up 6-Month Follow-up 9-Month Follow-up	**8.8** **7.6** **6.5** **5.4**	**25.7%** **22.2%** **19.0%** **15.7%**	**26.7%** **23.0%** **19.7%** **16.4%**

Duggleby Research Thread - Aggregated Outcome Data

Study	Participant Numbers	Intervention Resource Investment (Hours)	Measure of Hope	Baseline	Evaluation Point	Numerical Change	Percentage Change from Baseline	Percentage change across the Range of the Measure
Duggleby, Degner, Williams, Wright, Cooper, Popkin and Holtslander (2007)	60 (Service Users)	Variable 2 hrs structured input	Hope Herth Index (1992) Range 12-48	**36.81**	End of Therapy	**1.51**	**4.1%**	**4.2%**
Duggleby, Wright, Williams, Degner, Cammer and Holtslander (2007)	10 (Care-givers)	Variable 2 hrs structured input	Hope Herth Index (1992) Range 12-48	**37.0**	End of Therapy	**2.63**	**6.64%**	**8.2%**
Duggleby, Williams, Holtslander, Cooper, Ghosh, Hallstrom, McLean and Hampton (2013)	36 (Care-givers)	Variable 2 hrs structured input	Hope Herth Index (1992) Range 12-48	**37.79**	End of Therapy	**1.27**	**3.4%**	**3.53%**
					3-Month Follow-up	**0.38**	**1.0%**	**1.1%**
					6-month Follow-up	**1.55**	**4.1%**	**4.3%**
					12-Month Follow-up	**2.74**	**7.3%**	**7.6%**

Schrank Research Thread - Aggregated Outcome Data

Study	Participant Numbers	Intervention Resource Investment (Hours)	Measure of Hope / Self-Esteem	Baseline	Evaluation Point	Numerical Change	Percentage Change from Baseline	Percentage change across the Range of the Measure
Schrank, Brownell, Jakaite, Pesola, Riches, Tylee, Slade (2015)	47	11 X 90 mins group	Integrative Hope Scale (Schrank et al, 2011) Range 23-138	**92.46**	End of Therapy	**2.07**	**2.2%**	**1.8%**
			Rosenberg's Self-Esteem Scale (Rosenberg, 1965) Range of 0-30	**22.4**	End of Therapy	**1.3**	**5.8%**	**4.3%**

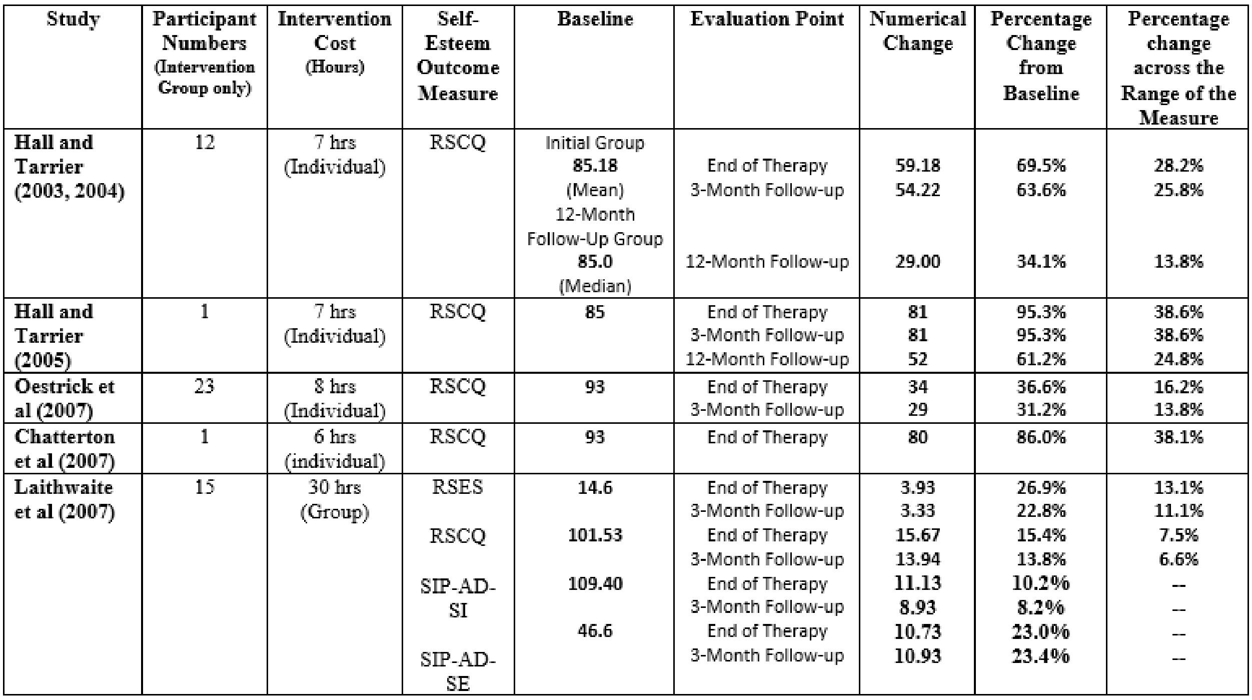
Appendix 2B(ii) - Self-Esteem-Targeting Studies

- *Fennel Thread*
- *Hall and Tarrier Thread*
- *Korrelboom Thread*
- *Lecomte Thread*
- *Yanos, Lysaker and Roe Thread*

Fennell Thread – Aggregated Research Outcome Data

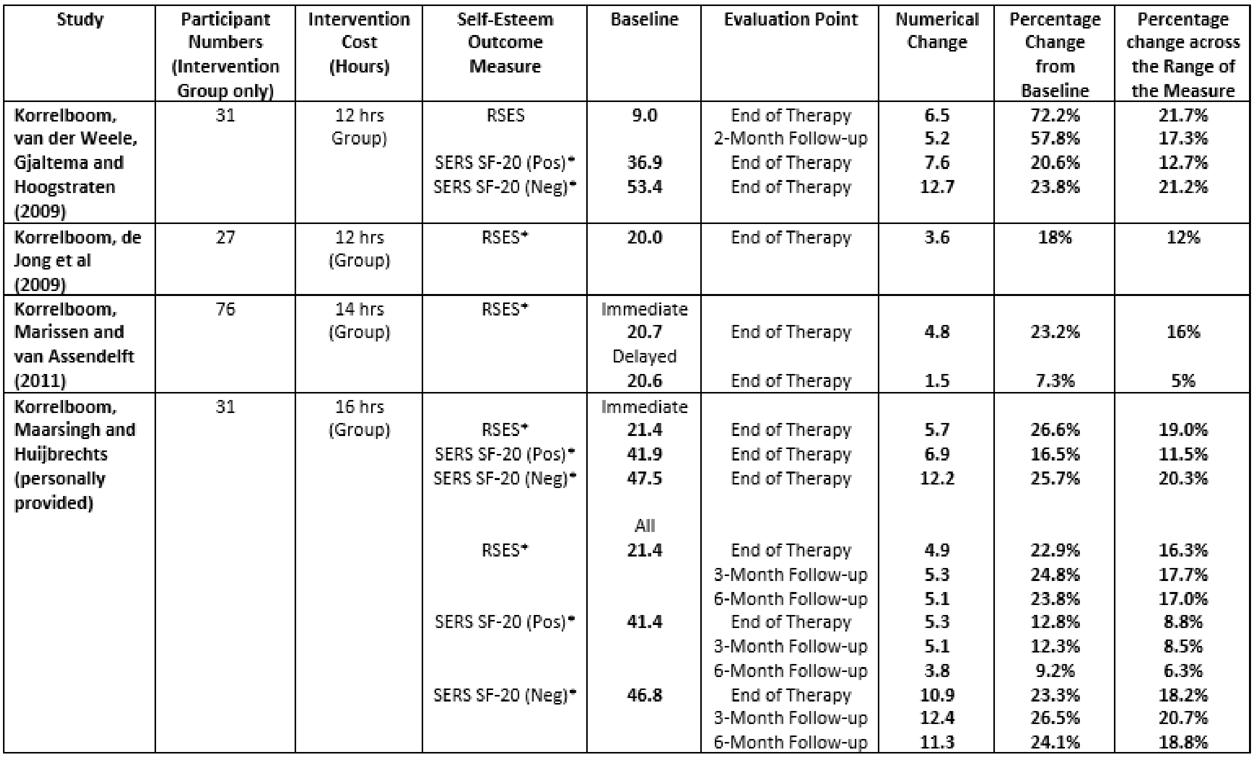
Study	**Participant Numbers (Intervention Group only)**	**Intervention Cost (Hours)**	**Self-Esteem Outcome Measure**	**Baseline**	**Evaluation Point**	**Numerical Change**	**Percentage Change from Baseline**	**Percentage change across the Range of the Measure**
Rigby and Waite (2006)	72	20 (Group)	RSES (Inverted scoring system)	**29.14**	End of Therapy	**5**	**17.2%**	**17%**
					3-Month Follow-up	**8.5**	**29.2%**	**28.3%**
Whelan, Haywood and Galloway (2007)	5	10 (Individual)	RSES (Adapted)	All **16**	End of Therapy	**2.2**	**13.75%**	**7.3%**
				Low S.E. **10.5**	End of Therapy	**5.2**	**49.5%**	**17.3%**
McManus, Waite and Shafran (2009)	1	12 (Individual)	RSCQ	**94**	End of Therapy	**27**	**28.7%**	**12.9%**
					12-Month Follow-up	**38**	**40.4%**	**18.1%**
Morton, Roach, Reid and Stewart (2011)	37	16 Group) plus individual sessions	RSCQ	**77.6**	End of Therapy	**27.8**	**35.8%**	**13.2%**
Waite, McManus and Shafran (2012)	22	10 (Individual)	RSCQ	Wait Group **89.82**	End of Therapy	**-5.1**	**-5.7**	**-2.7**
				Immediate **83.08**	End of Therapy	**39.64**	**47.7%**	**18.9%**
				All **86.45**	End of Therapy	**28.78**	**33.3%**	**13.7%**
					Follow-up	**33.6**	**38.9%**	**16%**
Brown, Elliott, Boardman, Ferns and Morrison (2004) **Brown, Elliot, Boardman, Andiappan, Landau and Howay (2008)**	44 (40 completers to 3 month follow-up; 101 completers to 24 month follow-up)	1 day educational workshop (7 hrs)	RSES (Rosenberg, 1965) Range 0-30	All **16.55**	3 month follow-up	**4.2**	**25.4%**	**14.0%**
				Depressed (> 14 on BDI) **14.14**	3 month follow-up	**5.26**	**37.2%**	**17.5%**
					12 months follow-up	**5.42**	**38.3%**	**18.1%**
					24 months follow-up	**5.57**	**39.4%**	**18.6%**
				Non-depressed (< or = 14 on BDI) **23.23**	3 month follow-up	**0.53**	**2.3%**	**1.8%**
					12 months follow-up	**3.90**	**16.8%**	**13.0%**
					24 months follow-up	**2.67**	**11.5%**	**8.9%**
Horrell, Goldsmith, Tylee, Schmidt, Murphy, Bonin, Kelly, Raikundalia, Brown and the CLASSIC trial group (2014)	228 (171 completers)	1 day educational workshop plus a booster session (total 9 hrs)	RSES (Rosenberg, 1965) Range 0-30	**11.9**	3 month follow-up	**2.70**	**22.7%**	**9.0%**

Hall and Tarrier Thread – Aggregated Research Outcome Data



Study	Participant Numbers (Intervention Group only)	Intervention Cost (Hours)	Self-Esteem Outcome Measure	Baseline	Evaluation Point	Numerical Change	Percentage Change from Baseline	Percentage change across the Range of the Measure
Hall and Tarrier (2003, 2004)	12	7 hrs (Individual)	RSCQ	Initial Group **85.18** (Mean)	End of Therapy	59.18	69.5%	28.2%
					3-Month Follow-up	54.22	63.6%	25.8%
				12-Month Follow-Up Group **85.0** (Median)	12-Month Follow-up	29.00	34.1%	13.8%
Hall and Tarrier (2005)	1	7 hrs (Individual)	RSCQ	**85**	End of Therapy	81	95.3%	38.6%
					3-Month Follow-up	81	95.3%	38.6%
					12-Month Follow-up	52	61.2%	24.8%
Oestrick et al (2007)	23	8 hrs (Individual)	RSCQ	**93**	End of Therapy	34	36.6%	16.2%
					3-Month Follow-up	29	31.2%	13.8%
Chatterton et al (2007)	1	6 hrs (individual)	RSCQ	**93**	End of Therapy	80	86.0%	38.1%
Laithwaite et al (2007)	15	30 hrs (Group)	RSES	**14.6**	End of Therapy	3.93	26.9%	13.1%
					3-Month Follow-up	3.33	22.8%	11.1%
			RSCQ	**101.53**	End of Therapy	15.67	15.4%	7.5%
					3-Month Follow-up	13.94	13.8%	6.6%
			SIP-AD-SI	**109.40**	End of Therapy	11.13	10.2%	--
					3-Month Follow-up	8.93	8.2%	--
			SIP-AD-SE	**46.6**	End of Therapy	10.73	23.0%	--
					3-Month Follow-up	10.93	23.4%	--

Korrelboom Thread – Aggregated Research Outcome Data



Study	Participant Numbers (Intervention Group only)	Intervention Cost (Hours)	Self-Esteem Outcome Measure	Baseline	Evaluation Point	Numerical Change	Percentage Change from Baseline	Percentage change across the Range of the Measure
Korrelboom, van der Weele, Gjaltema and Hoogstraten (2009)	31	12 hrs Group)	RSES	**9.0**	End of Therapy	6.5	72.2%	21.7%
					2-Month Follow-up	5.2	57.8%	17.3%
			SERS SF-20 (Pos)*	**36.9**	End of Therapy	7.6	20.6%	12.7%
			SERS SF-20 (Neg)*	**53.4**	End of Therapy	12.7	23.8%	21.2%
Korrelboom, de Jong et al (2009)	27	12 hrs (Group)	RSES*	**20.0**	End of Therapy	3.6	18%	12%
Korrelboom, Marissen and van Assendelft (2011)	76	14 hrs (Group)	RSES*	Immediate **20.7**	End of Therapy	4.8	23.2%	16%
				Delayed **20.6**	End of Therapy	1.5	7.3%	5%
Korrelboom, Maarsingh and Huijbrechts (personally provided)	31	16 hrs (Group)	RSES*	Immediate **21.4**	End of Therapy	5.7	26.6%	19.0%
			SERS SF-20 (Pos)*	**41.9**	End of Therapy	6.9	16.5%	11.5%
			SERS SF-20 (Neg)*	**47.5**	End of Therapy	12.2	25.7%	20.3%
			RSES*	All **21.4**	End of Therapy	4.9	22.9%	16.3%
					3-Month Follow-up	5.3	24.8%	17.7%
					6-Month Follow-up	5.1	23.8%	17.0%
			SERS SF-20 (Pos)*	**41.4**	End of Therapy	5.3	12.8%	8.8%
					3-Month Follow-up	5.1	12.3%	8.5%
					6-Month Follow-up	3.8	9.2%	6.3%
			SERS SF-20 (Neg)*	**46.8**	End of Therapy	10.9	23.3%	18.2%
					3-Month Follow-up	12.4	26.5%	20.7%
					6-Month Follow-up	11.3	24.1%	18.8%

Lecomte, Leclerc and Wykes Thread – Aggregated Research Outcome Data

Study	Participant Numbers (Intervention Group only)	Intervention Cost (Hours)	Self-Esteem Outcome Measure	Baseline	Evaluation Point	Numerical Change	Percentage Change from Baseline	Percentage change across the Range of the Measure
Lecomte et al (1999)	51	24	RSES**	29.90	End of Therapy	0.61	2.0%	2.0%
					3-Month Follow-up	0.99	3.3%	3.3%
Knight, Wykes and Hayward (2006)	21	7	ISE	51.72	End of Therapy	4.08	7.9%	4.1%
					6-week Follow-up	3.67	7.1%	3.7%
Borras, Lecomte et al (2009)	54	24		Immediate				
			SERS SF-20 (Pos)	31.7	End of Therapy	9.2	29.0%	7.7%
					3-Month Follow-up	7.2	22.7%	6.0%
			SERS SF-20 (Neg)	39.9	End of Therapy	9.8	24.6%	8.2%
					3-Month Follow-up	6.3	15.8%	5.3%
			Total	-8.2	End of Therapy	19.0	36.7% *	15.8%
					3-Month Follow-up	13.5	26.1% *	11.3%
				Delayed Start				
			SERS SF-20 (Pos)	32.7	End of Therapy	4.9	15.0%	4.1%
					3-Month Follow-up	5.0	15.3%	4.2%
			SERS SF-20 (Neg)	40.8	End of Therapy	-4.0	-9.8%	-3.3%
					3-Month Follow-up	6.2	15.2%	5.2%
			Total	-8.1	End of Therapy	1.0	1.9%	0.8%
					3-Month Follow-up	11.0	21.2%	9.2%
Lecomte, Leclerc, Corbiere, Wykes, Wallace and Spidel (2008) Lecomte, Leclerc and Wykes (2012)	48 (42 completers, 35 at 6 month follow-up, 14 at 12 month follow-up)**	24 sessions (Group) Time per session not specified	2008 Study Total	8.5	End of Therapy	6.9	10.1%	7.1%
					6-Month Follow-up	7.7	11.2%	6.4%
			2012 Follow-up SERS (pos)	42.4	End of Therapy	2.4	5.7%	4.0%
					6-Month Follow-up	2.7	6.4%	4.5%
					12-Month Follow-up	5.6	13.2%	9.3%
			SERS (neg)	34.3	End of Therapy	4.8	16.9%	8.0%
					6-Month Follow-up	1.7	5.0%	2.8%
					12-Month Follow-up	2.2	6.4%	3.7%
			Total	8.1	End of Therapy	7.1	10.5%	6.0%
					6-Month Follow-up	4.2	6.2%	3.7%
					12-Month Follow-up	7.8	11.5%	6.5%

Lecomte, Leclerc, Wykes, Nicole and Abdel Baki (2015)	??	24 sessions (Group) Time per session not specified	SERS (pos)	**46.98**	6-Month Follow-up	**0.91**	**1.9%**	**1.5%**
			SERS (neg)	**29.54**	6-Month Follow-up	**-1.96**	**-6.6%**	**-3.3%**
			Total	**17.44**	6-Month Follow-up	**-1.05**	**-1.3%**	**-0.9%**
Lecomte, Leclerc and Wykes (2017a)	48 (31 Completers)	24 sessions (Group) Time per session not specified	QuickLL (Lecomte and Leclerc, 2004) Range of 1-3	**2.29**	End of Therapy	**0.03**	**1.3%**	**1.5%**

Self-esteem and Self-Stigma Threads - Aggregated Research Outcome Data

Study	Participant Numbers (Intervention Group completers only)	Intervention Cost (Hours)	Self-Esteem / Hope Outcome Measure	Baseline	Evaluation Point	Numerical Change	Percentage Change from Baseline	Percentage change across the Range of the Measure
McCay, Beanlands, (2007)			Miller Hope Scale Range 40-200	**137.05**	End of Therapy	**6.47**	**4.7%**	**4.0%**
Hansson and Yanos (2016)	31		Rosenberg Self Esteem Scale Range 10-40	**25.3**	End of Therapy	**3.1**	**12.3%**	**10.3%**

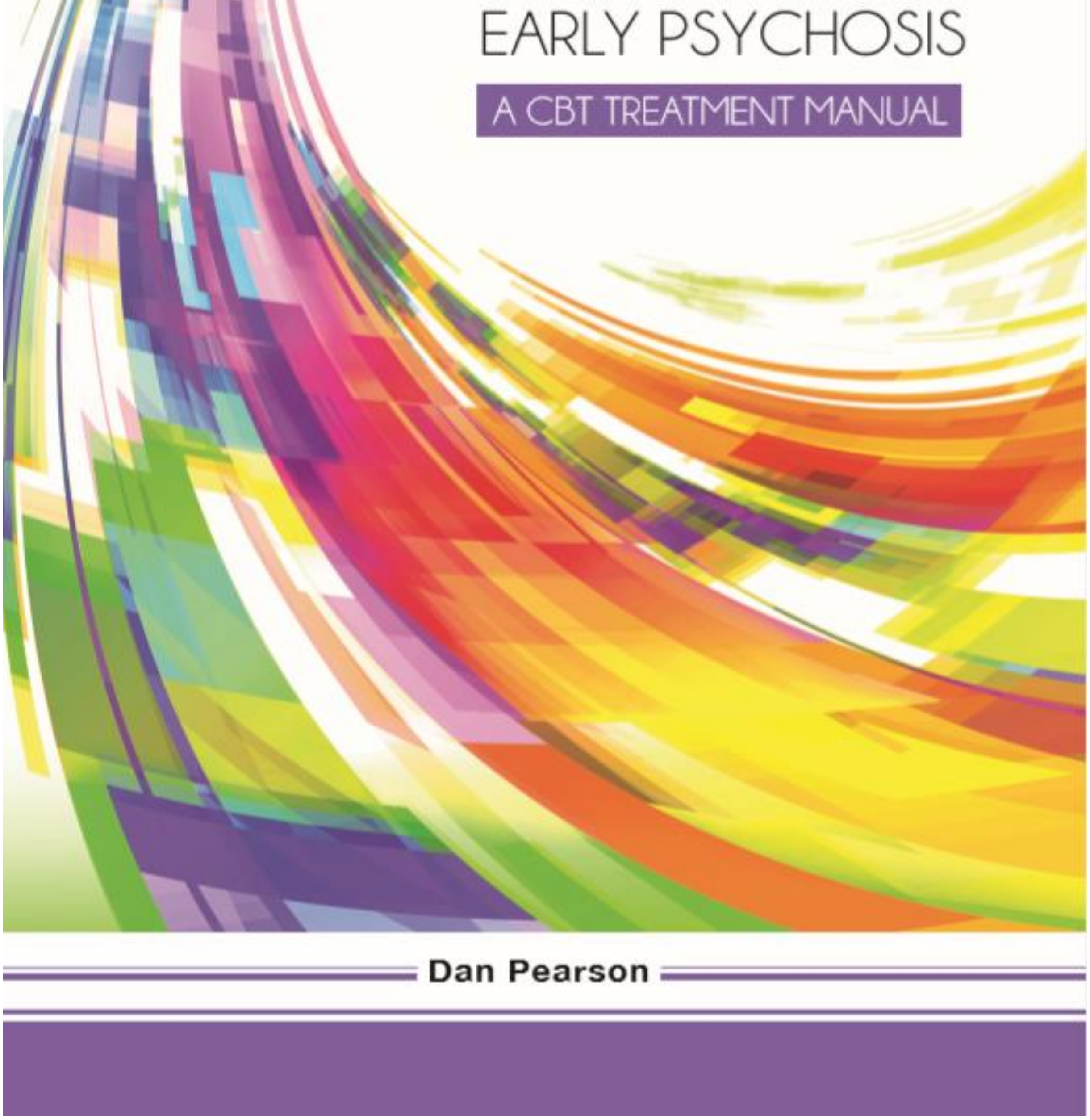
Appendix 3 – Therapy Programme

(Relating to Chapter 5)

Appendix 3 includes example features relating to the new Therapy Programme. The Therapy Programme has been described in detail in the Participant Handbook, which has been included as an attachment to the thesis. It is also discussed in some detail in Chapter 5. The Handbook included a number of Work-sheets specifically for use within the Therapy. Images of some of those Worksheets have been included below.

A. Book Cover
B. Illustrative Stories
C. Worksheets

Appendix 3A – Participant Handbook - Cover



INSPIRING HOPE AND SELF-BELIEF IN EARLY PSYCHOSIS

A CBT TREATMENT MANUAL

Dan Pearson

Appendix 3B – Illustrative Stories

These example stories were included in the Participant Handbook to illustrate key points and to encourage the reader towards a greater sense of connection with the material - making it real. The stories are, in each case, composites and are not intended to represent specific individuals.

- Service User Story 1
- Service User Story 2
- Service User Story 3

Stories 1 and 2 are accompanied by completed worksheets.

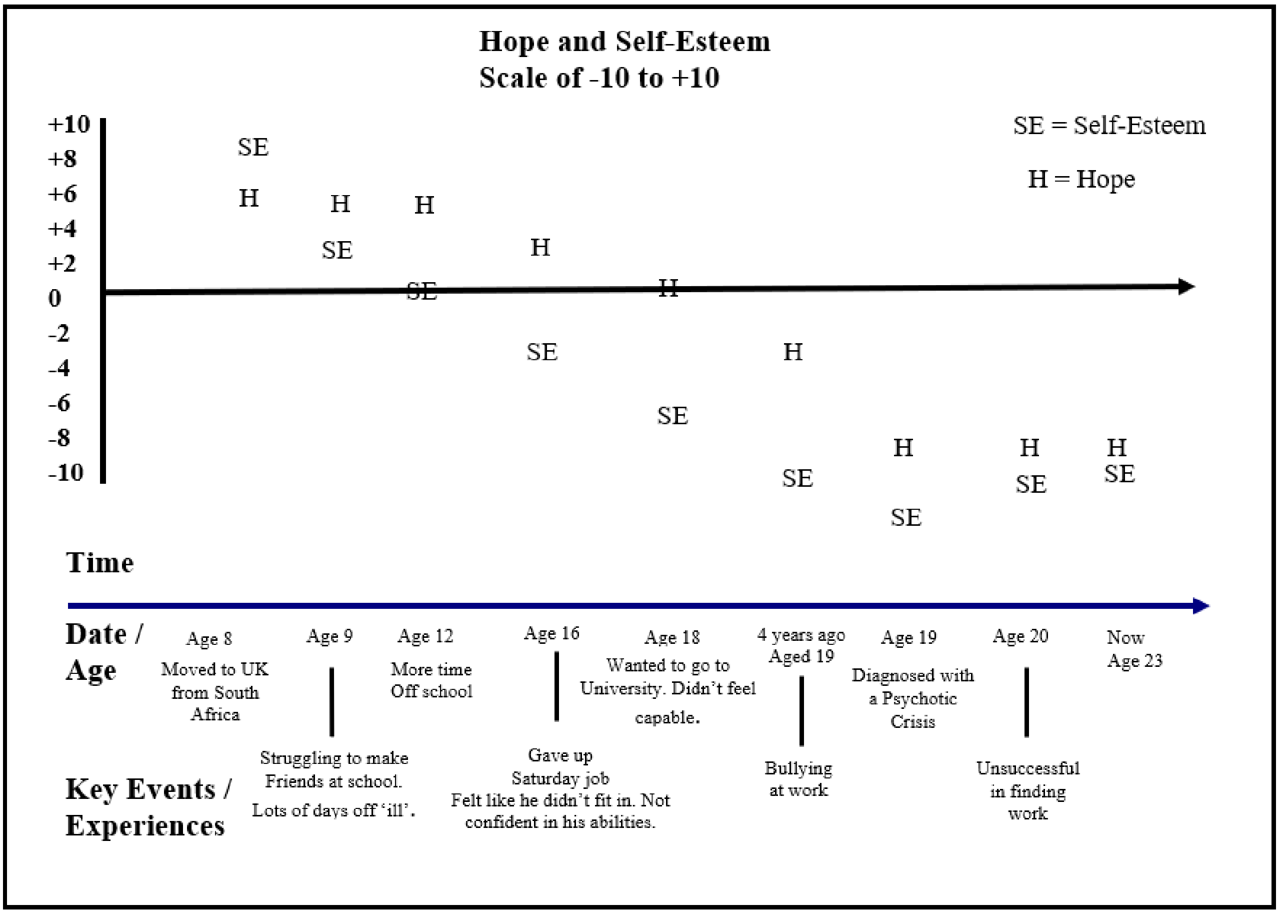
When I first met Joe (see Timeline Below) he blamed the onset of all of his problems on bullying that he experienced from colleagues in the first weeks of the first job that he had after leaving school. At the time those experiences had felt catastrophically overwhelming and he had, in fact, built up into a whole complex of persecutory beliefs; hence his referral to an Early Psychosis Service. He was, in retrospect, able to acknowledge that what he saw then as 'bullying' was probably just comparatively harmless 'banter'. When it happened, however, he didn't feel able to address things with his colleagues or his supervisor and simply walked out. The experience stayed with him and he found himself increasingly nervous about having to deal with, mostly, his male peers. This affected his confidence and, although he did keep applying for jobs; at least for a little while; his efforts were half-hearted and, on those one or two occasions when he got to be interviewed, his presentation and performance were compromised. After a while he stopped trying.

When I met him, he had been sitting at home doing very little; rarely leaving the house and never doing so on his own; for almost 3 years. The psychotic symptoms had resolved after a matter of 3 or 4 months, but his combined negativity about himself and hopelessness (and helplessness) about the future had been almost completely disabling.

One of the points to make here is that, when we tracked back further regarding, in particular, his views of himself, it became apparent that he had struggled with issues of self-confidence intermittently since his primary school days. What is more, the pattern of avoidance (hiding away from his fears) had, also, been established before he was 10, and had been regarded during his formative years as a perfectly reasonable and effective thing to do.

Joe's timeline shows a very positive attitude to himself and the future when he first came to the UK. However, although he remained generally quite a hopeful person whilst at school, his self-esteem, and latterly his sense of hope, deteriorated progressively over the years in response to a combination of experiences of rejection and failure. By the time that we started to talk, Joe's attitudes to himself and the future were both very low and pretty-well stuck.

Service User Story 1

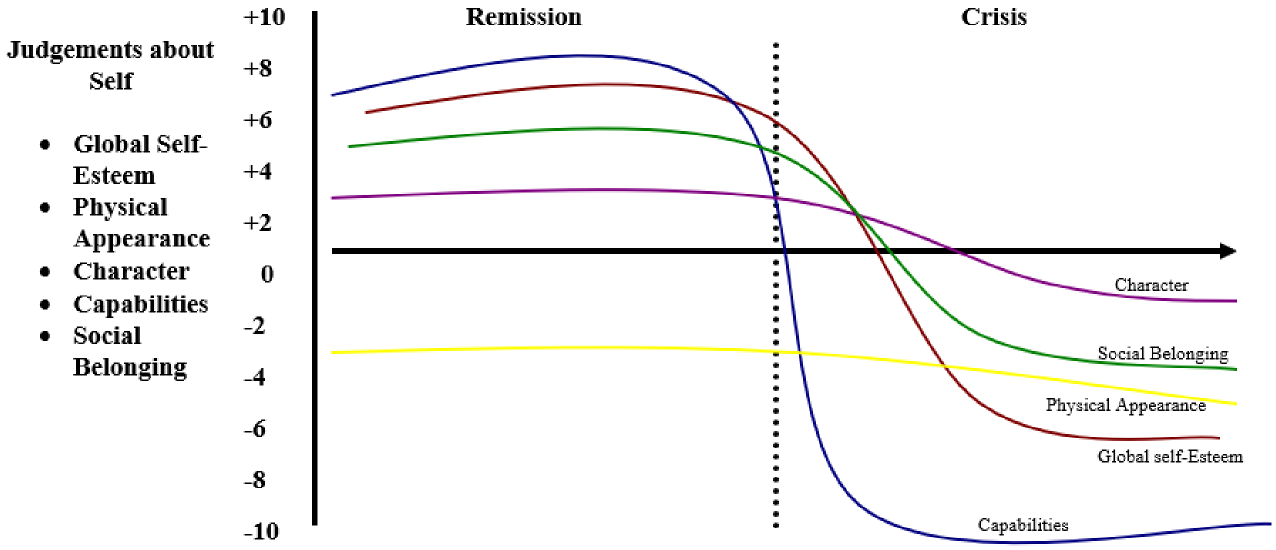

Hope and Self-Esteem
Scale of -10 to +10
SE = Self-Esteem
H = Hope
+10
+8
+6
+4
+2
0
-2
-4
-6
-8
-10
SE
H
H
SE
H
SE
H
SE
H
SE
H
SE
H
SE
H
SE
H
SE
Time
Date / Age
Age 8
Moved to UK from South Africa
Age 9
Struggling to make Friends at school.
Lots of days off 'ill'.
Age 12
More time Off school
Age 16
Gave up Saturday job
Felt like he didn't fit in. Not confident in his abilities.
Age 18
Wanted to go to University. Didn't feel capable.
4 years ago Aged 19
Bullying at work
Age 19
Diagnosed with a Psychotic Crisis
Age 20
Unsuccessful in finding work
Now Age 23
Key Events / Experiences

Sally's problems; or, at least, those diagnosed as psychosis; started when she was at college. A very bright, able and general confident person, she initially took to her time at college with huge enthusiasm and energy. Her first 'crisis' followed a very difficult few months in her second year, during which a long-term relationship came to a sudden end and she found herself struggling with her academic work. Her initial psychotic crisis resolved quickly, but left her subject to intermittent periods of reduced confidence, social withdrawal and brooding reflection. She had been supported by our Early Psychosis Service for about 18 months when she was referred for help with her Self-Esteem. Over those 18 months her mood had fluctuated a great deal, with three distinct periods of feeling very low. At the time that she was seen she was in a slightly more positive frame of mind about herself, but was worried about things getting worse again.

When she was asked of which specific aspects of her self-concept she was most critical, she pointed to her physical appearance. She said that she had had a long-standing problem with her weight, size and shape which she had always felt unable to rectify. If you look at the non-crisis (or remission) scores below you will see that her physical appearance was the only component which was rated with a minus number. On the following graph that translates to a score below the midline. On the whole her 'global' self-esteem at the time was not too bad, because, although her physical appearance was seen as most important, it was balanced by the positive views which she held about other aspects of self. On the graph, however, you can see that when she experienced a crisis (low mood, social withdrawal, rumination, reduced confidence) those other factors all deteriorated dramatically, whereas her views about her appearance only became a little bit worse. In fact, if you consider the weighted scores below for when she was in crisis you will notice that her biggest issues by far were with her sense of competence or capability. Put simply, in a crisis she felt like a complete failure - useless at everything.

If therapy had been organised in relation to her initial observations it would have given priority to issues relating to her physical appearance. Whilst that still needed to have some attention, it was, in the end, her attitudes to ability and success that took centre stage.

	Non-Crisis Judgement	**Non-Crisis Level of Importance**	**Non-Crisis Weighted Score**	**Crisis Judgement**	**Crisis Level of Importance**	**Crisis Weighted Score**
Physical Appearance	-3	6	-18	-4	4	-16
Character	+3	4	+12	-1	3	-3
Capabilities	+8	5	+40	-8	10	-80
Social Belonging	+5	5	+25	-3	7	-21



Level of Importance Scale of 0 to 10

Physical Appearance	6	4
Character	4	3
Capabilities	5	10
Social Belonging	5	7

Self-Other Focus

Self - 40% Other - 60%	Self - 85% Other - 15%

Before her psychotic crisis Ellie had been regarded by those around her as a very strong, capable and independent person. She lived in her own flat, worked hard, enjoyed keeping fit and had a close group of friends. To all outward appearances she seemed to be very successful; at least according to 'reasonable' standards. Ellie has said recently that she was never as confident as she appeared to others; that she worked really hard to put on a front; that sometimes it took every ounce of energy that she had to get out of the door in the mornings.

Her psychotic illness, she said, simply proved everything that she had always known about how 'rubbish' she was, and how dangerous and untrustworthy the world (and people) were. She noted that she had been able to keep herself going by reminding herself about her success at work and about owning her own flat. She also admitted (she said that she thought it might be regarded as a little superficial) that she liked being slim and pretty.

When she became unwell, she was unable to continue working. Her employers initially kept her job open for her, but only paid her sick-pay for a very short period. After a few months it became obvious that she couldn't keep up with the mortgage repayments, so she sold the flat (with a substantial loss) and moved in with her divorced father.

She was prescribed an atypical anti-psychotic medication which did seem to provide relief to both her voices and her fears, but with a cost - she gained 6 stones in weight. At the point that she was referred for psychological therapy she was feeling extremely negative about herself and hopeless about the future.

When she completed the mood diary a very clear pattern emerged in relation to both her sense of Hope and of Self-Esteem.

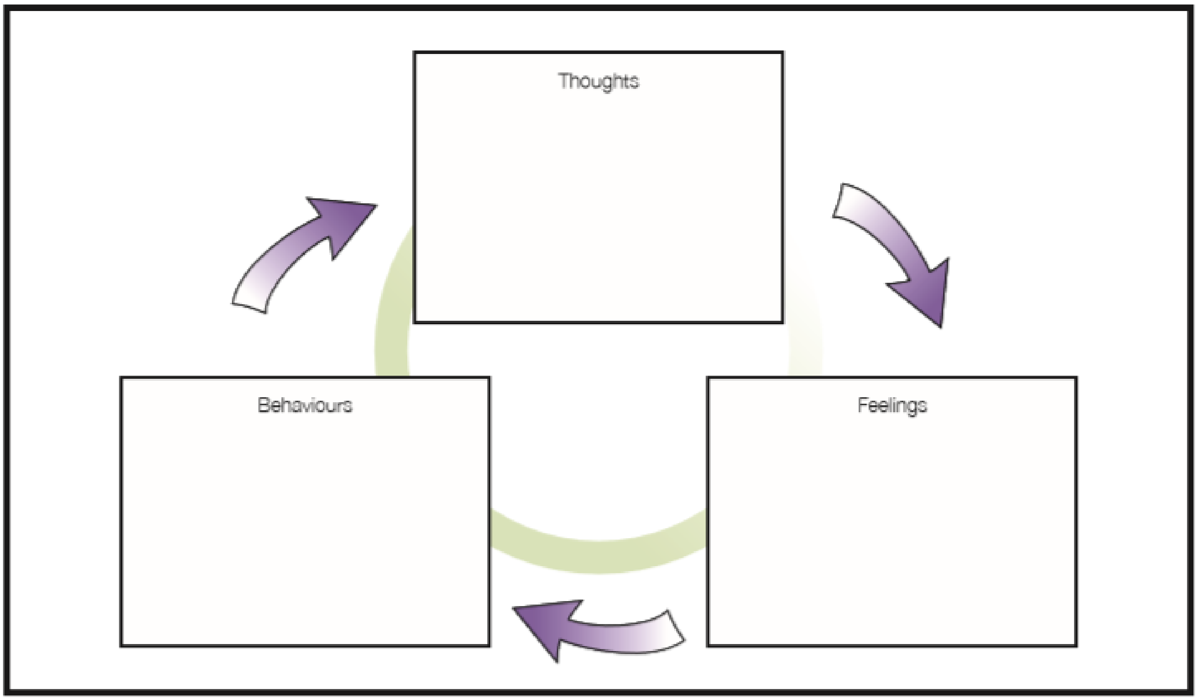
- *There was considerable variation on an hour-by-hour, day-by-day basis.*
- *More positive views were encouraged by experiences of love, affection or warmth from others (this didn't happen often and the effect was generally short-lived).*
- *Negativity was increased by experiences of disrespect or judgement by others, by feeling fat and by feelings of failure and incompetence.*

She was particularly hyper-vigilant to judgements by others and tended to perceive or interpret them even in what seemed like innocuous situations.

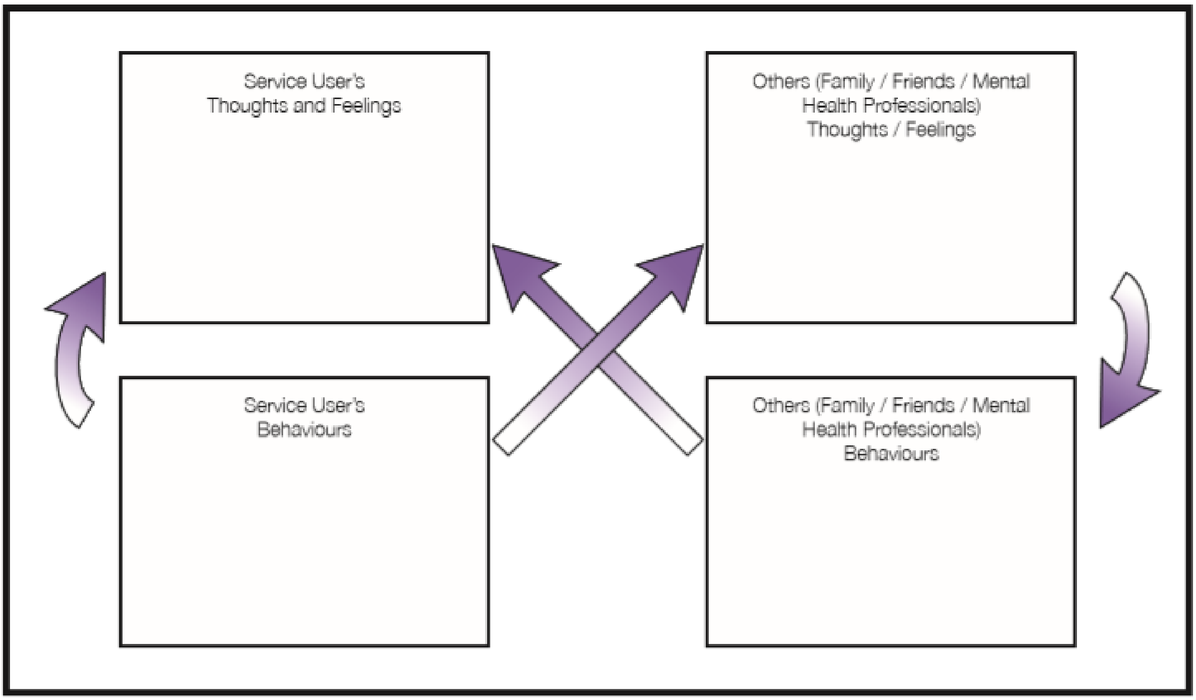
Service User Story 3

Appendix 3C - Worksheets

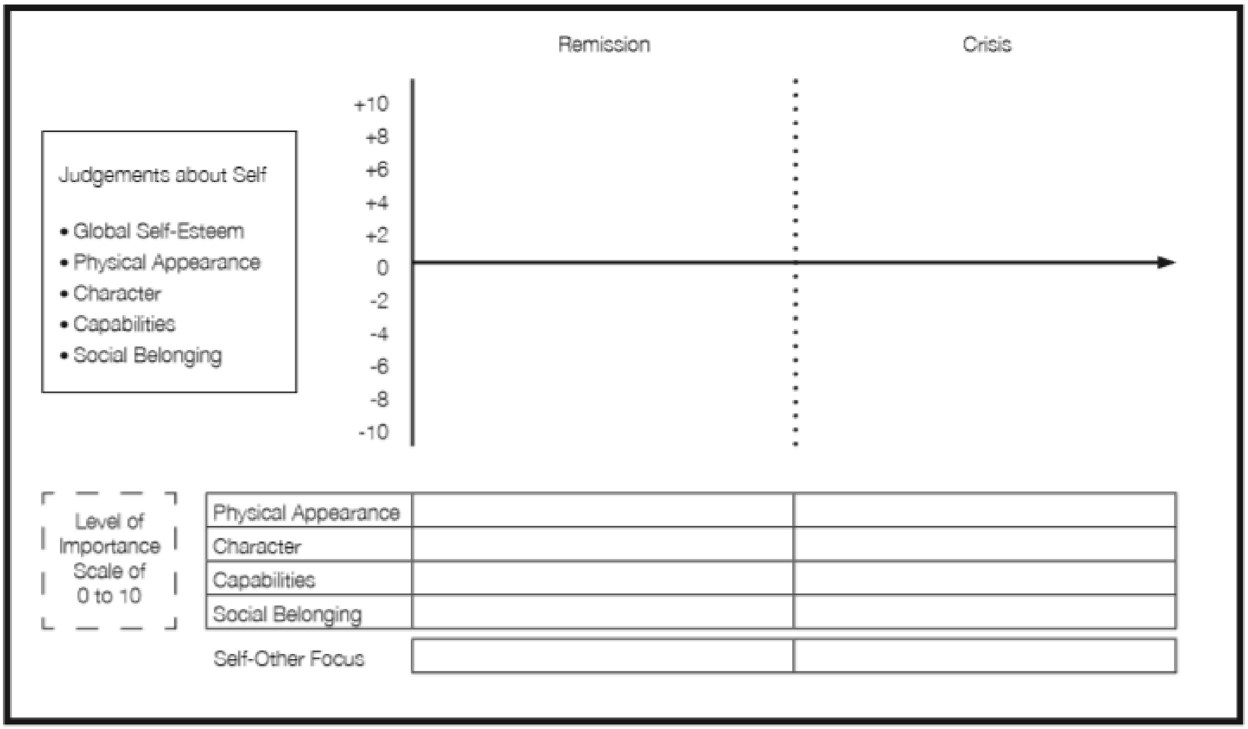
- Cognitive-Behavioural Triad – Maintenance Formulation
- Relational Formulation
- Changes to Global and Specific Evaluations of Self – Self-Esteem
- Changes to Global and Specific Evaluations of the Future – Hope
- Global Self-Esteem – A Balancing of Weighted Judgements
- Defining Standards
- Negatives to Address and Positives to Increase
- Collating Evidence in Support of Positive Self-Statements
- Social Network Map
- Steps Towards Achieving a More Ideal Social Network



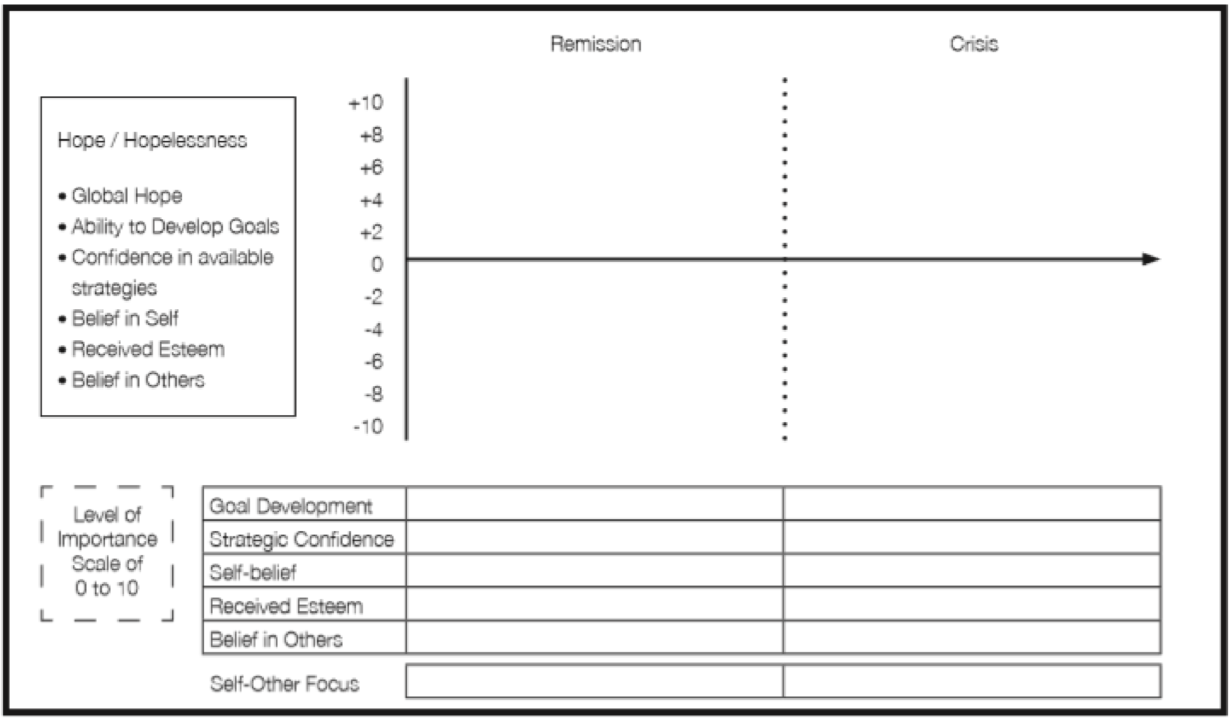
Cognitive-Behavioural Triad – Maintenance Formulation



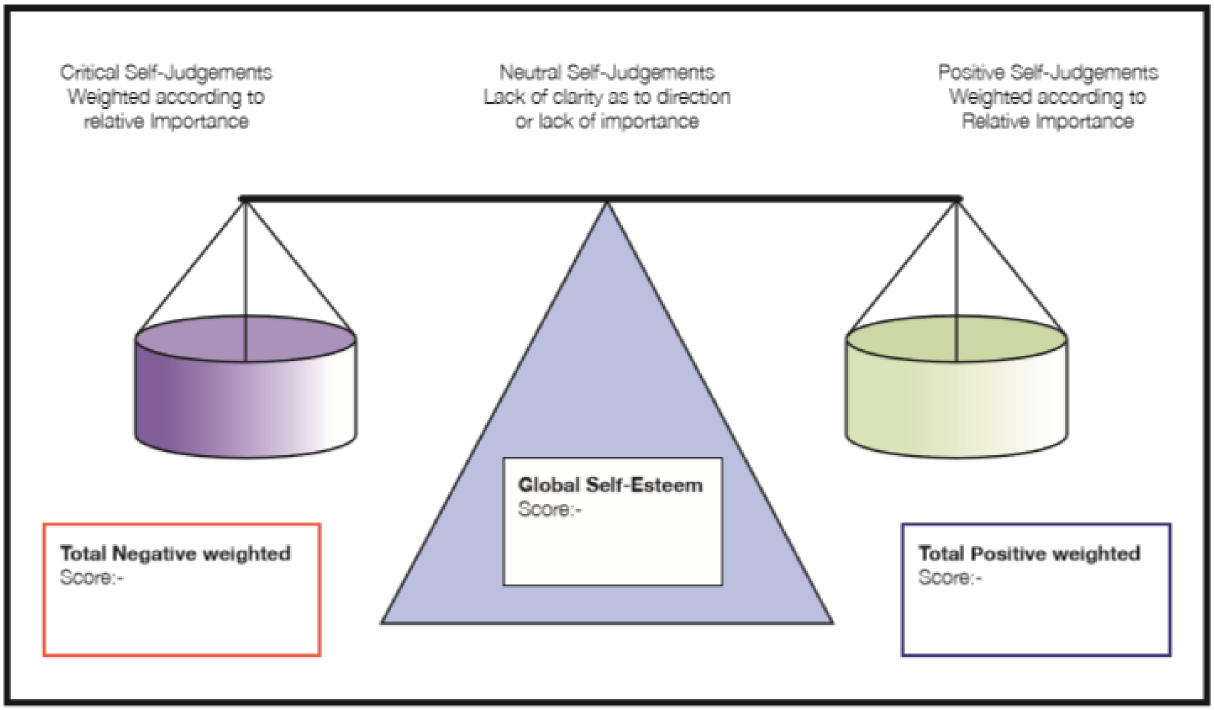
Cognitive- Relational Formulation



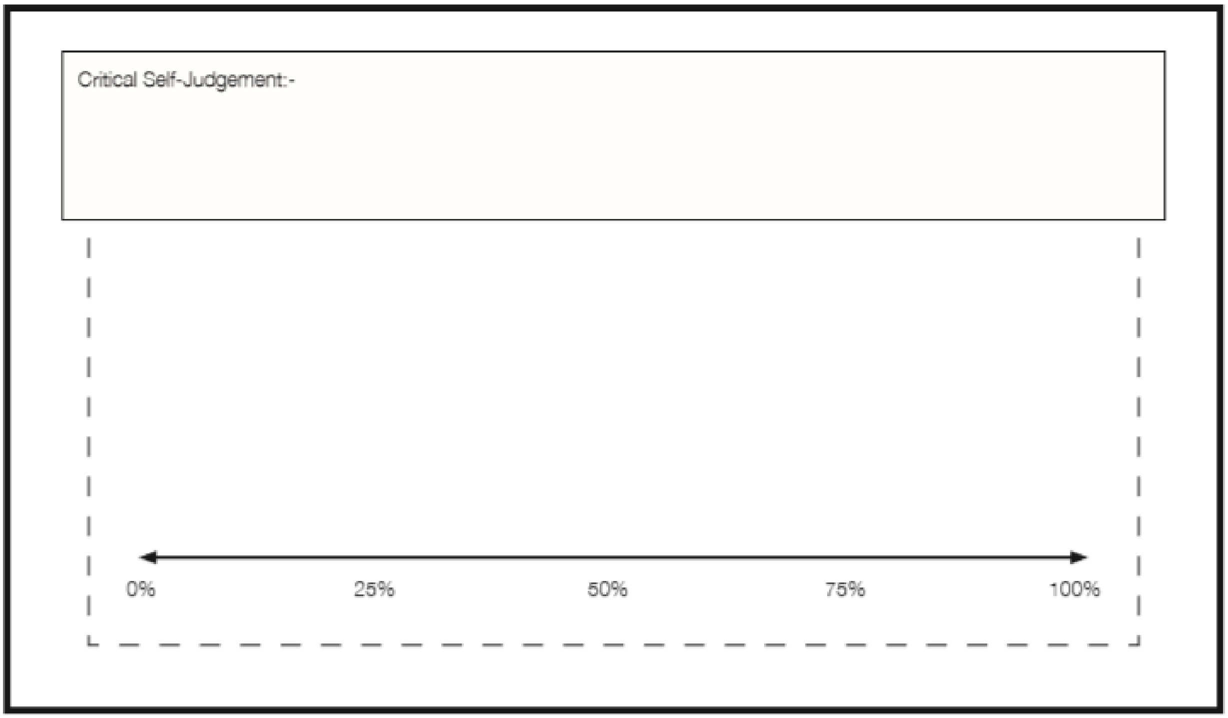
Changes to Global and Specific Evaluations of Self – Self-Esteem



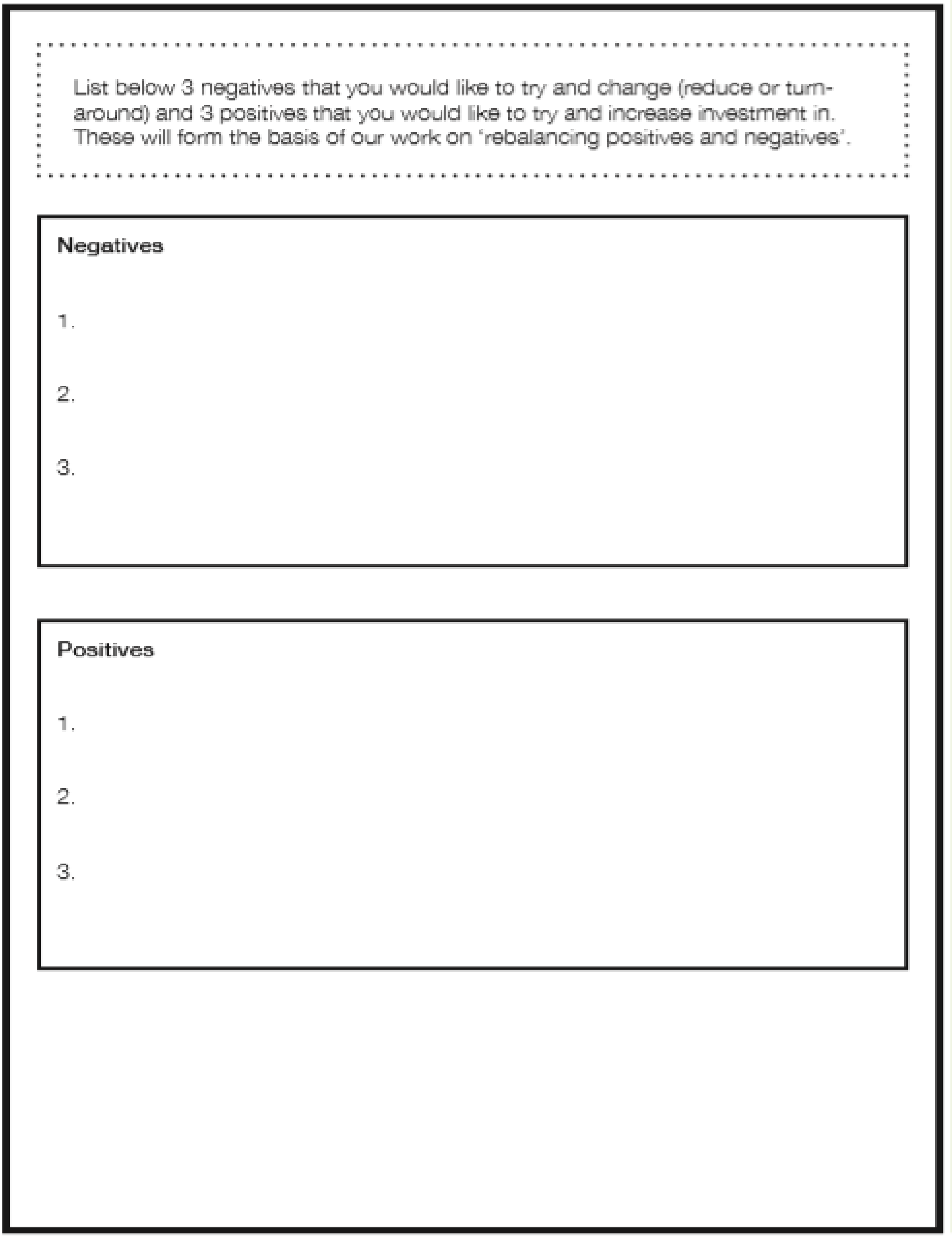
Changes to Global and Specific Evaluations of the Future - Hope



Global Self-Esteem – A Balancing of Weighted Judgements



Defining Standards



List below 3 negatives that you would like to try and change (reduce or turn-around) and 3 positives that you would like to try and increase investment in. These will form the basis of our work on 'rebalancing positives and negatives'.

Negatives

1.

2.

3.

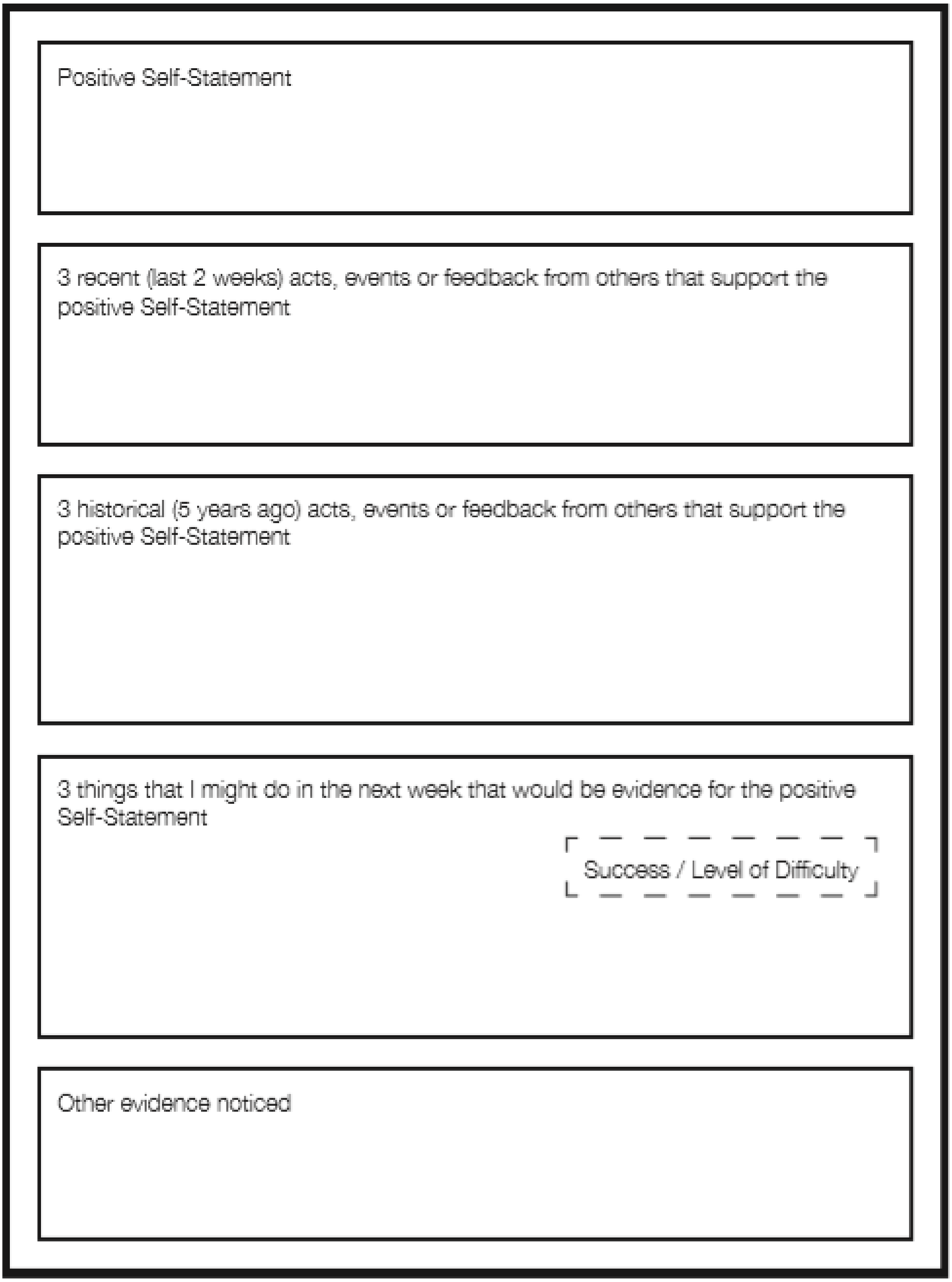
Positives

1.

2.

3.

Negatives to Address and Positives to Increase



Positive Self-Statement

3 recent (last 2 weeks) acts, events or feedback from others that support the positive Self-Statement

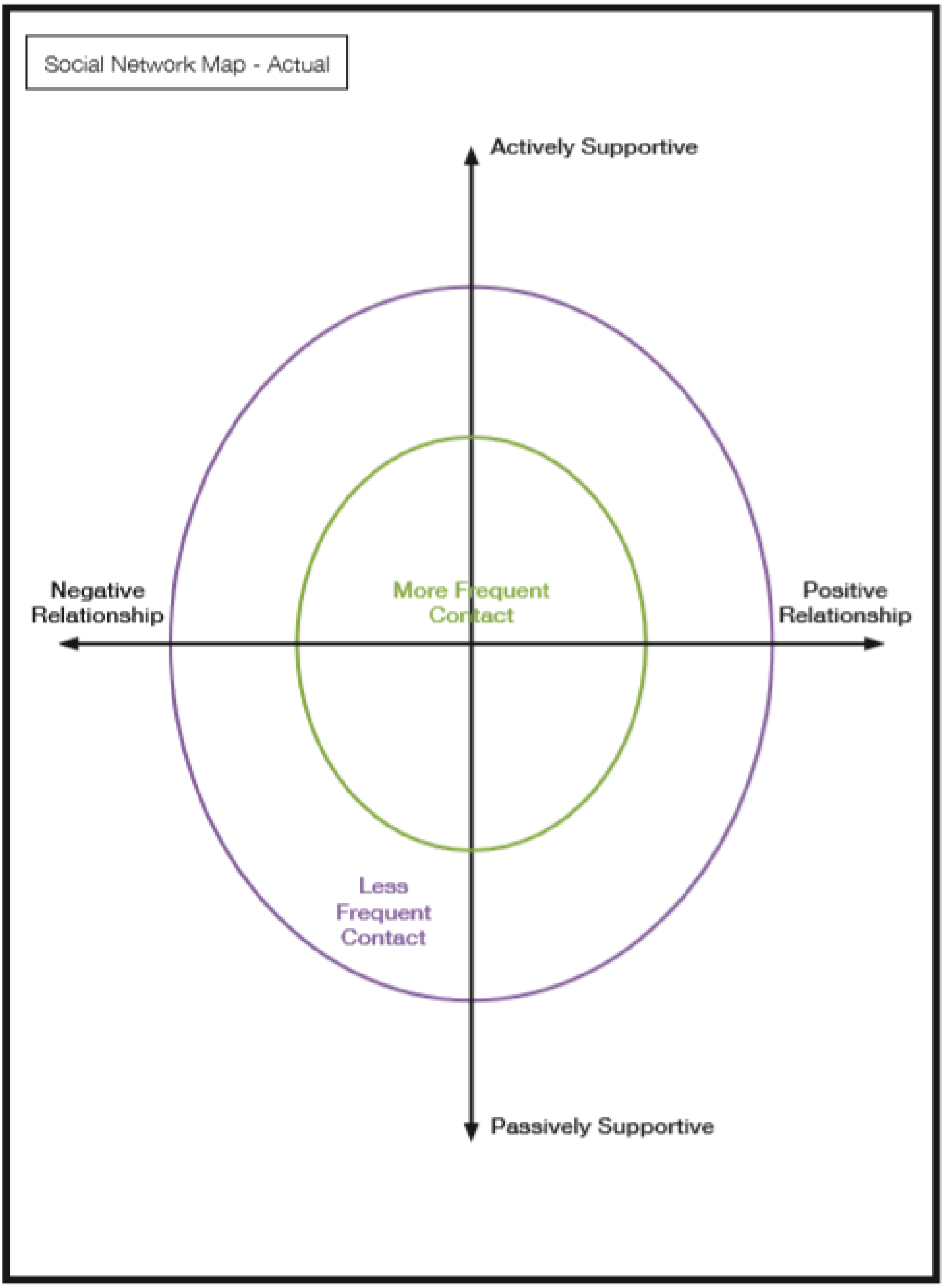
3 historical (5 years ago) acts, events or feedback from others that support the positive Self-Statement

3 things that I might do in the next week that would be evidence for the positive Self-Statement

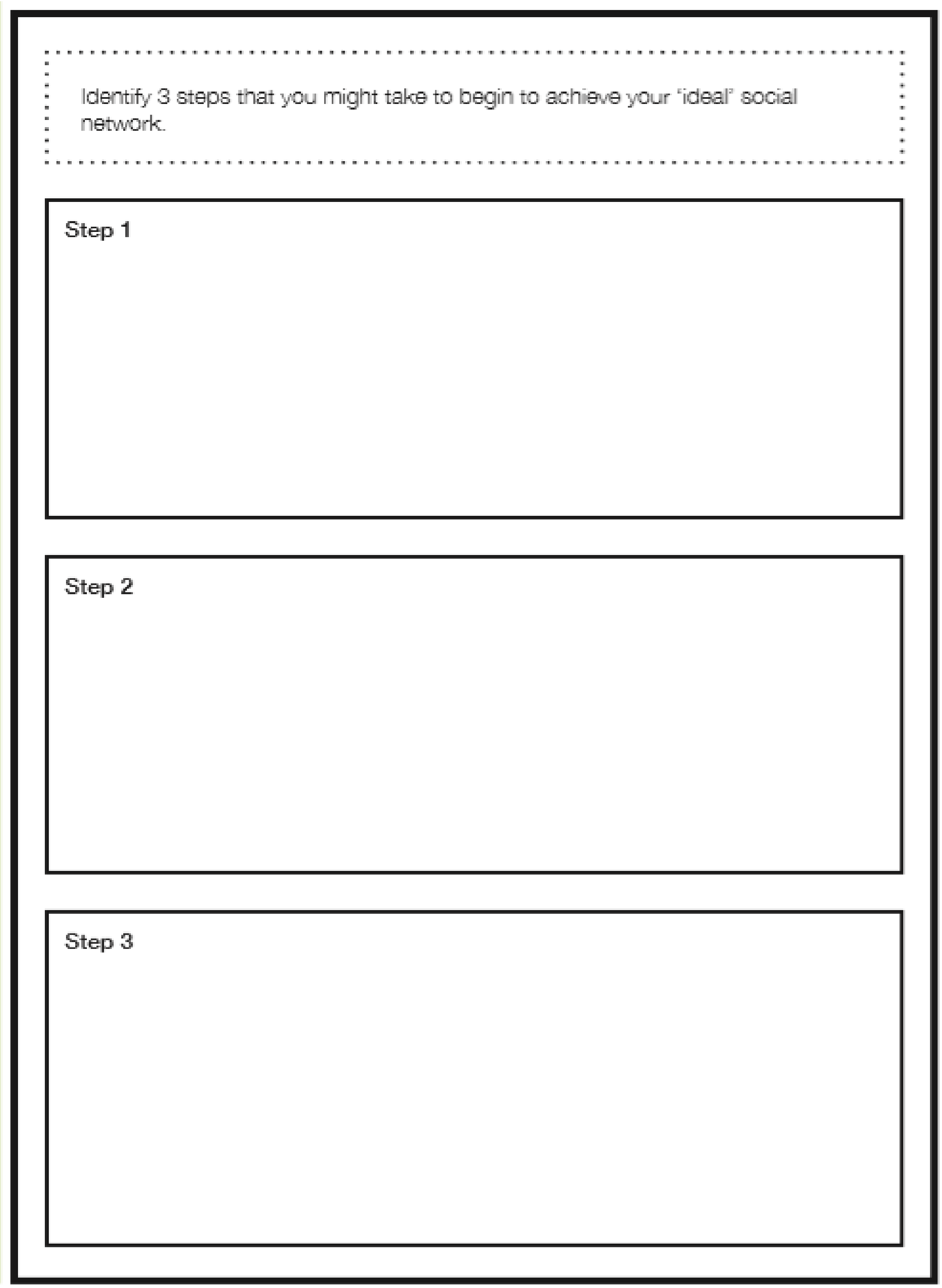
Success / Level of Difficulty

Other evidence noticed

Collating Evidence in Support of Positive Self-Statements



Social Network Map



Identify 3 steps that you might take to begin to achieve your 'ideal' social network.

Step 1

Step 2

Step 3

Steps Towards Achieving a More Ideal Social Network

Appendix 4 – Research Design

(Relating to Chapter 6)

A. Recruitment

- Introductory information sheet
- Detailed information sheet
- Participant Consent Form

B. Quantitative Data

- Outcome Measures– SADHS
- Outcome Measures – RSCQ
- Outcome Measures – CORE-OM
- Outcome Measures – Information of using outcome measures
- Outcome Measures – Clinical Significance

C. Qualitative Data

- Guidance for Semi-Structured Interview

D. Assurance Strategies

- Instructions for Researcher-Interview
- Extract from Summary re Participant Check-Back
- Audit of Fidelity Form

Appendix 4A – Recruitment

- *Inspiring Hope and Self-Belief in Early Psychosis - Participant Information Sheet (Version 2)*
- *Inspiring Hope and Self-Belief in Early Psychosis – Introduction to the Research (Version 2)*
- *Participant Consent Form*

Appendix 4A(i) - Inspiring Hope and Self-Belief in Early Psychosis - Participant Information Sheet (Version 2)

19th December 2013 – Version 2

Leicestershire Partnership NHS
NHS Trust

Inspiring Hope and Self-Belief in Early Psychosis

I am writing to let you know about a research project that I am conducting.

It is quite common for service users that we support within PIER to report feeling very hopeless about the future and very critical about themselves. Sometimes they relate these feelings to experiences in their pasts; often they describe them as arising from their involvement with mental health services, and the problems that brought them into contact with PIER.

I have developed a psychological therapy programme specifically designed to challenge these sorts of feelings. It includes a Resource Manual for those who are receiving the therapy. The programme is based on an established approach to therapy (Cognitive Behavioural Therapy) and uses strategies that have been proven to be effective in other contexts. As a whole thing, however, it is new and hasn't yet been tested out in practice.

I want to work with a small number of service users who are feeling particularly negative about themselves and their futures; providing the therapy on a one-to-one basis and then evaluating it. The evaluation will include questions about (i) whether it worked (and to what extent), (ii) people's experiences of going through the process, and (iii) any comments about how the programme and accompanying manual might be improved.

The therapy would be delivered in 16 meetings spread over about 5-6 months. If possible, however, I would also like to catch up with people every now and then over the following 2 years in order to check out how things were going and, in particular, whether any benefits from the therapy had been sustained.

If your Care Coordinator has passed this letter on to you it will be because they think you might regard it as relevant to your experiences; in other words, because they have an idea that you might be feeling this way too. If you think that this might apply to you and would be interested in knowing more, please let your Care Coordinator know. They will provide you with a lot more information and, if you want, will arrange for you to meet with me.

Please note:- there is absolutely no requirement for you to take part. If you don't want to be involved please just ignore this letter. Saying 'no' will in no way affect the rest of the support that you are receiving.

Yours

Dan Pearson

Consultant Therapist (CBT and Family Therapy), PIER Early Psychosis Service

Appendix 4A (ii) - Inspiring Hope and Self-Belief in Early Psychosis – Introduction to the Research (Version 2)

Leicestershire Partnership NHS
NHS Trust

Inspiring Hope and Self-Belief in Early Psychosis

Participant Information Sheet

Hi

If you have been given this information sheet it means that you have already read the letter about my research and you have said that you would like to know more.

The initial letter was really just about making you aware of the project. It didn't give a lot of detail about what is involved. This information sheet has been written to provide a much more comprehensive description, in order to help you to decide if you would like to take part.

I work in the PIER Service as a Cognitive Behavioural Therapist and Family Therapist. The research is part of a doctorate level training that I am pursuing at Derby University.

As I noted in my letter, the research is about Hope and Self-Belief. Within PIER we find that a lot of the people that we meet feel quite negative about themselves and the future. Sometimes they will report that these feelings have been longstanding; perhaps dating back to events in childhood or adolescence. Sometimes they are presented as consequent to the shock, fear and confusion experienced during the onset of recent mental health problems, or to do with worries about what the future might hold. Whether longstanding or fairly recent we do know that these feelings can be really distressing and can undermine the recovery process. In other words they can make it harder for the person to get back on with their life.

If your care coordinator (key worker) or Consultant Psychiatrist has given you information about this study it means that somehow they have got the idea that you might be struggling with these sorts of feelings too.

There is a particular form of psychological therapy (Cognitive Behavioural Therapy or CBT) which has been shown to be effective in helping people who have experienced a psychotic crisis. Over the years it has been adapted in various ways to tackle low self-belief and hopelessness. There has, however, never previously been a specific programme to address the two together. A therapy programme, based on CBT, has now been developed to do just that. Although most of the interventions in the programme have been shown to be helpful in other situations, the approach as a whole is new. It hasn't yet been tested out to see how well it works or how acceptable people find it to be. That is the purpose of this small project.

There are, therefore, two parts to the study:-

1. **Receiving the Therapy**
2. **Evaluating the Therapy**

Receiving the Therapy

The therapy will be provided by me as a course of ***16 meetings***. These will take place initially on a ***weekly*** basis, although later appointments might be more spaced apart depending on how things are going. Each appointment will last for about ***1 hour***. We could meet in ***my office or in your own home***; whichever you preferred.

Cognitive Behavioural Therapy (CBT) is based on the idea that if someone is emotionally distressed, and if those distressing feelings are stuck, then somehow that person's ways of thinking about themselves and their circumstances (their cognitions) and their approaches to trying to resolve their problems (their behaviours) are not helping (or not helping enough). CBT, therefore, does exactly what it says on the label:- it aims to help the person to think differently about their problems and to find more effective ways of resolving them.

CBT is a very collaborative way of working. It's not about the therapist 'fixing' the person's problems; rather it's about the two (client and therapist) working together to explore what is stuck and to come up with new ideas. The approach assumes that the main benefits of the therapy come about because of the things that the client does between the therapy meetings. Consequently it (the therapy) involves a lot of 'homework' for the client to undertake. Sometimes that might be about keeping a diary of certain thoughts or experiences. On other occasions it might involve experiments or tasks - trying new ways of doing things. The point is that it is a very active process.

It is also a very focussed approach. The beginning of therapy usually involves a great deal of time and attention spent gathering an in-depth understanding of the person's difficulties and identifying the various goals that they want to achieve through the therapy. The therapy process is then reviewed regularly to ensure that it remains on track. As part of that the client might be asked, fairly regularly, to complete questionnaires about their experiences, in order to measure any changes that might be taking place. In the case of this new programme there will be 3 such questionnaires, concerned respectively with:- (i) Hope, (ii) Self-Belief and (iii) General Wellbeing. I have included copies of those assessments with this information sheet so that you will know exactly what they involve.

This new programme will include interventions to challenge negative thoughts about self and to nurture more positive self-judgements; to promote more effective problem solving and, where appropriate, to develop more productive and supportive relationships with family and friends.

Evaluating the Therapy

There are three basic parts to the evaluation process.

Analysing the scores on the assessments that have been completed as part of the therapy

As I have noted above, those taking part will be asked to complete three questionnaires at the beginning of the therapy programme, every few meetings and, again, at the end. Each questionnaire takes about 5 minutes to complete; so 15 minutes in total each time. That is something that would be done as part of the therapy even if the approach wasn't being evaluated. The evaluation doesn't require that the client do anything else during the therapy, but I would be keen to catch up with each person at intervals after the therapy was finished (if possible, at 3, 6, 12 and 24 months) and to get them to repeat the questionnaires each time, in order to check out whether any benefits from the therapy have been sustained. That sort of follow-up wouldn't normally happen. In terms of the analysis of the questionnaires, I would be interested in looking to see how much each person's scores changed over the course of the therapy (and in what ways), as well as examining any patterns of change across all of those involved.

Exploring people's experiences of the therapy

This is the main part of the evaluation. After the therapy has finished, I would like to meet with each of those who takes part to ask about their experience of the process:- What they liked and disliked? What they felt worked for them and what bits of the therapy they thought were perhaps less useful? In particular I would like their opinions on how the programme (and the accompanying manual) could be improved. In order to get the clearest understanding of the points being raised I intend to video-record those conversations and have the recordings transcribed (written out) by one of the secretaries in PIER. That will ensure that I don't miss any important points that are made. It will also let me more accurately compare the comments made by different people.

Evaluating fidelity

It will be important to be able to state with authority that the therapy that has been received; and which is being evaluated; is consistent with what I said I would be doing. This is usually referred to as 'evaluating fidelity to the approach'. In order to do that, I intend to video-record all of therapy sessions and will ask another Cognitive Behavioural Therapist in the mental health trust to check a small random sample of those tapes (about 10%) to see if I am doing what I am supposed to. That person will only be focussing on what I am doing, not on the client, and anyone involved would be welcome to have their back to the camera or even to be out of camera shot if they wanted. Each person will need to provide formal consent for me to record the therapy sessions and the post-therapy discussion and I also enclose a copy of the relevant consent form for you to take a look at.

What happens next?

There are three possibilities:-

If, after reading this information sheet you were to decide that you did not wish to be involved:- There is, absolutely, no requirement for you to agree to take part just because your care coordinator has made you aware of the project. Saying 'no' will not affect the rest of your care in any way.

If, after reading this information sheet, you were to think that you would like to take part in the research:- Please let your care coordinator know. They will need to double check that you meet the conditions for the research – which will include completing the enclosed questionnaires on Hope and Self-Concept. Your care coordinator will also need to check with everyone else involved in your care to make sure that they don't have any concerns about your taking part. If you meet the criteria for involvement in the research, if there are no concerns about your involvement, and if you still want to be involved, they will then let me know and I will arrange for us to meet – to answer any further questions you might have and to sort out a start date. It should be stressed that taking part in the research would require your agreeing to all of the parts described above.

This process might seem a little drawn out, but, at this stage, I can only work with 8 people for the research and it is important that those who take part really want to be involved and haven't felt pressured into volunteering. The repeated checking gives them (you) plenty of opportunity to express concerns and, if you want, to back out. Once we have met and any last questions have been answered we would be able to get on with the therapy almost immediately – within a few days. If, after signing up for the project you were to change your mind, it would be perfectly OK for you to withdraw. You can, in fact, choose to leave the project and even ask for any recordings and other contributions to be deleted, at any time before or during therapy, and within 2 weeks of your feedback interview being completed. You would, also, be able to elect not to meet me for subsequent follow-up reviews if you so wished. Again, there would be no negative affect on the rest of your care if you were to so choose.

If, after reading this information sheet, you were to be interested in receiving the therapy, but didn't want to be part of the research:- I would be happy to talk to you about my providing the therapy as part of your general support package from PIER (ie separate from the research). It is, however, important for me to point out that I have some ring-fenced time to do the research – which is why I can start the research therapy so quickly. Providing the therapy programme outside of the research would, I'm afraid, mean a temporary delay. In addition, those taking part in the research would be given their own copies of the resource manual. Unfortunately, I only have a limited number of copies. I would only be able to provide photocopied pages to those receiving the therapy but not taking part in the research.

Confidentiality and Data Protection

You need to be aware of a few details concerning how your information will be handled. There are three particularly important principles: - (a) That your confidentiality is maintained throughout, (b) That any information (data) relating to your experiences or observations is handled securely, and (c) That nothing is done with your information without your clear (written) permission.

1. The therapy will be delivered as part of your care by PIER – so details of the meetings will be recorded in your medical notes. This information will only be shared with the team in PIER and your GP unless you disclose information that strongly indicates that you or someone else is at risk.
2. The video-recordings of the therapy will be saved on encrypted (ultra-safe) data sticks (for computers). They will be stored securely in a locked box, in a locked room at the PIER team base. Those that are selected for audit of fidelity (see above) will be taken by the Cognitive Behaviour Therapist to be studied in their own NHS office. Once viewed they (and all other recordings) will be immediately deleted. Once the project has finished the data sticks will be destroyed.
3. The video-recordings of the feedback conversations at the end of therapy will be given to a secretary in the same PIER team base to be transcribed (typed out). Once I have checked the transcripts for accuracy those recordings will also be deleted and the data sticks destroyed.
4. Transcripts will be read by more than just me, but they will have all identifiable information – names, addresses, and so on – removed and they will be filed with a code number to preserve your confidentiality.
5. If specific comments made by you are included in the doctoral write-up (thesis), or in academic articles or books, you will be given a different name, and again, every effort will be made to ensure that you cannot be identified by a reader. The only exception would be if you actively asked for your contributions to be acknowledged. Under those circumstances I would be delighted to openly recognise the help that you had given.

Potential Benefits and Disadvantages

It is important that I am as clear as possible about the potential benefits and risks of your taking part in the research.

The treatment programme is designed to help people feel less negative about themselves and their future. If you were to be involved it would be because you were struggling with feelings of hopelessness and low self-esteem and so, hopefully, the therapy would help you to challenge those feelings and to improve your wellbeing. You are, of course, entitled to receive the therapy without being involved in the research part. The benefits to taking part in the project, therefore, would be that you would be able to access that therapy more quickly and that you would be provided with a free copy of the Resource Manual that has been written to support the therapy; as well as a copy of the revised manual after the research has been completed.

No-one, of course, can ever guarantee that any psychological therapy will help all of those people to whom it is offered. Although almost all of the individual elements of the approach have been shown to be helpful in other programmes and studies, this is a new approach and so the benefits, in terms of effectiveness, are particularly unknown.

Even were that to be the case your feedback about your experiences; including your thoughts about why the therapy had not been so helpful for you; would still be extremely valuable to the study. However, involvement in the project would be time-consuming. The main possible disadvantage of agreeing to take part, therefore, is that you might make that investment of time and energy and not, in the end, feel that the outcomes were worth it in terms of benefits to you.

It is extremely unlikely that involvement in the study would be, in any way, detrimental to your wellbeing. It is important, however, that I make sure that you know that were you to have any concerns about any aspect of the study, you would be able to talk to me about it and that I would do my very best to resolve them. If, after that, you were to remain unhappy and wished to complain formally, you would be able to do so by contacting the Manager of the PIER Service (Mr Richard Holland) at Swithland House, or by approaching Leicestershire Partnership Trust Complaints Department directly. Their address is included at the bottom of the page.

By law I also need to inform you that if anything were to go wrong and you were harmed during the study, and if that harm were to be due to my negligence then you might have grounds for legal action for compensation against Leicestershire Partnership NHS Trust. You might, however, have to pay your own legal costs. Under those circumstances the normal National Health Service complaints mechanisms would still remain available to you (if appropriate).

Thank you for taking the time to read this Information Sheet. If you wish to know more please feel free to contact me on 0116 225 5600 or write to me at Swithland House, 352 London Road, Leicester, LE2 2PL.

Dan Pearson

Consultant Therapist (CBT and Family Therapy)

PIER Early Psychosis Service

Leicestershire Partnership Trust Complaints Department can be contacted at:-

FREEPOST RSUL-LSXC-AGJU

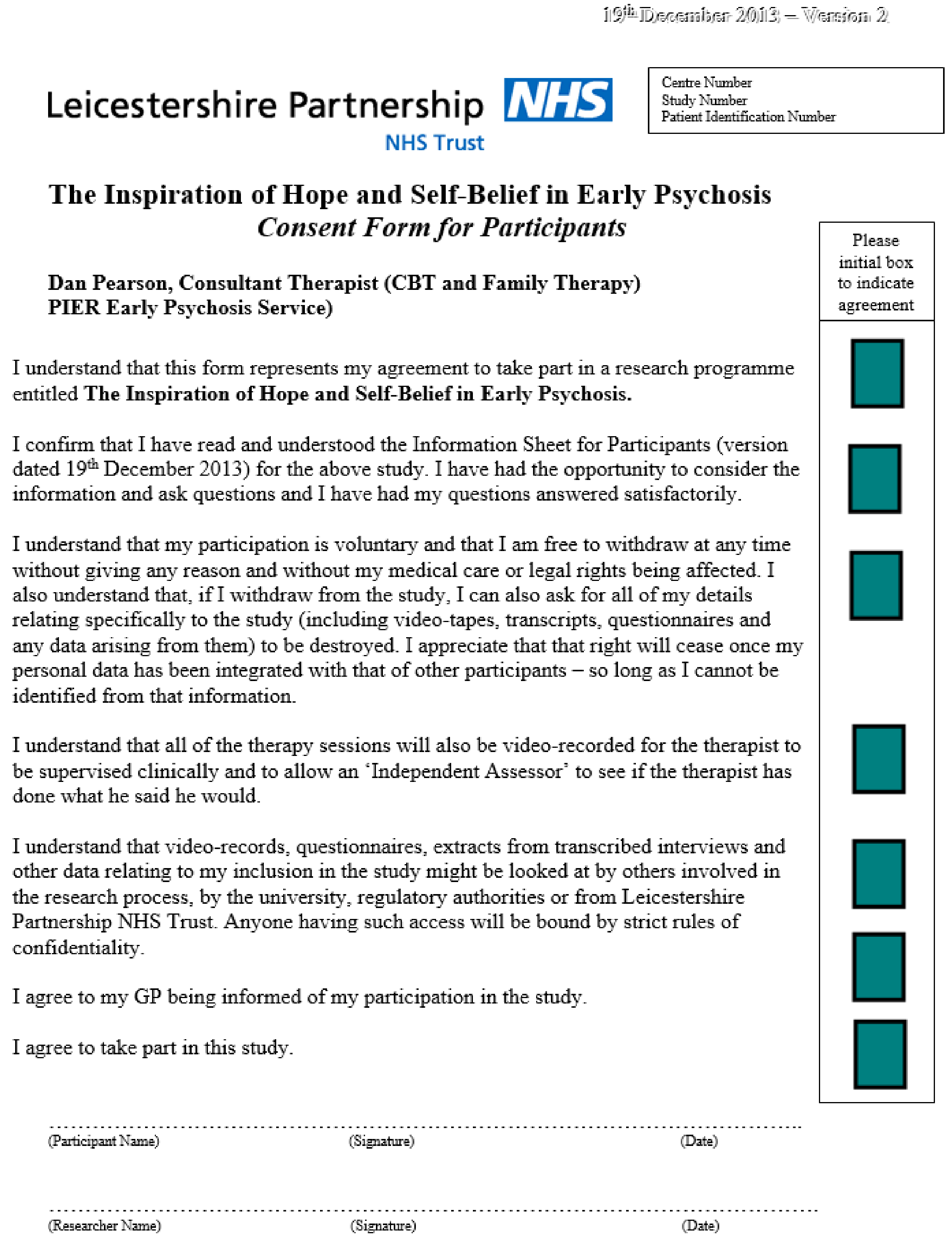
Customer Services, Leicestershire Partnership NHS Trust, Lakeside House,

4 Smith Way, Grove Park, Enderby, Leicestershire LE19 1SS

Tel: 0116 295 0830 or 0116 295 0831; Mobile/text: 07917202647

Fax: 0116 2950843; Email: customerservices@leicspart.nhs.uk

Appendix 4A(iii) – Participant Consent Form



19th December 2013 – Version 2

Leicestershire Partnership NHS
NHS Trust

Centre Number
Study Number
Patient Identification Number

The Inspiration of Hope and Self-Belief in Early Psychosis
Consent Form for Participants

Dan Pearson, Consultant Therapist (CBT and Family Therapy)
PIER Early Psychosis Service)

	Please initial box to indicate agreement
I understand that this form represents my agreement to take part in a research programme entitled **The Inspiration of Hope and Self-Belief in Early Psychosis.**	☐
I confirm that I have read and understood the Information Sheet for Participants (version dated 19th December 2013) for the above study. I have had the opportunity to consider the information and ask questions and I have had my questions answered satisfactorily.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my medical care or legal rights being affected. I also understand that, if I withdraw from the study, I can also ask for all of my details relating specifically to the study (including video-tapes, transcripts, questionnaires and any data arising from them) to be destroyed. I appreciate that that right will cease once my personal data has been integrated with that of other participants – so long as I cannot be identified from that information.	☐
I understand that all of the therapy sessions will also be video-recorded for the therapist to be supervised clinically and to allow an 'Independent Assessor' to see if the therapist has done what he said he would.	☐
I understand that video-records, questionnaires, extracts from transcribed interviews and other data relating to my inclusion in the study might be looked at by others involved in the research process, by the university, regulatory authorities or from Leicestershire Partnership NHS Trust. Anyone having such access will be bound by strict rules of confidentiality.	☐
I agree to my GP being informed of my participation in the study.	☐
I agree to take part in this study.	☐

....
(Participant Name) (Signature) (Date)

....
(Researcher Name) (Signature) (Date)

Appendix 4B – Outcome Measures

- Snyder’s Adult Dispositional Hope Scale (Snyder et al, 1991)
- Robson’s Self Concept Questionnaire (Robson, 1989)
- Core-Om (Barkham et al, 1998)
- Clinical Significance

Please note that, of the versions presented, the RSCQ and CORE-OM are ‘original’ electronic versions, but the SADHS has been reproduced from Lopez, S.J., Ciarelli, R., Coffman, L., Stone, M. and Wyatt, L. (2000).

Appendix 4B(i) – Snyder's Adult Dispositional Hope Scale

This scale has been removed from the electronic version of the thesis due to copyright reasons.

Appendix 4B(ii) - Robson’s Self Concept Questionnaire

This questionnaire has been removed from the electronic version of the thesis due to copyright reasons.

Appendix 4B(iii) - CORE-OM

This measure has been removed from the electronic version of the thesis due to copyright reasons.

Appendix 4B(iv) – Clinically Significant change

It has been argued by Jacobson and Truax (1991), amongst others, that it is more meaningful in considering the efficacy of psychotherapeutic practice to examine clinically significant change than statistically significant change. They suggest that therapeutic benefits, such as 'potency, .. impact on clients, or … ability to make a difference in peoples' lives' (p12) are missed by 'conventional statistical comparisons'.

In 1984, Jacobson, Follette and Ravenstorf published a formula for calculating the Clinical Significance of change. They hypothesised a distribution of scores for many problem-focussed outcome measures that might present with two 'normal' curves – representing the 'clinical' and 'non-clinical' populations. They suggested that these normal distribution patterns might be completely separate, might partially overlap or significantly overlap – as illustrated below by Diagrams 1, 2 and 3.

For each pattern; separate, partial- and significant-overlap; they suggested that there might be three distinct definitions of a clinically significant change (the move towards normal functioning). Assuming that the service user's baseline score was within the clinical population, clinical significance might be determined by;-

- Progress out of the clinical population – Cut-off 'A'.
- Progress from a point that was closer to the clinical mean to one that was closer to the non-clinical mean – Cut-off 'B'.
- Progress into the range of the non-clinical population – Cut-off 'C'.

It is important to appreciate the differences; intellectually and pragmatically; between these three points.

Cut-off point 'A' represents the 'reasonable' limit of the clinical population, calculated as 2 standard deviations from the population mean. If the outcome is 'problem-scored' (the higher the score – the greater the problem) the relevant limit of the clinical population would be 2 standard deviations ***below*** the population mean. If the measure was 'inverse-problem scored'; as represented in Diagrams 1, 2 and 3; the relevant limit would be 2 standard deviations ***above*** the population mean.

Diagram 1 - Separate Clinical and Non-Clinical Populations

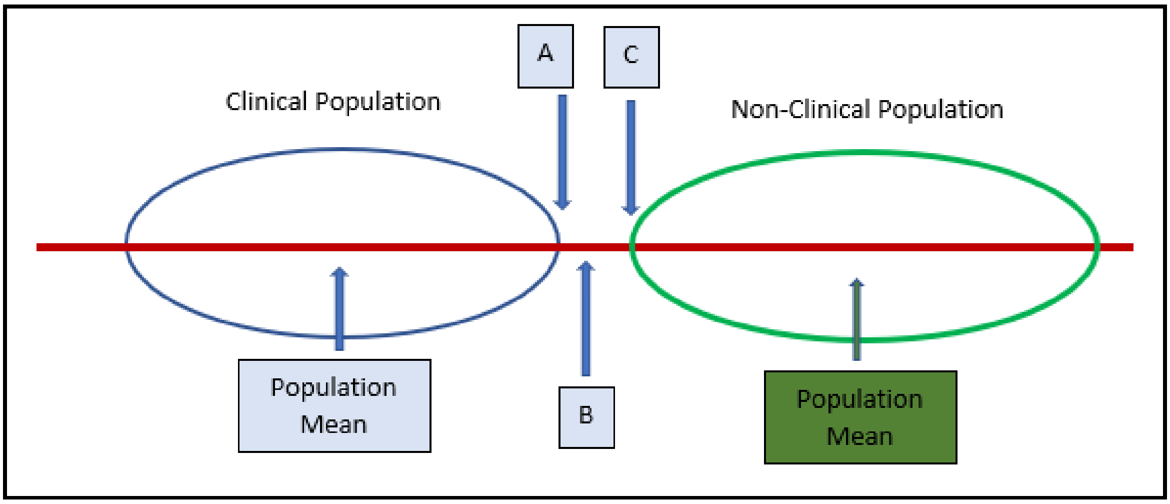


Diagram 2 – Partially Overlapping Clinical and Non-Clinical Populations

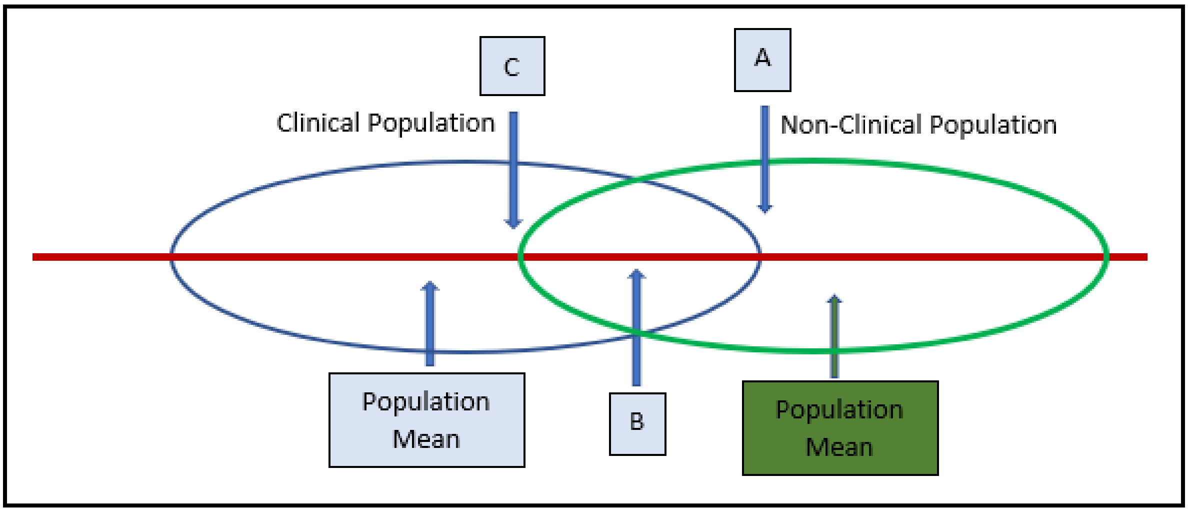
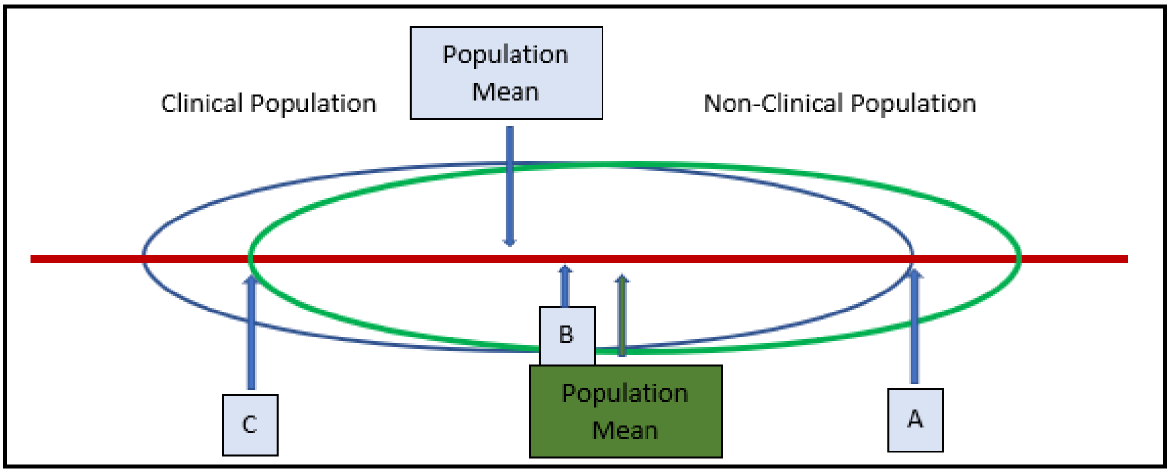


Diagram 3 – Significantly Overlapping Clinical and Non-Clinical



Cut-off ‘B’ represents a point exactly halfway way between the population means for the clinical and non-clinical populations

Cut-off ‘C’ represents the ‘reasonable’ limit of the non-clinical population, calculated as 2 standard deviations from the population mean. If the outcome is ‘problem-scored’ (the higher the score – the greater the problem) the relevant limit of the population would be 2 standard deviations ***above*** the population mean. If the measure was ‘inverse-problem scored’ the relevant limit would be 2 standard deviations ***below*** the population mean.

Where the two populations are separated (Diagram 1) an individual engaging in an effective treatment program, whose pre-therapy score was within the clinical population, would experience clinically significant change in the order A-B-C. They would move on from a clinical ‘geography’, through ‘no-mans-land’, and into a non-clinical locality.

Where the two populations are overlapping; partially (Diagram 2) or significantly (Diagram 3); an individual engaging in an effective treatment program, whose pre-therapy score was within the clinical population, would experience clinically significant change in the order C-B-A. They would move into a non-clinical locality before leaving the clinical ‘geography’, with no dividing ‘no-mans-land’. In this scenario therapy might be defined as effective even if the person was still within the clinical population – if they had crossed the threshold into the non-clinical range or even passed the midpoint between the two means.

Jacobson and Truax (1991) note that each cut-off might be more / less conservative or lenient depending on the degree of overlap of the two populations, and recommend that the decision as to which cut-off to use, should be dependent upon the availability of normative data (population means and standard deviations) for the measure employed. They do, however, point to ‘C’ as the most useful cut-off in situations of significant overlap.

Jacobson et al’s (1984) recommendations have subsequently been moderated for greater statistical sophistication (Christensen and Mendoza, 1986; Hageman and Arrindell, 1999; Jacobson et al, 1999; Jacobson et al, 2002), and when used with larger population samples. Their original formulation remains highly useful for small scale studies, including when such quantitative data is secondary to qualitative, as in this study.

To avoid confusion, it is important to be aware that Jacobson et al (1984) label the three cut-off points slightly differently.

Calculating Statistically Significant Change with the SADHS

Snyder and colleagues have developed a number of Hope scales (Lopez et al, 2000). As noted with reference to choice of measure, the Adult Dispositional Hope Scale (SADHS) is the only one that has been validated with respect to both clinical and non-clinical populations. Table 4 (below) presents the mean, standard deviation and cut-offs (‘A’,’ B’ and ‘C’) for this measure.

Data for the SADHS presents combined population norms across all aspects of diversity – including gender, but does include separate means and standard deviations for the subscales, as well as the total. The SADHS can be scored on a 4-point or 8-point format. The 8-point version was used in order to maximise sensitivity. The population norms are presented by the authors with reference to the 4-point scale, and have simply been doubled to accommodate the 8-point version used in this study. It is possible that ‘official’ normative data for the 8-point instrument would show different means and standard deviations from that employed.

	Non-Clinical		Clinical				
	Mean	**SD**	**Mean**	**SD**	**Cutoff A**	**Cutoff B**	**Cutoff C**
Agency Thoughts Subscale	25.22	3.46	22.50	5.72	33.94	23.86	18.30
Pathway Thoughts Subscale	25.22	3.30	22.50	4.70	31.90	23.86	18.62
Total	50.48	5.62	46.22	8.9	64.02	48.35	39.24

The SADHS is ‘inverse-problem scored’, so the lower the number the greater the difficulty – less Hope. Improvement (moving from the clinical towards the non-clinical population), therefore, is evidenced by an increase in scores. Cut-off ‘A’ is, consequently, two standard deviations above the mean of the clinical population, and Cut-off ‘C’ is two standard deviations below the mean for the non-clinical population.

From the above Table it is evident that the two populations (clinical and non-clinical) significantly overlap – as with Diagram 3. Indeed, the lower boundary of the non-clinical population (Cut-off 'C') is actually below the mean for the clinical population and the upper boundary of the clinical population (Cut-off 'A') is the maximum possible score – 64. It is also clear that the difference between the population means (clinical and non-clinical) is fairly small – 4.26 for the total score – from a 56-point scale-range. With 8 active questions, that requires only 5 questions to show a 1-point positive swing to potentially generate a transition from the clinical mean to the non-clinical mean, and only 3 questions to show a 1-point swing to move from the mean of the clinical population and to cross Cut-off 'B'.

For those reasons, the inclusion criteria specified that participants score particularly low - below 36 (the midpoint of the 8-64 range), which was between 1 and 2 standard deviations below the mean of the clinical population and, more significantly, was 3.24 points below Cut-off 'C' – the lower limit of the non-clinical population.

Calculating Statistically Significant Change with the RSCQ

The population norms for the RSCQ (Robson, 1989) include separate (and combined) gender scores for the 'control' population, but combined scores only for the clinical populations. The scale was validated against four different clinical sub-populations - Adult Psychiatric (112), Psychotherapy Referrals (100), Heroin or Alcohol Dependent patients (108), and Generalised Anxiety Disorder (106). Standard deviations for the different groups were comparative. In this study, it was decided to use the GAD data as representing a mid-point amongst these different clinical clusters. Table 3 (below) presents the mean, standard deviation and cut-offs (A, B and C) for this measure. The RSCQ is 'inverse-problem scored', so the lower the number the greater the difficulty. Improvement (moving from the clinical towards the non-clinical population), therefore, is evidenced by an increase in scores. Cut-off 'A' is, consequently, two standard deviations above the mean of the clinical population, and Cut-off 'C' is two standard deviations below the mean for the non-clinical population.

	Non-Clinical		Clinical				
Gender	**Mean**	**SD**	**Mean**	**SD**	**Cutoff A**	**Cutoff B**	**Cutoff C**
Male	141	19.5	106	25.9	157.8	123.5	102
Female	139	20.5	106	25.9	157.8	122.5	98

From the above Table it is evident that the two populations (clinical and non-clinical) significantly overlap – as with Diagram 3. Indeed, the lower boundary of the non-clinical population (Cut-off 'C') is actually below the mean for the clinical population for both men and women.

The RSCQ incorporates a number of subcomponents (see above), but they are not represented by separate norms. Assessment of clinically-significant change was, therefore, limited to the measure as a whole. Changes to the scores of service-user participants were considered with respect to all 3 cut-off points.

Calculating Statistically Significant Change with the CORE-OM

Unlike the SADHS and RSCQ, the CORE-OM has specifically been developed and presented with the concept of 'clinical significance' in mind. The Users' manual, available on the official website, includes details of mean scores and standard deviations for clinical and non-clinical populations. The developers found a small difference; statistically significant for the clinical population, but not the non-clinical population; between males and females, so that data is also available. Table 2; below; presents cumulative details regarding population means and standard deviations, together with the 'A', 'B' and 'C' cut-offs for the CORE-OM.

	Non-Clinical		Clinical				
Dimension	Mean	SD	Mean	SD	Cutoff A	Cutoff B	Cutoff C
Wellbeing Male	0.68	0.71	2.22	0.98	0.26	1.37	2.10
Female	1.10	0.87	2.41	0.97	0.47	1.77	2.84
Problems Male	0.78	0.64	2.32	0.92	0.48	1.44	2.06
Female	1.00	0.76	2.28	0.87	0.54	1.62	2.52
Functioning Male	0.83	0.62	1.92	0.87	0.18	1.29	2.07
Female	0.86	0.67	1.84	0.85	0.14	1.3	2.20
Risk Male	0.23	0.47	0.69	0.75	0.00	0.43	1.17
Female	0.15	0.40	0.61	0.77	0.00	0.31	0.95
All N-R items Male	0.79	0.59	2.13	0.84	0.45	1.36	1.97
Female	0.95	0.70	2.11	0.82	0.47	1.5	2.35
All items Male	0.69	0.53	1.88	0.78	0.32	1.19	1.75
Female	0.81	0.61	1.85	0.77	0.31	1.29	2.03

Clinical and Non-clinical populations are presented with reference to each subscale, the total score and the total score not including risk, and in relation to each gender. As can be seen, for all scales and both genders, there is a significant level of overlap between the clinical and non-clinical populations – consistent, broadly, with Diagram 3 above.

Please note that the CORE-OM is 'problem scored', so 'A' is calculated as 2 SD's below the clinical mean, 'B' as half-way between the two means, and 'C' is 2 SD's above the non-clinical mean.

The inclusion criteria for the study did not make any reference (or requirement) with respect to baseline CORE-OM scores. In the following chapter (results), the question of clinically significant change for each service user has been determined uniquely – dependent upon their starting point. In each case their scores have been discussed with reference to all 3 cut-offs. For the risk subscale, however, it should be noted that Cut-off 'A' is 0 (zero).

Appendix 4C – Qualitative Data

- Guidance for Semi-Structured Interview
- Detailed Example of Step-by-Step Analysis from the Speech Segment to identifying of Key Themes and Significant Points relating to Participant MJ7

Appendix 4C(i) - Guidance for Semi-Structured Interview

Rationale

There is an underpinning philosophy to this research that the whole therapy programme; and research process; represents a developing, collaborative conversation between the researcher–therapist and service user-participant. This is most clearly evidenced in the ‘feedback interview’.

Although designated an ‘interview’ it is intended that this be more of a dialogue in which the interviewer contributes observations and information as well as asking questions. It is, as such, a valuable forum to integrate the picture that has emerged from analysis of the completed measures; a semi-objective statement about the value or impact of the approach; with the participant’s more subjective sense of their experience of it – in terms of both efficacy and accessibility.

Each feedback interview will, therefore, start with the feeding-back to the participant of the results of the completed outcome measures. It is a beginning point. The primary purpose of the interview is, however, to gather the reflections of the participant and so the greatest emphasis will be dedicated to the exploration of their experiences.

The questions included in this guidance are exactly that; they are guides for how to develop the discussion. The conversation is likely to flow most easily if it progresses from discussions of efficacy to discussions of accessibility (experience); from internal or cognitive experiences, to experiences of action and then interaction with others; and from the treatment programme to the resource manual. It is important, however, to allow the participant some responsibility for the direction of travel of the conversation and the order of questions might be very different. None of the recommended / guide questions needs to be asked exactly as it is recorded here. It is important, however, that each of the broad areas; indicated by highlighting of the question; be considered.

Introduction to the Interview

As you will be aware your therapy has been part of a research study. As I explained to you when we first met, almost all of the different components of the programme have been tried and tested either as interventions in their own right or as elements within other therapy models. A few aspects have been developed to help create this unique programme and, of course, the approach as a whole is new.

From the point of view of research, the priority has been to test out the treatment programme as a whole; including the resource manual that I gave to you at the beginning and to which we have been referring throughout.

There are a number of aspects that I would like to explore with you today, but they all revolve around the simple question:-

How was it for you?

That question can probably most usefully be split into two parts:-

- How did you experience the approach? – In terms of how accessible it was? How much sense it made to you? Whether you felt that it 'fitted' your needs?
- What difference did it make? – To your sense of yourself and the future? To your wellbeing more generally?

When we get into thinking about these questions it will be really important that you are honest with me; even harsh if that is what is appropriate. I intend to revise the programme and the manual in response to your; and other people's; feedback. I would far rather know now if there are problems or weaknesses in the content, style, process or anything else; so that I can make the amendments at this point; than present the approach to the world as something complete only to then get challenged by people who don't know me and have no reason to protect my feelings.

Some Feedback about the 'Outcome' Measures completed over the course of the therapy

Before we start exploring some of those questions, however, I would like to give you some feedback about the measures that you completed during the course of the therapy. I'm sure that you will remember that you filled in questionnaires on Hope, Self-Esteem and your more general wellbeing at various points along the way, as well as giving a score for Hope and Self-Esteem at the beginning of each of our meetings. I have commented at times on the picture that was emerging from these measures. I wanted to start today by giving you a more complete breakdown of your responses over the course of the last few months.

I have three graphs to show you; changes in Hope, Self-Esteem and Wellbeing / Symptoms. You will see that for each of Hope and Self-Esteem there are two lines – reflecting your answers to the standard measures and, also, the SUDs ratings – those more instinctive assessments that you gave – on a -10 to +10 scale.

I also wanted to tell you a little about what the numbers say when they are analysed; how much of a change? What significance that has?

One of the interesting questions in relation to the use of these measures concerns the timing of particular changes in your experiences of Hope, Self-Esteem and Wellbeing. Just because there is a sudden shift immediately after a particular session of intervention doesn't necessarily mean that it was that intervention that was responsible. It might well be that earlier events were only just having an effect at that point. It is, also, possible that something completely outside of the therapy might have been making a difference then. But it is useful to point at those more dramatic changes to think about your experiences at the time and your ideas about what was happening.

What sort of picture do you think the graphs and numbers will show?

Participants' Experiences of the Treatment Programme

Picking up on these measures, what are your thoughts about how effective or helpful the therapy has been?

What about the accessibility of the programme – how easy, meaningful or enjoyable did you find it?

What do you think has most changed for the better as a consequence of the therapy?

What do you think has changed the least or even become worse?

Was there something that you expected to be different as a consequence of the therapy, but that just hasn't changed that much?

What is different (for the better) in your life - in the way that you think or act - as a consequence of the therapy?

Who do you think has noticed that change? How have they shown that they have noticed? What difference has it made to your relationship with them?

Has anybody else shown that they have been aware of you feeling or being different?

How have they responded to those changes in you?

How has that felt to you?

How much of that changing picture do you think would have happened anyway – even if you hadn't taken part in the therapy programme?

If you feel that you would have got there anyway – did the treatment programme make a difference to how soon things improved?

How has it left you feeling about the future?

I know that Hope is always about the future, but how confident are you that you will be able to sustain the changes that you have experienced?

Supposing for a moment that the therapy was helpful (at least to some degree) – what bits of it do you think were of most benefit?

Which bits felt least relevant?

Were there sessions that could have been completely skipped over?

If so – which ones?

If you could make 3 recommendations about how the programme could be improved what would they be?

Do you have more than 3 recommendations?

What is the most important thing that I need to take onboard, do you think, to make the programme better?

What about the handbook?

You have had a chance to really get to grips with it over the last few months.

How helpful did you find it as a resource?

What was most useful about it?

What was least useful?

Is there anything that you feel could be taken out of it?

Is there anything that is missing – that needs to be added?

Where does it need changing – in terms of style (how it is presented) or the content?

Would you recommend it for other people to read?

Appendix 4C(ii) - Detailed Example of Step-by-Step Analysis from the Speech Segment to identifying of Key Themes and Significant Points - Participant MJ7

- *Two examples of Speech segments from transcript and the relevant reflections in the critical interpretative analysis*
- *Three examples of Key Themes and Significant Points*
- *List of All key Themes arising from the Analysis of the Interview with MJ7*

Two examples of Speech segments from transcript and the relevant reflections in the critical interpretative analysis

Participant's Transcribed Words	Interpretive Analysis
I think just talking openly and because I was talking about new things that I hadn't talked about before. So it was like the first time that I was talking about it to someone. So I think that helped. Just generally having someone listening to you because you don't usually talk about yourself so much during the day, and have someone else also talking just about you. So I think that helped having the one-to-one discussion. And I think you tried to put it into the whole bigger picture. So you tried to understand how, at university when I started feeling lower, and I think you drew it out on a graph as well, and to pinpoint exactly when things started going wrong and I think that helped in trying to understand it that way in terms of the timing. I just thought I was going downhill from the start, but there were specific times during university when I was doing OK and when things were getting too much.	What makes a difference? Talking openly? Talking about new things? Having someone to listen? These are all very generic – the central tenets of all therapies – not something that is specific to this program. These observations talk to my skills as a therapist or to my personhood. They don't speak to this new program – except to say that it needs to operate by the same rules as every other therapy program of worth. 'Understanding the bigger picture' speaks to the importance of operating from a basis of a formulation of his experiences. It also speaks to the question of flexibility – doing something off of the shelf – which is not formulation driven – but is simple and easy to research and to repeat vrs doing something very idiographic, but being too flexible and maybe losing the way. He comments on the importance of understanding the bigger picture inc. reference to recognising that there were times when things were going well – not just all downhill. This was a new story for him. How important was that new story? How radical? It doesn't deny that there were difficult times and failures even – but it offers a believable story of positive times too. One of the challenges, of course, is that the stories that someone is beginning to connect to aren't always immediately obvious as new or important. Question – did I miss an emerging cognitive shift – or under-value an emerging cognitive shift – by getting seduced into the application of the ideas to the specifics of finding employment? He came to the start of therapy motivated to change what had been a stuck position (for some time). The motivation to seek out therapy was paralleled by a commitment to find work – so he was independently pursuing that goal as well. If Snyder is correct that this sort of motivation is an act of hope – then, even though the Self-esteem scores might still be low, there should have been a small leap in Hope **before** therapy started. The early scores should represent a journey already begun. Any changes in Hope and Self-esteem that emerge in the period following the onset of therapy are, by definition, also happening in the period following the onset of work-seeking behaviours. Any gains can, therefore, not be confidently attributed to only one. One other client in the research appeared to be showing a positive benefit to connecting with these very specific targets. That perceived benefit is likely to have translated into how I experienced and responded to similar dynamics with him.

	‘You don’t usually talk about yourself so much during the day.’ At one level – this is simply a statement of truth – or at least truth in the sense of the commonality of human experience. But, more specifically, he is a very isolated and lonely individual. His life has closed down. He says he wants friends and a wife, but he struggles to develop these aspirations. He doesn’t get to talk about himself with many people. It is unusual to be asked about self-confidence, self-esteem, self-concept etc – in any non-therapy context. I wonder whether this idea of talking about self (human connection) might connect to the previous comments about being listened to / treated with respect etc – human qualities. I know that it doesn’t speak to the innovative elements of the program, but…..although not manualised in the normal sense, this is a defined approached (albeit delivered with flexibility). Some of the fears / risks were that it might be experienced as too inaccessible, or too high-brow (the language of the handbook) or too rigid. It might also have been experienced as not relevant enough. These comments seem to reflect a man who feels respected, listened to, heard – for whom the approach was accessible. He picks up on two key themes:- (i) the novelty of talking about self, (ii) seeing the whole picture. Talking about the bigger picture was good. I have commented on later work in terms of the shift from pure to applied / thinking to doing. There is another shift here as well – moving from the bigger picture to a much more narrow one – replacing the wide-angled lens with a zoom lens. Is there a possibility that I used the zoom too much? Is there a possibility that I zoomed in on the wrong area too much? He talked about newness – doing something new. What if part of the value, though, is that it is starting something new – so not just putting hope / faith in something, but putting hope / faith into something new, or putting hope / faith into something old but in a new way?

Participant's Transcribed Words	Interpretive Analysis
I think it will make a difference because I won't fall into the same trap that I set myself, which is to stop or not go right to the end of it. If that's in work then work. If it's in education then it will be in that area where maybe I'm going to start a course or something, or go to it and keep going to it instead of just saying, like you aid, talk myself out of it. The thing or the reasons why I talk myself out of it is because I say 'this course is not great anyway. There are loads of other things that I can do'. And just make excuses that way. But I'll miss out on some chances as well. Chances to learn and stuff like that.	He appears to be vindicating the strategy employed. Is that passive agreement or a statement of personal view? Earlier in the interview I indicated that I thought the successful approach (even whilst failing to achieve employment) should be regarded as positive. Has he been influenced by that? This speaks to the question of the constructed story of the interview. He volunteers a more detailed statement about how he might do differently next time. He confuses the reasons that he talks himself out of things with the reasons he tells himself that he does so. This is the epitome of map and territory – real / actual and empirical. 'I won't do that again' he says. How 'true' is that? How 'true' does he believe it to be? He clearly thinks that his attitudes / views have changed. How would we know? Only really if we review in a while and see what has been sustained. In outcomes, but also in approaches. He does appear to present insight into his own workings. Certainly that might be the basis from which to police things. How possible might he find it to do? It might be regarded within CBT as evidence of a successful outcome – he challenged his fears, did things differently, had a different / better outcome and intends to do things differently even more in the future. He even extrapolates further – to chances that he might miss in the future if he continues. I shouldn't knock it. 'I talk myself out of it because I say..' – that misses the point – what he says is the mechanism by which he talks himself out of it – it is not the reason why he does so. I wonder how much that might reflect hidden tensions for him – the confusion between what he does and why he does it – that feels almost like a form of thought-action fusion – though different from the way that term is used in CBT for OCD. Saying 'this course is not great anyway' – challenges the goal / pathway. It is a recipe for hopelessness. It does, however, imply that any failure might be because of the pathway not the person – does it have a function of ego-defence – self-protection? That raises an interesting thought – is hope risked to preserve Self-confidence? He uses the term 'trap'. What significance might that word have for him? A trap involves elements of manipulation, trickery and deliberate intent. He talks about the trap in a neutral way – un-owned. Is it a trap that he sets for himself or that is imposed upon him by others? If so – who?

Three examples of Key Themes and Significant Points

Theme	Individual Reflections
The balance of Pure and Applied elements of the Therapy	Pure elements (focussing directly on evaluations of Hope and Self-Esteem and on cognitive restricting of those perspectives) - ?more abstract? Applied elements (focussing on behavioural change / life changes that might be associated with aspects of low SE or low H and where amelioration of the situation or strategy / approach might be predicted to be connected to improved Hope or Self-Esteem. Much more pragmatic. Applied is less curious about the person and their experience of themselves and more concerned with how to make things better in the future - more specific, practical and directly relevant. Neither is right / more important than the other. They both belong. It's about balance. He found the first two sessions particularly helpful – the first introduction to difference – in terms both of content and process (being listened to etc). This represents the first shift to his attitudes. It also introduces ideas about Hope and Self-Esteem. It has a more pure focus. So – was he saying that the pure was more helpful than the applied? Or that earlier conversations have more power than later – or something else? Applied – what would need to change for him to feel able to do more? What were the consequences of doing more? The implication was that:- If he could address the things that got in the way (inc issues of confidence) he would feel able to do more. If he felt able to do more he would follow through with action. If he did more he would be like to feel better (partly due to internal judgements of doing more and partly due to increased positives from outside – inc successes) and one outcome of feeling better would be increased Hope and Self-Esteem. The balance of pure and applied with regard to fidelity to the model of the approach. Practical help – which surprised him – and which he connects with a more applied approach. Therapy helped him to challenge unhelpful / unhealthy strategies of avoidance (that sounds like a more 'applied' approach). Work was his biggest priority – but was there too much emphasis on it? At the time of the feedback interview the answer seemed to be 'yes'. At the time of the follow-up (having found employment and used it as a stepping stone to returning to academia) he was much more positive. How much of this was a response to his agenda? How much to my concern with Hope and the applied nature of hopefulness? He suggests that he valued the pure more. Research suggests that pure Self-esteem without an applied element might be less effective.

Theme	Individual Reflections
Therapist as Researcher - A co-constructed process	Therapist as researcher – connects to research interview as a booster session, issues of honesty and openness (this connects also to participants as collaborators in the research). The impossibility of neutrality. Stressing openly the need for improvement and asking for help to make those improvements by identifying flaws (participants as collaborators). Participant-collaborator – co-construction - encouraging critique, promoting power in the other, being non-critical of their performance as a customer / consumer of the therapy. Therapy-developer as researcher – issues of investment – wanting critique in order to improve, but discomfort with criticism (even more so than merely criticism of delivery of a therapy which is criticism as a technician or deliverer). Connecting with prior and privileged stories of / knowledge about the client – from the therapy process – not a new contact. In the interview and in the interpretative analysis I have access to information from the therapy that an independent researcher would not. Constructing the interview – connecting with my story of therapy rather / more than his reflections upon it?! Inviting critique as part of the research is consistent with 'normal' processes of therapy. Client prefaces his critique with 'it's not your fault'. He is expressing some criticism – which implies either that he has really taken on my expressed desire for critical reflections (so is still trying to be perfect) or that he feels able to be honest in his critique.

Theme	Individual Reflections
Recommendations re the Handbook	Psychosis as a central element in the handbook and the therapy. More on psychosis – 'you probably know more about psychosis than the person who is experiencing it.' Discussion of psychosis – the offering of a more hopeful story about psychosis – but a story that offers another view. Motivation – addressed as a specific issue on a number of occasions – conceptualised, reflected upon in the theoretical and tracked / deconstructed in the personal. Perhaps it needs its own space in the therapy and the book. As an issue central to the doing and success of the therapy it might need to come early – cover direction, strength, importance, stability, coherence, salience etc – it is the point at which H and SE come together – an explicit awareness of the factors at work – openly or not – to move forward or to resist. This assumes a two-dimensional (or even 1 dimensional) view of opposing / contradictory forces. What if we consider factors pushing in multiple directions and dimensions? Language – self-esteem and self-confidence – participant-clients appeared to connect with / prefer the latter. Book is both a description of intervention and intervention in its own right. Book – conversational style is good – very engaging. Some sentences too long. Skim read and only engaged with 20% ish – so too long generally / too heavy. Some is complex (? too complex?) and other parts explained well. Suggests must be hard to explain in print – compassion and sensitivity. Not a book for academics he says – I don't need to be balanced – offering different sides – I can be more definite. Maybe needs to be as two books. Says I switch from scientific / formal to generic and back. He now suggests 2 books. Or smaller book. To be accessible to those looking for information. Case studies – he likes these – personalise it – make it easier to connect to – I am more uncomfortable – are they true (and a breach of confidentiality) or made up. They actually represent a composite of elements from different people. The ethical dilemmas of asking a client for permission to use an amended version of their story. Lots of emphasis (use specific statements here). How much do the case studies have power because they are believed to be real / accurate? ?Addition / inclusion of the notes generated in the room? Esp. the diagrams – but how? What is missing is more of the therapist's own personal experiences and positions – being more personal. 'It's lacking that bit of quality that you have as a therapist'. Appearance – thumbs up.

List of All key Themes arising from the Analysis of the Interview with MJ7

Reflections on the Complexity of Experience *Experience of the therapy program – Content*	Reflections on the Complexity of Experience *Experience of the Therapy Program – Process of Delivery*	Reflections on the Complexity of Experience *Therapy Program – Recommendations*	Reflections on processes of construction in the research interview and analysis	Critical Reflections on the Design and Delivery of the Research
The balance of Pure and Applied elements of the Therapy	Structure and Flexibility (inc. Questions of Fidelity)	Focussing on Positives – Strengths, Competencies and Achievements	Reciprocity and Mutuality of Influence across the Interviews and Analyses	Therapist as Researcher – Cost-Benefit considerations with regard to the validity or credibility of the Research Outcomes
The balance between Cognitive and Behavioural Elements of the Therapy	Collaboration	Developing a more Productive Story of Psychosis	Motivation of the Participant	Interpretative Analysis
Generic and Specific Elements of the Therapy	Hopelessness and Low Self-esteem in the Therapy Room	Recommendations re the Handbook	Therapist as Researcher - A co-constructed process	Further Research
The Personal Connection	Timing of when to deliver it	Motivation	Structure of the Interview – the impact of the Introduction	The therapeutic significance of the feedback interview
	The 'Feedback Interview' as a booster session		Interviewer's Language and Personal Style	Biases in the Process of the Interview
			The language of the interview – first and other languages	
			Hopelessness and Self-Esteem in the Research Interview	

Appendix 4D – Assurance Strategies

- Researcher-Interview – Instructions for Independent Interviewer
- Participant Check-Back – Extract from Summary Letter
- Audit of Fidelity – Audit Tool and Instructions for Independent Auditor

Appendix 4D(i) – Researcher-Interview – Instructions for Independent Interviewer

Thank you for agreeing to act as an '**Independent Interviewer'** with regard to my research. When we spoke, you asked if I might send you some further information to help to clarify the expectations of your role and I have attached here the 'Information Sheet' that will be provided to those Service Users who are considering being involved. I thought, however, that it might be useful to explain things a little more in this letter.

As you are aware the primary research agenda has been; and is still; to develop a CBT-based Intervention to Promote (or Inspire) Hope and Self-Belief in young people diagnosed with Early Psychosis. It is, of course, important that this intervention be relevant, evidence-based, effective, efficient and robust.

Neither consideration has, I feel, been adequately explored or addressed in relation specifically to Early Psychosis in spite of the fact that, in my experience, reports of Hopelessness and lost or Compromised Self-Esteem are incredibly common amongst this client group. What is clear in the evidence from other fields is that attitudes to Hope / Hopelessness and Self-Esteem have an enormous impact on issues of motivation, engagement, commitment to therapy and consistency of adherence to treatment regimes, and that these considerations, are of primary importance in determining the long-term prognosis of those diagnosed with Early Psychosis. Feelings of Hopelessness or Low Self-Worth are, of course, also quite distressing and challenging in their own right. I believe very strongly, therefore, that directly addressing these issues should be a central consideration of all Early Psychosis Services.

Although, again, there has been little research exploration of the relationship between the two constructs, dominant theoretical models; and associated psychological interventions; would suggest that there is substantial overlap in the experience of them – attitudes to self shaping hopes or fears for the future, and attitudes to the future, in turn, influencing sense of self. It seems reasonable to question whether an intervention or approach that considers both sets of attitudes together might have the potential to generate significant and sustainable gains in, first and foremost, Hope and Self-Belief, but also, perhaps, symptoms, quality of life and, possibly, therefore, prognosis.

Some of these questions are, of course, aspirational and very much for the future.

As you know, over the course of this last year I have been working to put together an intervention based on, what I believe to be, the best available evidence of 'what might work' in relation to Inspiring both Hope and Self-Belief. Almost every element that has been included in this new intervention has been tested and validated in other settings. Where theoretical ideas have been translated into novel practical approaches, that has, first of all, been carried out consistently with established CBT practice, and, secondly, the emergent ideas have been explored in routine clinical practice with current clients.

The ‘Intervention’ has been written formally as a reference text (or ‘Manual’) for involved service users. Although not presented as a step-by-step recipe, it is, I hope, also, sufficiently detailed as to act as a guide for the therapist.

The provisional ‘Manual’ has been taken through a series of consultations with professional colleagues (locally, regionally and nationally), service users and carers, consequent to which it has been substantially refined – although most feedback and changes related to the presentation rather than the content of the intervention.

The research focus of next year is concerned with the progression of this Intervention through clinical trials. The primary purpose remains – to develop the Intervention and its description in the form of the Manual. To this end I will be examining both the possible efficacy of the approach and the experiences of the Service-User Research Participants who engage with it.

As I am sure you can work out from that description, the collection and analysis of ‘data’ will follow two separate, but intersecting processes:-

1. Evaluating reported changes in participants’ experiences of Hope, Self-Esteem, Quality of Life and Symptomology over the course of the Intervention and beyond.
2. Assessing participants’ subjective experiences of the Intervention and the Manual, and their observations or recommendations about how they might be improved.

The second of these elements will be progressed through the conducting of semi-structured ‘Feedback Interviews’ with each participant after their completion of the treatment.

The research is founded upon an understanding that, whilst objects might really exist and events might really happen, our awareness of such things is based on a consensual, rather than absolute, form of knowledge. We construct our explanations, in particular, through social discourse. I know that, from your own research background, you will have an appreciation of this perspective.

Extrapolating from that, it is not unreasonable to regard any conversation with the Research Participants (including the ‘Feedback Interviews’) as co-constructed.

The role of the ‘Independent Interviewer’ is to interview me (the Therapist) with regard to the ideas that I might be taking into these ‘feedback Interviews'. These ‘Researcher Interviews would be video-recorded, transcribed and thematically analysed. The purpose would be to help to shine light upon those aspects of the ‘Feedback Interviews’ that were significantly distinct from my pre-expectations and which might, therefore, be tentatively attributed to the participant in each case.

The plan is that I will recruit and work with a total of 8 participants, across two cohorts. Although I believe that interviewing me before each of the ‘Feedback Interviews’ might be methodologically valid (possibly even the ‘gold-standard’ of research design) I don’t think that it would be realistically feasible within the time frame – given, in particular, the complex and time-consuming nature of the analysis required for each interview.

I would, therefore, like to suggest that you interview me just twice – before the set of 'Feedback Interviews' with Cohort 1 (approximately July 2013), and then again for the interviews with Cohort 2 (possibly January 2014).

The interviews need to be comparatively brief (45 minutes only perhaps) in order to help me to be focussed and clear in my reflections.

As already noted, the content of the 'Feedback Interviews' will be focussed on (i) participants' attitudes to Hope and self-Esteem (historically and currently), (ii) their experiences of the Intervention and, in particular the Manual (a copy of which will be given to each participant as part of the Intervention - to use as a reference text) and (iii) their observations or suggestions as to how each (Intervention and Manual) might be improved. At the beginning of their interview, each participant will be provided with a summary of the completed analysis of the changes reported in their Hope, Self-Esteem, etc as reflected in the completion of the relevant measures throughout the delivery of the Intervention. It is expected that discussing this will form a starting point for most of the 'Feedback Interviews'.

I have deliberately not included here a series of recommendations as to the sorts of questions that you might ask me in the 'Researcher Interviews'. It is important for you to be free to ask novel questions to help me to think from outside of my current attitudes and expectations. I do think, however, that it would be useful for there to be some degree of overlap with the questions that I will be asking participants.

I will, of course, need your written consent to that part of the above that relates to your interviewing me. Although the focus would be on my reflections, by definition you would be included in the recording. I enclose a relevant Consent Form.

I hope that this all makes sense. Please feel free to come back to me if you have any questions. I do appreciate that you help in this, but please do bear in mind that you can, of course, change your mind about helping. It won't, in any way, affect any other work that we do together.

Appendix 4D(ii) – Participant Check-Back – Extract from Summary Letter

Dear

When we met a couple of months ago to talk about how you had found the course of therapy, I promised to get back to you with a summary of what came out of that discussion.

We talked for quite a long time about how much difference you felt that the therapy had made to your life. I know that you have valued the process. I remember when we first met and you were worried that you wouldn't have enough to say to fill the hour. I can't think of a meeting, though, that didn't stretch a bit beyond the time that we had agreed.

One of the things that touched on a great deal in the feedback meeting was the sense of feeling connected with as a person. You talked about seeing me as going the 'extra mile', but you brought this up in relation to 'being listened to', 'being taken seriously' and 'being treated as if you had something meaningful to say'. The theme of 'the personal', also came up when you were talking about the handbook and how it could be improved. You said that you 'connected with' the colour and style, and found yourself really inspired by the personal stories of service users that I had used to illustrate particular points. When I was thinking about it afterwards, I found myself remembering the descriptions that you gave about how the university had responded when you first started to struggle – allocating someone to provide pastoral support who you experienced as completely indifferent to you as a person.

It also made me think about our conversations about how isolated you had felt before, stuck at home, with few friends. I wondered how much your connecting with 'the personal' in relation to my style of doing therapy was, also linked to the changes that you have made to your wider social network, as well as the greater feeling of belonging at home.

Appendix 4D(iii) – Audit of Fidelity – Audit Tool and Instructions to Independent Auditor

Fidelity Audit Tool

This tool has been designed to evaluate whether the clinical practices that are observable in the video-recordings of the therapy conversations show reasonable fidelity to the strategies and recommendations for practice that are described in the Treatment Manual.

It is a central assertion of the Manual (and of the approach) that the treatment should be tailored to the unique needs of each individual Service-User-Participant. It is intended, therefore, that that tailored approach should be open to some degree of flexibility with regard to the ordering of particular elements, the specific strategies that are given priority, the worksheets that are utilised, the images and examples that are used to illustrate a point or explain a rationale and, more generally, the language that is employed.

As such it is not expected that the observed practice should 'match' exactly to the words, examples or interventions as they are described in the manual. Rather, there should be a close fit to the 'spirit of the approach', and only an approximate fit to the 'letter of the Manual'.

In addition, this treatment programme is based upon a Cognitive-Behavioural Therapy paradigm. It is expected that the observed process should also show reasonable fidelity to the practice of CBT.

The audit tool consists of two sections. The first relates to the general process of CBT; the second to the specific content of the treatment programme / Manual.

Please remember when using this tool that the purpose is to look for evidence of fidelity not to evaluate the quality of the work undertaken.

Part 1 – Fidelity to the broad processes of CBT

In relation to this Audit Tool CBT is considered with regard to the following 5 characteristics:- That it should be ***Structured, Progressive*** and ***Collaborative***; that ***Conceptual Integration*** and ***Processes or Change*** should be transparent, and that strategies for change should target both ***Cognitive*** and ***Behavioural processes***.

Each of these 5 broad elements should be clearly evident in the observed session. Please put a **X** in the box to indicate if the specific element described is evident. Note:- Not all components of each process need to be present for that aspect of CBT to be deemed to be manifest.

1. ***Structured***. Is there evidence that the observed therapy session was planned, targeted and managed?

- Negotiation of an Agenda at the commencement of the meeting. ☐
- Adherence to that Agenda. ☐
- Structural narrative - discussion of the process of the conversation. ☐

2. ***Progressive***. Is there evidence that the therapy session followed in a logical progression from previous conversations and that there was some degree of open acknowledgement as to how the therapy might progress in subsequent meetings?

- Discussion of Homework from previous meetings. ☐
- Reflections on previous discussions. ☐
- Connections made to previously identified patterns and understandings. ☐
- Discussion of future direction and strategies. ☐
- Negotiation of further Homework to be completed. ☐

3. ***Collaborative***. Is there evidence of collaborative interaction between the Therapist and Service-User-Participant?

- Concurrent negotiation of consent to video-record the session. ☐
- Clear two-way dialogue between Therapist and Service-User-Participant. ☐
- Opportunities for the Service-User-Participant to reflect on the process of the therapy. ☐
- Invitations to the Service-User-Participant to ask questions about the content or process of the therapy. ☐
- Clear rationales offered for strategies that are progressed. ☐
- Willingness on the part of the Therapist to negotiate regarding understandings and approaches to therapy. ☐
- Service-User-Participant offered choices. ☐
- Responsiveness of the Therapist to the language and imagery of the Service-User-Participant. ☐

4. ***Conceptual Integration.*** Is there evidence of active transparency in discussions about the development or maintenance of the problems experienced by the Service-User-Participant?

- Discussion of the relationships between, in particular, thoughts, feelings and actions. ☐
- Reflections on how the Service-User-Participant's problems have become stuck. ☐
- Reflections on the history, or development, of the specific elements of difficulty under consideration. ☐

5. ***Processes of Change***. Is there evidence that the processes of change are openly discussed and that they include attention to both Cognitive and Behavioural Processes?

- Discussion of how the processes of therapy, including the specific strategies employed, relate to the agreed problem-formulation. ☐
- Use of Psycho-educational approaches to cognitive change. ☐
- Use of Socratic (Guided Discovery) approaches to cognitive change. ☐
- Use of surveys, experiments and diaries to encourage new understandings. ☐
- Cognitive Deconstruction or Restructuring. ☐
- Negotiation of tasks and experiments to encourage new behaviours (strategies). ☐
- Use of Exposure programmes. ☐

Part 2 - Fidelity to the specific content of the Treatment Programme (and to the Manual)

Fidelity to the Treatment Programme ('does the observed practice fit with the strategies described in the Manual') can be determined by answering the following 2 questions:-

- ***Is it possible, simply through observation, to identify the stage of therapy and the specific recommended strategy that is being progressed?***
- ***Is there a reasonable fit between the observed delivery of that strategy and the description offered in the Manual?***

A. Is it possible, simply through observation, to identify the stage of therapy and the specific recommended strategy that is being progressed?

The table below lists each strategy, for each element of each of the 3 Stages of the Treatment Programme. Any given therapy session that is part of this time-limited Programme should develop at least one of the strategies described in the manual (or something comparable). Some sessions might pick-up on and progress a strategy that has been developed in a previous conversation, as well as introducing something new.

Please indicate on the table which strategy (or strategies) are explored in the observed practice.

Stage	Element	Strategy	X
Beginnings			
	Assessment	Time-line (Developmental Processes)	
		Maintenance Processes	
		Relational Processes	
		Differential effects of a crisis	
		Fragility of Hope and Self-Esteem on a moment-by-moment basis	
	Formulation		
	Goal Development	Negotiating SMART Goals	
		Challenging difficulties identifying long-term, meaningful goals	
		Challenging difficulties with identifying initial, short-term goals.	
Treatment			
	Rebalancing Positive and Negative Self-Judgements	Identifying significant and specific positive and negative self-judgments	

		Critically Analysing Negative Self-Judgments	
		Examining Standards	
		Examining Evidence	
		• Analysing current events	
		• Using Experiments or Surveys to make predictions	
		• Exploring the past	
		Dealing with legitimate negative self-judgments	
		Nurturing Positive Self-Judgments	
		Positive Data Logging	
		Promoting positive self-statements	
	Changing Behaviours	Increasing recognition of the importance of changing behaviour	
		Identifying and Countermanding unhelpful strategies	
		Avoidance	
		Performance	
		Recognising and Promoting exceptions	
		Problem-Solving Training	
	Improving Relationships	Encouraging more positive ‘Reflected Appraisals’	
		Encouraging more effective support	

Endings			
	Handing over the reigns		
	Planning for the future		
	'Saying goodbye'		

B. Is there a reasonable fit between the observed delivery of the strategy pursued and the description offered in the Manual?

If you have been able to identify a specific strategy that has been progressed in the observed session (or more than one) – please identify below up to 4 key elements of that strategy as they appear on the recording.

1. ……
……
2. ……
……
3. ……
……
4. ……
……

Instructions to Independent Auditor

Thank you for agreeing to act as an ‘Independent Assessor’ with regard to my research. In your email you asked if I might send you some further information to help to clarify the expectations of your role and I have attached here the ‘Information Sheet’ that will be provided to those Service Users who are considering being involved. I thought, however, that it might be useful to explain things a little more in this letter.

As you are aware the primary research agenda has been; and is still; to develop a CBT-based Intervention to Promote (or Inspire) Hope and Self-Belief in young people diagnosed with Early Psychosis. It is, of course, important that this intervention be relevant, evidence-based, effective, efficient and robust.

Neither Hope or Self-Belief has, I feel, been adequately explored or addressed in relation specifically to Early Psychosis in spite of the fact that, in my experience, reports of Hopelessness and lost or Compromised Self-Esteem are incredibly common amongst this client group. What is clear in the evidence from other fields is that, attitudes to Hope / Hopelessness and Self-Esteem have an enormous impact on issues of motivation, engagement, commitment to therapy and consistency of adherence to treatment regimes, and that these considerations, are of primary importance in determining the long-term prognosis of those diagnosed with Early Psychosis. Feelings of Hopelessness or Low Self-Worth are, of course, also quite distressing and challenging in their own right. I believe very strongly, therefore, that directly addressing these issues should be a central consideration of all Early Psychosis Services.

Although, again, there has been little research exploration of the relationship between the two constructs, dominant theoretical models; and associated psychological interventions; would suggest that there is substantial overlap in the experience of them – attitudes to self shaping hopes or fears for the future, and attitudes to the future, in turn, influencing sense of self. It seems reasonable to question whether an intervention or approach that considers both sets of attitudes together might have the potential to generate significant and sustainable gains in, first and foremost, Hope and Self-Belief, but also, perhaps, symptoms, quality of life and, possibly, therefore, prognosis.

Some of these questions are, of course, aspirational and very much for the future.

As you know, over the course of this last year I have been working to put together an intervention based on, what I believe to be, the best available evidence of ‘what might work’ in relation to Inspiring both Hope and Self-Belief. Almost every element that has been included in this new intervention has been tested and validated in other settings. Where theoretical ideas have been translated into novel practical approaches, that has, first of all, been carried out consistently with established CBT practice, and, secondly, the emergent ideas have been explored in routine clinical practice with current clients.

The ‘Intervention’ has been written formally as a reference text (or ‘Manual’) for involved service users. Although not presented as a step-by-step recipe, it is, I hope, also, sufficiently detailed as to act as a guide for the therapist.

The provisional ‘Manual’ has been taken through a series of consultations with professional colleagues (locally, regionally and nationally), service users and carers, subsequent to which it has been substantially refined – although most feedback and changes related to the presentation rather than the content of the intervention.

The research focus of next year is concerned with the progression of this Intervention through clinical trials. The primary purpose remains – to develop the Intervention and its description in the form of the Manual. To this end I will be examining both the possible efficacy of the approach and the experiences of the Service-User research participants who engage with it.

A key consideration in relation to that method will be whether there is sufficient fidelity between the observed delivery of the intervention and its written description in the Manual. In other words ‘as the therapist involved, do I do in the treatment sessions what I recommend, or say that I am going to do, in the Manual?’

To that end I intend to video-record all therapy sessions (consent to the recording will be an explicit inclusion criterion for involvement in the research) and to then to have a random selection evaluated with regard to fidelity. That is where you would come in. I have attached a fairly simple Audit Tool. After familiarising yourself with the Manual, I would like you to use the Audit Tool to review a small, random selection of tapes from across all those service users that have taken part.

In order for you to be clear about time commitments, I should say that:- the treatment programme for each person will be for 16 sessions and I hope to trial the approach with a total of 8 Service User research participants, in 2 cohorts of 4. In total there would be, therefore, somewhere up to 128 recorded sessions. I would be grateful if you would review between 12 and 13 of those sessions (10%).

I should stress that the Audit Tool is not designed to evaluate the quality of the clinical work, but merely to reflect on whether the sessions appear to be generally consistent with the content of the intervention as described in the Manual. Again – the Manual stresses that interventions should be delivered with flexibility; tailored to the unique needs of each client; so the audit would be concerned with approximate comparison, based on just a few key tracking points

I would like, also, at the end of the period of treatment and the completion of your evaluations, to interview you about your experience of this. I would like to video-record and analyse that conversation. Questions will concern, in particular, the ease or difficulty with which the Manual has lent itself to this evaluation process. I would, also, though, be interested in any observations that you had about the Intervention, the Manual or the Research consequent to your scrutiny of the video-recordings.

I will, of course, need your written consent to that part of the above which relates to your being interviewed, together with the recording and analysis of that conversation. I enclose a relevant Consent Form.

I do hope that this all makes sense. Please feel free to come back to me if you have any questions. I do appreciate that you would be giving a great deal in taking this on. You can, of course, change your mind about helping. It won't, in any way, affect any other work that we do together.

Appendix 5 – Findings

(Relating to Chapter 7)

Appendix 5A – Brief Synopses of Non-completer Participants

Appendix 5B – Demographic Data

Appendix 5C – Outcome Data – Relating to SADHS, RSCQ and CORE-OM

Appendix 5D – Participant Observations from the Interviews – Related to Themes explored in the Findings

Appendix 5E – Audit of Fidelity – Results

Appendix 5F – Recommendations For Core Structure to the New Therapy Programme

Appendix 5A – Brief Synopses of Non-completer Participants

(Completers have been discussed in detail in the main text)

MS1

MS1 was a 34 year-old male of African origin. He had entered the UK as an illegal immigrant and, at the time of the therapy, was processing an appeal against the decision of the home-office to deport him. Prior to coming to the UK, he had received a very good basic education from a missionary school and, as a young man, had been successful in business. He left Africa after the targeted killings of all of his immediate, and most of his extended, family. He had lived in the UK for greater than 10 years prior to coming to the attention of immigration services, during which time he had been married and employed. His 'wife' had been deported 2 years previously. His psychotic symptomology included extreme persecutory paranoia; deemed to be excessive even in the context of his traumatic history; and auditory hallucinations; voices which criticised and abused him and which predicted external threats.

His attendance was tidal, with periods of punctuality and commitment, interspersed with DNA's and lack of communication. There was a clear; and acknowledged; pattern that his attendance was more consistent when the asylum-seeking appeal process appeared to be neutral or positive in progress, and was more erratic when the appeal encountered difficulties. At one point, for instance, the home-office rescinded his right to legal aid.

Therapy came to an end when, he later explained, he became convinced; based on evidence rather than mere paranoia; of an imminent deportation order, and temporarily disappeared. By the time of his re-surfacing, several months later, he had been discharged from the host EIP Service.

AC4

AC4 was a 28 year-old, white-British female. She lived with a long-time partner and her pre-pubescent son from a previous relationship. She had experienced domestic violence in her relationship with her son's father, which continued, intermittently, to be a problem. Pre-morbidly (prior to her psychotic illness) she had struggled with low self-confidence, poor self-worth and social anxiety. She, also, had significant and chronic physical health problems. Her mother lived locally and was behaviourally, emotionally and materially supportive, but her support was described by AC4 as often feeling disempowering. Her psychotic phenomenology primarily took the form of 'punishment (bad-me) paranoia' (Chadwick, Birchwood and Trower, 1996) and might be regarded as an extreme exacerbation of her pre-morbid negativity towards self. In remission, she experienced high levels of anxiety and low mood, expressed feelings of hopelessness and was perceived by the care team as generally unmotivated or ambivalent.

Her attendance for the therapy was initially very consistent (sessions 1-5), but became more erratic with numerous cancelled appointments and then gaps where she would not reply to communications. When engaged and attending, she was highly motivated, punctilious with completing homework assignments and enthusiastic with regard to the participant handbook. She invariably brought her copy with her and it was filled with extensive notes and questions. She attributed most of her cancellations to physical health crises, though did acknowledge that the strategies designed to garner support from others had actually resulted in a sense of resistance and increased tensions. Shortly after disclosing this concern; defined by her as feeling that she had to choose between them and the therapy; she DNA'd an appointment (the only time that she had done so) and failed to respond to any subsequent contacts from the researcher-therapist. A few months afterwards, she also brought her contact with the host EIP Service to an end.

GH5

GH5 was a 25 year-old, white-British single male, living with his parents and sibling. He was in full-time employment, having left education at 18 after the successful completion of his 'A' levels. Until immediately prior to his psychotic crisis he had, he thought, been seen by others as very successful in work, sport and relationships. His 'crisis' was manifest primarily in elements of thought disorder and confusion, with clear, though brief, delusions of grandiosity and persecution-paranoia (Chadwick, Birchwood and Trower, 1996). He reported an emotional numbness or detachment, and showed a significant change in attitudes and behaviours towards others; in particular a blunt and hurtful insistence on 'complete honesty' and an absolute prioritisation of his own needs over those of others.

Consequent to his reluctance to compromise his employment by taking time off, and to talk at home when others were around, most meetings took place in a local health centre. Scheduling of appointments, therefore, was complicated by the need to coordinate diaries with respect to small windows of availability – his, the venue and the therapist. Although the full 16 sessions of the therapy were completed, there were periods of broken contact, outcome measures not returned, the scheduled feedback interview was DNA'd, and all further contacts left unanswered.

MM6

MM6 was a 19 year old, white-British single male, living on his own. He was unemployed, having left education at 16 with no qualifications. His parents separated when he was young and his mother moved to a different part of the country. His subsequent childhood and adolescence were chaotic, with moves backwards and forwards between his parents, several times consequent to expulsion from school. Throughout that period, he used alcohol and illicit substances regularly and had contact with the criminal justice system on several occasions. His first contact with mental health services followed an arrest for disorderly behaviour and he was admitted to a psychiatric in-patient unit on a compulsory basis, under a section of the mental health act. On admission he presented with both extensive persecutory delusions, and derogatory and abusive voice-hearing experiences (auditory hallucinations). Prior to admission he had been effectively homeless. New accommodation was arranged for him as part of his discharge-planning.

At the point of recruitment for the research and therapy he presented as very motivated to improve his circumstances – to address feelings of worthlessness; of being unloved and unwanted; and to proactively take advantage of his new opportunities; accommodation, stable income (through benefits) and the support of the host EIP Service. Unfortunately, ongoing familial tensions, alcohol and drug use, and increasing social isolation resulted in a fairly rapid deterioration of health. He was readmitted to hospital, once again on a compulsory basis, and, when discharged, was subject to a community treatment order (CTO). That latter situation was defined in the research design as an absolute exclusion criterion for the research. His involvement in the research was, therefore, closed. He was offered the chance to continue with the therapy within the auspices of 'treatment-as-usual', but declined – along with any other facet of support that was not required within the conditions of his CTO.

Appendix 5B – Demographic Data

Demographic details of all of those who expressed an interest in involvement in the research.

Number / Code	Gender	Age	Ethnicity	Employment	Education	Social Living	Children	Exit Point 1 A	Exit Point 2 B	Exit Point 3 C	Exit Point 4 D	Accepted E
1 (MS1)	Male	34	African	Asylum seeker	16	Single	None					Yes
2	Male	23	White British	No	18	Single	None	Yes				
3	Female	22	White British	Yes	18+	Family Of Origin	None		Yes			
4	Male	19	British Asian	No	18	Family of Origin	None	Yes				
5 (FJ2)	Female	35	South American	Yes	18+	Partner	None					Yes
6	Male	27	White British	Yes	16	Family of Origin	None	Yes				
7 (AC3)	Female	28	White British	No	16	Partner Child	Yes					Yes
8	Male	19	British Asian	Student	18+	Single	None	Yes				
9	Male	24	White British	No	18	Family Of Origin	None			Yes		
10	Female	33	British Asian	No	16	Partner Children	Yes		Yes			
11	Male	23	British Mixed Race	Yes	18+	Family of Origin	None				Yes	
12	Male	20	White British	Student	18+	Single	None	Yes				
13	Male	29	Black British	Yes	18	Partner Children	Yes	Yes				
14 (UJ4)	Male	21	White British	Student	16+	Family of Origin	No					Yes
15 (GH5)	Male	25	White British	Yes	18	Family Of Origin	None					Yes
16 (MM6)	Male	19	White British	No	16	Single	None					Yes
17	Female	20	White British	Student	18+	Family Of Origin	None	Yes				
18	Female	26	British Asian	No	18	Single	None			Yes		
19	Male	25	British Asian	Yes	18	Family Of Origin	None		Yes			
20	Male	22	White British	Student	18+	Single	None		Yes			
21	Female	32	White British	No	16	Single Child	Yes	Yes				
22 (CP7)	Male	30	British Asian	No	18+	Family Of Origin	None					Yes
23	Female	18	Black British	No	18	Family Of Origin	None				Yes	
24	Male	28	British Asian	Yes	18+	Single	Yes		Yes			
25	Male	36	British Asian	No	16	Single	No		Yes			
26 (LJ8)	Female	29	White British	Yes	18+	Partner	None					Yes

Comparison of Service-Users who expressed an interest in the research, based on the point at which they left the recruitment process (or took part) – with respect to age, gender, ethnicity, employment status, education, living circumstances and whether they had children.

	No	Mean Age Age Range	Gender	Ethnicity	Employment	Education	Social Living	Children
Service Users Approached (A+B+C+D+E)	26	25.65 18-36	Male - 65.4% Female – 34.6%	WB – 50.0% BA – 30.8% BB – 11.5% Other - 7.7%	Yes – 34.6% No – 42.3% Student – 19.2% Other – 3.8%	16 – 26.9% 18 – 30.8% >18 – 42.3%	FO – 42.3% SM – 3.8% S – 34.6% FM – 19.2%	Yes – 15.4% No – 84.6%
Service Users Expressing Interest after reading Initial Introductory Letter (B+C+D+E)	18	26.55 18-36	Male – 61.1% Female – 38.9%	WB – 44.4% BA – 33.3% BB – 11.1% Other - 11.1%	Yes – 38.9% No – 44.4% Student – 11.1% Other – 5.6%	16 – 27.8% 18 – 27.8% >18 – 44.4%	FO – 44.4% SM – 0% S – 33.3% FM – 22.2%	Yes – 11.1% No – 88.9%
Service Users Expressing Interest after Reading Patient Information Sheet (C+D+E)	12	26.00 18-34	Male – 58.3% Female – 41.7%	WB – 50.0% BA – 16.7% BB – 16.7% Other – 16.7%	Yes – 33.3% No – 50.0% Student – 8.3% Other - 8.3%	16 – 25.0% 18 – 33.3% >18 – 41.7%	FO – 50.0% SM – 0% S – 25.0% FM – 25.0%	Yes – 8.3% No – 91.7%
Service Users Who Met the Inclusion Criteria (D+E)	10	26.2 18-34	Male – 60.0% Female – 40.0%	WB – 50.0% BA – 10.0% BB – 20.0% Other – 20.0%	Yes – 40.0% No – 40.0% Student – 10.0% Other – 10.0%	16 – 30.0% 18 – 20.0% >18 – 50.0%	FO – 50.0% SM – 0% S – 20.0% FM – 30.0%	Yes – 10.0% No – 90.0%
Service Users who Signed Up to Take Part in the Research (E)	8	27.625 19-34	Male – 62.5% Female – 37.5%	WB – 62.5% BA – 12.5% BB – 0% Other – 25.0%	Yes – 37.5% No – 37.5% Student – 12.5% Other – 12.5%	16 – 37.5% 18 – 12.5% >18 – 50.0%	FO – 37.5% SM – 0% S – 25.0% FM – 37.5%	Yes – 12.5% No – 87.5%
Service Users approached who chose not to take part in the end (A+B+D)	16	24.75 18-36	Male – 68.75% Female – 31.25%	WB – 43.75% BA – 37.5% BB – 18.75% Other - 0%	Yes – 37.5% No – 37.5% Student – 25.0% Other – 6.25%	16 – 25% 18 – 31.25% >18 – 43.75%	FO – 43.75% SM – 6.25% S – 37.5% FM – 12.5%	Yes – 18.75% No – 81.25%

Comparison of Service-User Participants who did and did not complete the Therapy Program.

	No	Mean Age Age Range	Gender	Ethnicity	Employment	Education	Social Living	Children
Service Users who Signed Up to Take Part in the Research (E)	8	27.625 19-34	Male – 62.5% Female – 37.5%	WB – 62.5% BA – 12.5% BB – 0% Other – 25.0%	Yes – 37.5% No – 37.5% Student – 12.5% Other – 12.5%	16 – 37.5% 18 – 12.5% >18 – 50.0%	FO – 37.5% SM – 0% S – 25.0% FM – 37.5%	Yes – 12.5% No – 87.5%
Service User-Participants who completed the Therapy	5	28.0 21-35	Male – 60% Female – 40%	WB – 60.0% BA – 20.0% BB – 0% Other – 20.0%	Yes – 60.0% No – 20.0% Student – 20.0% Other – 0%	16 – 0% 18 – 20.0% >18 – 80.0%	FO – 60.0% SM – 0% S – 0% FM – 40.0%	Yes – 0% No – 100.0%
Service User-Participants who dropped out	3	27.0 19-34	Male - 66.7% Female – 33.3%	WB – 66.7% BA – 0% BB – 0% Other – 33.3%	Yes – 0% No – 66.7% Student – 0% Other – 33.3%	16 – 100.0% 18 – 0% >18 – 0%	FO – 0% SM – 0% S – 66.7% FM – 33.3%	Yes – 33.3% No – 66.7%

Appendix 5C – Outcome Data – Relating to SADHS, RSCQ and CORE-OM

Research-Completers - SADHS data

	1 (Pre-therapy)	**2 Week 4**	**3 Week 8**	**4 Week 12**	**5 Post Therapy**	**6 Follow-up**
FH2	29	41	45	51	52	48
UH3	30	36	39	38	31	44
MJ7	14	17	21	21	21	23.5
LJ8	25	47	46	44	🟦	55

Research-Completers – RSCQ data

	1 (Pre-therapy)	**2 Week 4**	**3 Week 8**	**4 Week 12**	**5 Post Therapy**	**6 Follow-up**
FH2	104	107	118	136	138	133
UH3	95	106	114	121	98	133
MJ7	32	53	84	78	78	89
LJ8	78	141	139	143	🟦	172

Research-Completeters – CORE-OM data

	1 (Pre-therapy)	2 Week 4	3 Week 8	4 Week 12	5 Post Therapy	6 Follow-up
FH2	1.8	1.5	1.4	1.15	0.87	0.38
UH3	1.4	1.4	1.2	0.71	1.71	1.29
MJ7	2.38	2	1.76	2.44	1.76	1.26
LJ8	2.09	1.09	1.24	0.91	🟦	0.32

Appendix 5D – Participant Observations from the Interviews – Related to Themes explored in the Findings

Key Theme of 'Pure' and 'Applied' Elements of the Therapy Programme – Significant Points and Participants' Spoken Words

Significant Points	Participants words
The relative values of pure and applied	*'Writing the positives down. That was helpful. The scales, the negatives and trying to rebalance stuff'* ***(LJ8).*** *'Having your input was quite good and I was pleased that you did give me the time and you put some input into the practical side of it as well. The practical side of writing the letter, what I would say, who to write it to. That sort of thing, I wouldn't have had anywhere else to get it from.'* ***(MJ7).*** *'I won't fall into the same trap that I set myself, which is to stop or not go right to the end of it. If that's in work then work. If it's in education then it will be in that area where maybe I'm going to start a course or something, or go to it and keep going to it instead of just saying … talk myself out of it.'* ***(MJ7****).*
Chronology / timing	*'Helping the person not just with therapy, but practical help as well'* ***(MJ7).*** *'Cos the thing that stuck in my mind was the positives every day and I got into a routine of doing it. Doing that at the beginning would have made it last longer'* ***(LJ8).*** *'Cos the thing that stuck in my mind was the positives everyday and I got into a routine of doing it. If I think you had started with the whole self and drilled that in at the beginning I think it would have made it last longer. Doing that at the beginning would have made it last longer.'* ***(LJ8).***
Balance	*'I think when I was talking about the thoughts and feelings and things, it felt more like just having a conversation.'* ***(UH3).*** *'It does make sense to me that if we'd added the strengths and values in there from closer to the start, maybe not straight away, but that it would have been something to add to each week and go back to briefly, maybe to kind of build-up'* ***(UH3).*** *'I know we had the link with finding work and doing the academia letters stuff like that, but in terms of me, my personal image of myself, maybe we could've delved a bit more into how I get through the day'* ***(MJ7).***

Key Theme of Developing Hopeful Illness Narratives – Significant Points and Participants' Spoken Words

Significant Points	Participants words
Knowing nothing and the importance of understanding	*'When you don't know nothing about this. When you have, because you are - you suffer from this pathology, but you don't know nothing, because you don't have the knowledge – you don't have any previous training in this kind of problem – so you need to understand what has happened in some way.'* ***(FH2).*** *'I feel that if I had known about this before, about what psychosis was, if I had known about it, I think I would have been able to have stopped it from happening.'* ***(LJ8).*** *'And I think you tried to put it into the whole bigger picture, so you try to understand how at university I started feeling lower. And you pinpointed exactly when things started to go wrong and I think that helped in trying to understand it. I had thought I was just going downhill from the start, but there were specific times at university when I was doing OK and others when things were getting too much.'* ***(MJ7).***
Hopeful and empowered stories	*'I always remember the graph that you do – the stress and vulnerability thingy. That's totally stuck in my head. I even showed my friend the other day. I said – "everybody's on this. It's not just me.'* ***(LJ8).*** *'But I wouldn't have put too much significance on focussing on the psychotic episodes and everything because it is an illness and maybe it's like kind of … well yeah I could say it's kind of beyond my control.'* ***(UH3).*** *'You give some very good examples that people can continue living with that problem in the future, and maybe you give an example of a person that was a very successful person in his life in spite of the illness. And I guess it's important to understand that it's not the end of the life and you can manage if you do the work.'* ***(FH2).***
Timing	*'So there were some useful conversations in the beginning that were to do with actually putting things in perspective, getting a different, less overwhelming sense of things.'* ***(MJ7).***

Key Theme of Structure and Flexibility in the Process of Delivering the Therapy Programme – Significant Points and Participants’ Spoken Words

Significant Points	Participants words
Structure, flexibility, collaboration in the delivery of the programme	*‘I think there’s probably quite some merit to the patient not really dictating the course of what to go through in each stage – like, maybe, some structure to the sessions is desirable really, but that flexibility is useful to be able to talk about what’s going on at each time.’* **(UH3).** *‘When you gave me an exercise I looked at it…If you said to me to do it, I would do it. That is probably true. I’m more motivated if someone asks me to do it. But if I do it off my back I’m a bit like – oh I can’t really.’* **(LJ8).** *‘What could you have done better? Could have … like …. an order thing of what we are going to talk about each week, maybe. I think I might have quite liked that.’ (LJ8).* *‘But that’s me you see. If it was on there then, maybe, maybe, I might have looked in the book before you were talking about it. Yeah. I probably would have done. If I’ve got something where someone’s got a plan… If I know I can get there before they’ve sort of….so you know I’m on board with it.’* **(LJ8).** *‘I think I always knew there was …. Cos every session you took time to really … maybe, say this is what we’re going to talk about and this is why we’re going to talk about it.’ (***UH3).** *‘I guess you have more control during our meetings …. But I guess that you know very well what .. because I was completely lost … But I feel That I was active during the process. It was … my process.* **(FH2).** *‘I didn’t have any previous experiences of therapy of any kind. Like I just went with it as it was going along.’* **(UH3).**
Structure, flexibility, fidelity, credibility and generalisability	

Key Theme of the hopelessness and low self-esteem in the dynamic of the therapy - Significant Points and Participants' Spoken Words

Significant Points	Participants words
Hope and self-esteem in the therapy room	*'But I didn't know where this was leading. I used to sometimes think we're going over the same thig probably this week, but I don't know where this is going. 'How am I going to get better?' sort of thing.'* ***(LJ8).*** *'Sometimes it was like a game and I couldn't understand why there was the reason for these different activities.'* ***(FH2).*** *'To be honest I find it very difficult to read in general at the beginning. So even more I start to read, but not too much time ago. Not all of the chapters.'* ***(FH2).*** *'I can't see any reason why something like that would make me feel worse if I went away and didn't manage to do it.'* ***(UH3).*** *'There's always going to be more benefit taking a bit of a risk than not suggesting things in the first place.' (UH3).* *'I think I do remember about one of the weeks where I started keeping track of maybe positive things that day, but that did taper off and I didn't continue it after the space of about a week or so.'* ***(UH3).*** *'There is something that holds you back. You're feeling self-conscious and you won't say something, but because I thought it was therapy I thought it was best just to come out and say what I was really thinking. Then I wasn't too worried about it. Because I just assumed, you'd be professional and I didn't really think about what you were going to think or what you were going to say. I think I just assumed that you would have something good to explain things.'* ***(MJ7).*** *'If I can remember what you were saying … like .. "You've done well so far. Go to it and see what happens .. instead of already making the outcome in your mind.'* ***(MJ7).***
The risk of trying to win	
Therapist as a Role Model / Comparator	

Key Theme of experience of the Place and Value of the Participant Handbook - Significant Points and Participants' Spoken Words

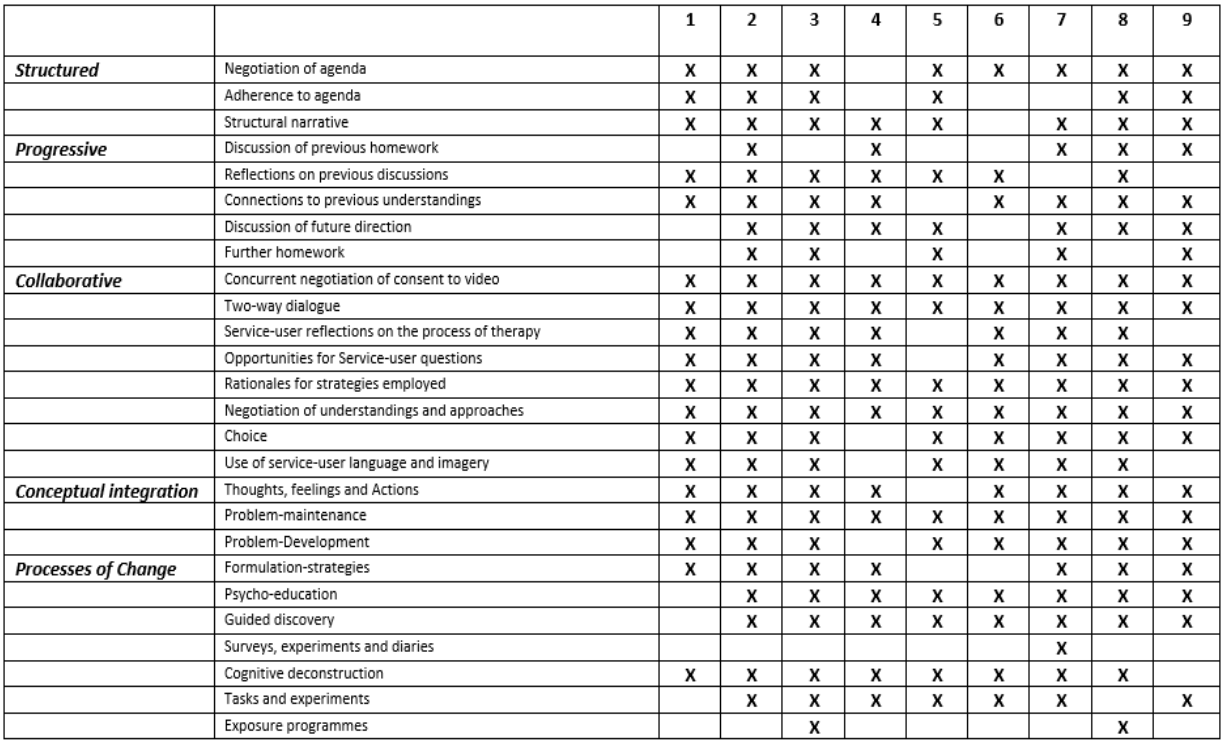
Significant Points	Participants words
Place, value and delivery of the Participant Handbook	*'To be honest with you I didn't really read the book very much. I've got that in my drawer. I did have it out for a bit but I didn't go into depths of looking at it because I felt like I just didn't want to get too …. I found the book too much.'* ***(LJ8).*** *'It just reminds me of the psychosis. It would have been easier to look at if it had simply been a book on hope and self-esteem. I didn't like the word 'psychosis' on the front.'* ***(LJ8).*** *'I find it very difficult to read at the beginning. I start to read not too much time ago. I read some. Not all of the chapters, but when I remembered something, I looked in the book. But I didn't read all of the book.'* ***(FH2).*** *'I understand how people can feel about books. For me it's normal. I feel comfortable with books. I use books every day and every night. I don't know what will be the impression of other people.'* ***(FH2).*** *'I think at the beginning I probably went away and looked through quite a few chapters and tried to get an overview of things and try and figure out what we might do in future sessions and things like that. And then there were other points later in the programme where I had to read something specific, but I haven't read it cover to cover.'* ***(UH3).*** *'Well I've read through and skimmed chapters 1 and 2 a little. And read some of chapter 3 because I think that was the main chapter. Probably percentage-wise I've probably read about 20% of it. Because I didn't just read it from start to finish. I just went to the page or section that I wanted to and read it from there.'* ***(MJ7).*** *'That's me you see. If it was on there [a clear written plan] then maybe I might have looked in the book before you were talking about it.'* ***(LJ8).*** *'When you gave me an exercise, I looked for it. If you said for me to do it I would do it.'* ***(LJ8).***

Key Theme of experience of the Style and Content of the Participant Handbook - Significant Points and Participants' Spoken Words

Significant Points	Participants words
Presentation, Structure and Content	*'I guess that it's more interesting ..to have this kind of format, than papers. The colours and so on – it's very friendly. It's a proper size.'* ***(FH2).*** *'But it's quite a big book. Say if it was something like that thick [indicates a much slimmer book] I'd have been like – oh I'll have a quick look through that. But whereas it was a bit like – oh my god, this is like all about me. I was a bit just like – oh god what have I got myself into?'* ***(LJ8).*** *'I feel I have some difficulties to understand the text.'* ***(FH2).*** *'For example, when you write about the different processes at the beginning. When you do some references about some other authors – it was fine. I could read it because it was easy to understand. But then when you explain about CBT and this kind of things it was more difficult.'* ***(FH2).*** *'Maybe the language is different and some structures are different from technical English – because I used to read technical English and I don't have any problems.'* ***(FH2).*** *'I think it's different to other books in that style of writing is a conversation type and you can tell when you are trying to explain something and some of your sentences are quite long, so when you start reading it and when you get towards the end of the sentence or paragraph, I think I can't remember exactly what I've just read. It's just sometimes you get lost in the paragraph. But on the flip side that's a good way of writing as well. It's not just boring fact after fact after fact.'* ***(MJ7).*** *'And some of it does sound very complex and in parts you explain it quite well. But some of it, by its nature, is quite complex stuff to talk about.'* ***(MJ7).*** *'I would think that it's the kind of thing where it seems like it's more geared towards – to some extent geared towards somebody who already has a kind of a psychological knowledge of some sort – that it seemed like a kind of a text book for a psychology student. But an introductory style and it is accessible, but it's not in layman's terms – it's not universally accessible. It's slightly specialised.'* ***(UH3).***

Appendix 5E – Audit of Fidelity - Results

Audit of Fidelity – Part 1 – Summary of Audit observations regarding components of CBT evidenced in the therapy sessions



		1	2	3	4	5	6	7	8	9
Structured	Negotiation of agenda	X	X	X		X	X	X	X	X
	Adherence to agenda	X	X	X		X			X	X
	Structural narrative	X	X	X	X	X		X	X	X
Progressive	Discussion of previous homework		X		X			X	X	X
	Reflections on previous discussions	X	X	X	X	X	X		X	
	Connections to previous understandings	X	X	X	X		X	X	X	X
	Discussion of future direction		X	X	X	X		X	X	X
	Further homework		X	X		X		X		X
Collaborative	Concurrent negotiation of consent to video	X	X	X	X	X	X	X	X	X
	Two-way dialogue	X	X	X	X	X	X	X	X	X
	Service-user reflections on the process of therapy	X	X	X	X		X	X	X	
	Opportunities for Service-user questions	X	X	X	X		X	X	X	X
	Rationales for strategies employed	X	X	X	X	X	X	X	X	X
	Negotiation of understandings and approaches	X	X	X	X	X	X	X	X	X
	Choice	X	X	X		X	X	X	X	X
	Use of service-user language and imagery	X	X	X		X	X	X	X	
Conceptual integration	Thoughts, feelings and Actions	X	X	X	X		X	X	X	X
	Problem-maintenance	X	X	X	X	X	X	X	X	X
	Problem-Development	X	X	X		X	X	X	X	X
Processes of Change	Formulation-strategies	X	X	X	X			X	X	X
	Psycho-education		X	X	X	X	X	X	X	X
	Guided discovery		X	X	X	X	X	X	X	X
	Surveys, experiments and diaries							X		
	Cognitive deconstruction	X	X	X	X	X	X	X	X	
	Tasks and experiments		X	X	X	X	X	X		X
	Exposure programmes			X					X	

Audit of Fidelity – Part 2(a) – Summary of Audit observations regarding components of Novel ‘Hope and Self-Esteem’ Therapy evidenced in the therapy sessions

Stage	**Element**	**Strategy**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Beginnings	**Assessment**	Time-line (Developmental Processes)	X	X	X		X	X	X	X	
		Maintenance Processes	X	X	X	X	X	X	X		X
		Relational Processes	X		X	X	X	X	X	X	X
		Differential effects of a crisis		X	X		X	X			
		Fragility of Hope and Self-Esteem on a moment-by-moment basis	X	X	X		X	X	X	X	X
	Formulation										
	Goal Development	Negotiating SMART Goals		X	X	X	X	X	X	X	X
		Challenging difficulties identifying long-term, meaningful goals	X	X	X	X	X	X		X	
		Challenging difficulties with identifying initial, short-term goals.	X	X	X	X	X	X	X	X	X
Treatment	**Rebalancing Positive and Negative Self-Judgements**	Identifying significant and specific positive and negative self-judgments	X	X	X		X	X	X	X	X
		Critically analysing negative self-judgements	X	X	X	X	X	X	X	X	X
		Nurturing positive self-judgements	X	X	X	X		X	X	X	
	Changing Behaviours	Increasing recognition of the importance of changing behaviours	X	X	X	X		X	X	X	X
		Identifying and countermanding unhelpful strategies	X	X	X	X	X	X	X	X	X
		Recognising and promoting exceptions	X	X	X	X	X	X		X	X
		Problem solving training	X	X	X	X	X	X		X	
	Improving Relationships	Encouraging more positive ‘Reflected Appraisals’	X	X	X	X	X	X	X	X	X
		Encouraging more effective support	X	X	X	X	X	X		X	
Endings	**Handing over the reigns**		X	X	X		X	X	X		
	Planning for the future		X	X	X	X	X	X	X	X	X
	‘Saying goodbye’		X	X	X		X	X	X	X	

Audit of Fidelity – Part 2(b) – Examples of Qualitative Descriptions of Strategies evidenced in the Session Reviews

	Describe up to 4 elements of a strategy as it appears in the recording
Audit 2	***Changing behaviours*** – stressing the importance of changing behaviours to prevent relapse. What behavioural strategies the client can use for a current or future relapse.
	Goal development – negotiating and identifying goals to prevent problem development. Recognising what environmental factors contribute to problems.
	Conceptual integration – identifying how an unhelpful lifestyle – eg, very late nights, plus staying in bed all day contribute to problem development. Following an activity log and its negatives and positives.
	Collaborative – therapist asking client to evaluate the last session, and content of session and effects of the session on change for positive. Developing relationship between thoughts and behaviours and how these will relate to for positive contributions and confidence to employment / work situations.
Audit 8	***Process of change***: discussing 'coaching football' in relation to a process and theme the client uses to deal with the outside world, by challenging himself. Clarifying steps to changing.
	Conceptual integration: recognising when the client has become stuck, with a narrative re: being stuck and unable to change (refusing to take up offers to coach in other contexts).
	Treatment re-balancing – identifying self-critical judgements re feelings of inadequacy and clarifying with the client the critical narratives.
	Changing behaviours – encouraging the client to recognise potential via listening to his statements to gain insight into his beliefs and thought processes.

Appendix 5F – Recommended Core Structure to the New Therapy Programme

Comprehensive Assessment

- Detailed assessment of the relevance, composition and development of negative evaluations to self and the future.
- Development of specific goals for therapy – to include attention to the articulation of wider aspirational 'applied' goals.
- Assessment of the immediate 'applied' pressures on the person and negotiation of priorities for attention within the Therapy Programme.
- Exploration of the place of self-esteem and hope in the process of doing therapy – modelling an openness to acknowledging these issues within the therapeutic relationship.

Introducing the 'Pure' elements of the approach (as discussed above)

- Developing clear and detailed formulations of hope and self-esteem.
- Introduction of ideas with regard to global and specific elements of hope and self-esteem, to the weighting of importance, issues of stability and fragility, and of compartmentalisation and integration.
- Consider experiences of hope and self-esteem in relation to psychotic crisis.
- Explore narratives of psychosis, with the focus on encouraging productive, positive and appropriate understandings.
- Introduce behavioural exercises associated with the rebalancing of attitudes to self and the inspiration of hopeful pathway thoughts.

Engaging with the 'Applied' elements of the approach

- Developing greater clarity as to the links between hope and self-esteem and impediments to the achievement of life goals.
- Introduce behavioural and cognitive exercises designed to focus developing hopefulness and increased self-esteem towards the attainment of those 'applied' goals.
- Explore the ramifications of change to life circumstances before action.

Endings

- Addressing questions of relapse.
- Working towards greater self-management.

Follow-up Booster Session(s)