BUILDING RELATIONSHIPS WITH PEOPLE WITH EARLY PSYCHOSIS: PSYCHOLOGISTS' ACCOUNTS

Kim Reid

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Doctor of Counselling Psychology

August 2012

32875 words (excluding references and appendices)

Abstract

Objectives: The evidence for CBT for early psychosis is limited yet it is used in early intervention for psychosis services across the UK. Whilst engagement is considered important in CBT for early psychosis, little is known about how therapists go about achieving this in clinical practice. This study aimed to explore therapists' subjective accounts engaging people with early psychosis when working from a cognitive behavioural perspective.

Design: A critical realist version of grounded theory was used in data collection and analysis.

Method: Seven psychologists who had experience of working with people with early psychosis in London were interviewed.

Results: The analysis showed a model of engagement from the therapists' perspective. The interpretation of the data highlighted the process of engaging people with early psychosis being influenced by the categories: *tenderness*, *client led*, *flexibility*, *therapist influences* and *outside influences*.

Conclusion: The results indicate the importance therapists placed on relational aspects of therapy and that they did not adhere to their professed cognitive behavioural ways of working. These findings have been linked to relevant literature. Practical and clinical implications have been suggested.

Student declaration

UEL University of East London — The Graduate School

Student Declaration form

Student Name:	**Kim Reid**
Student Number:	**U0511245**
Sponsoring Establishment:	
Degree for which thesis submitted:	**Professional Doctorate in Counselling Psychology**

Concurrent registration for two or more academic awards:

(* Please complete/ delete as appropriate)

either ✓	* I declare that while registered as a research degree student at UEL, I have not been a registered or enrolled student for another award of this university or of any other academic or professional institution
or	* I declare that while registered as a research degree student at UEL, I was, with the university's specific permission, also an enrolled student for the following award (see below):
Award title:	

Material submitted for another award:

(* Please complete/ delete as appropriate)

either ✓	* I declare that no material contained in the thesis has been used in any other submission for an academic award
or	* I declare that the following material contained in the thesis formed part of a submission for the award of (see below):
Award and awarding body: (list material here)	

Signature of student _____ **Date** 26/4/11

Acknowledgements

I owe my greatest thanks to the psychologists who kindly gave of their time to participate in my research.

I am very grateful to both of my research supervisors: Professor Rachel Tribe and Dr Kendra Gilbert for their help and support over years.

I would also like to thank my fellow class mates for their on going support and encouragement, without you this really would not have been possible.

A special thank you goes to Tove Steedman whose comments and suggestions helped me immensely in the final stages.

I am grateful to my friends and family for their love and support over the years of completing this thesis.

Note on style

This thesis has been written with a view to submission to a British Psychological Society Journal. It has therefore been written and referenced according to the British Psychological Society's Style Guidelines.

On the whole, the thesis has been written in the third person, but sections outlining personal reflexivity have been written as a first person account for ease of reading.

Table of Contents

Chapter one: Literature review

1.1 Introduction

This chapter will begin by positioning the researcher as a critical realist and as a counselling psychologist. These two concepts inform how the literature has been reviewed, the rationale and methodology of the research. The understanding of cognitive behavioural therapy (CBT) will then be explored followed by an understanding of psychosis. These concepts are linked to provide a rationale for CBT for psychosis. The topic of early intervention in psychosis will be introduced followed by a critical evaluation of research in the area of CBT for early psychosis as well as the broader psychosis literature. These studies draw attention to the value of the therapeutic alliance. The concept of the therapeutic alliance will be outlined highlighting the importance of the therapist in establishing therapeutic relationships. This will be followed by a discussion of the engagement literature in terms of service engagement and therapeutic engagement both of which involve forming relationships with clients. The therapeutic alliance and engagement be examined within the context of CBT for early psychosis and it will be concluded that a study of CBT for early psychosis from the perspective of the therapist with a focus on therapeutic engagement would be a useful addition to the literature.

1.2 Critical realism and research

It is important for researchers to be clear about the philosophical framework which they are working from as understanding the study's purpose, goals and methods necessitates

this knowledge (Ponterotto, 2005). The philosophical framework also aids evaluation of the research (Elliot, Fischer & Rennie, 1999; Madill, Jordan & Shirley, 2000; Morrow, 2005).

The chosen position of the researcher is critical realism. Stickley (2006) claims that critical realism posits that there is a real world but it can only be known through subjectivity, construction and interpretation between people and cannot be perfectly known. He goes on to say that in critical realism all knowledge is local, provisional and context specific, recognising both the reality of structures and the events and discourses of the social world. The objective of critical realism is therefore not to predict outcomes but to explain and make sense of phenomena (Willig, 1999) and consequently involves subjectivism using qualitative methodologies. This view of reality and knowledge informs the researcher's chosen profession – counselling psychology.

1.3 Counselling Psychology and research

The British Psychological Society's (BPS) Division of Counselling Psychology's Professional Practice Guidelines (2005, p.1) define counselling psychology as 'a branch of professional psychological practice influenced by human science research as well as the principal psychotherapeutic tradition….it draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology. It continues to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base

grounded in the primacy of the counselling or psychotherapeutic relationship'. This definition highlights how both clinical work and research are vital to counselling psychologists as well as the importance of the therapeutic relationship. Counselling psychology seeks to engage with subjectivity, inter-subjectivity, values and beliefs, accepting first person accounts as valid in their own terms as well as recognising the context within which people operate (BPS, 2005). The guidelines outline that there should be congruence between the values expressed in counselling psychology and the way that research is carried out to make it more relevant to clinical practice. Morrow (2007) states that it is important for the science-practice divide in counselling psychology to be addressed as academic research is often not meaningful to practitioners who work in the field. Williams and Hill (2001) suggest that qualitative research methods may help to make research more relevant to practitioners and therefore help to narrow the science-practice divide.

Rennie (2007) posits that critical realism is necessary in humanistic psychology and hence counselling psychology. He argues that realism reduces people downwards to biology and behaviour whilst relativism reduces people upwards to language, culture and tradition. He posits that the tendency to engage in either upward or downward reduction does not do justice to the person and he therefore calls for a middle ground which accommodates both realism and relativism. Rennie (2007) contends that avoiding this reduction at the level of ontology means that it carries through into the epistemology and methodology. He goes on to say that the vision of humanistic

psychology is to restore the person back to psychology and proposes we do this by avoiding reduction and taking a critical realist perspective. As the position of critical realism fits with the values of counselling psychology with its emphasis on subjectivity and interpretation, this is the chosen framework of the researcher. By using this approach, the researcher aims to make this research relevant to clinical practice.

From the above discussion, it can be concluded that it is important to carry out research as a counselling psychologist that fits with the values of counselling psychology and that narrows the science-practice divide, making research more meaningful to practitioners. To do this is may be important for research to be grounded in the value of the therapeutic relationship. It can be seen that counselling psychology fits well with critical realism. It is from a position as a critical realist and counselling psychologist that the literature will be reviewed and critiqued.

1.4 Understanding cognitive behaviour therapy

CBT is a therapy based on a combination of behavioural therapy and cognitive therapy. Each of these will be considered in turn.

1.4.1 Overview of behaviour therapy

According to Hawton *et al*. (1989) behavioural therapy is based on conditioning which is a process of learning or behaviour modification in which a subject associates a desired behaviour with a previously neutral or unrelated stimulus. They outline two major

types of conditioning: classical conditioning and operant conditioning. Classical or Pavlovian conditioning is when a behavioural response learned is an innate response for a neutral stimulus, for example a dog salivating to the sound of a ringing bell. Operant or Skinnerian conditioning is when the behaviour is voluntary (as oppose to innate or reflexive in classical conditioning). In operant conditioning it is possible to change behaviour using reinforcement and punishment. Development of these ways of understanding behaviour and its modification gave rise to various therapies including: aversion therapy, systematic desensitization and exposure treatments.

1.4.2 Overview of cognitive therapy

Cognitive therapy is based on Beck's (1976) cognitive model of emotional disorders. This model assumes that the way a person feels about a situation or event is determined by their perception or interpretation of the situation, not just by the situation. The model goes on to explain how these perceptions can be influenced by different levels of cognition. People develop beliefs about themselves, others and the world through their experiences for example a person who perceived their parents as unloving may develop a belief about themselves as being unlovable – "I am unlovable". Experience also leads people to develop conditional beliefs or assumptions for example the person who believes they are unlovable may have an assumption "If other people find out what I am really like, they will find out I am unlovable and reject me". Beck (1976) goes on to explain how these assumptions influence a person's perceptions and behaviours. In this way, how a person thinks is governed by a set of beliefs and

assumptions developed throughout their life. In turn, how a person thinks then influences how they feel and how they behave. Beck (1976) bases cognitive therapy on this model of understanding with a basic premise of changing the way a person thinks about or interprets something can change the way they feel about it. Cognitive therapy therefore aims to challenge unhelpful thoughts and beliefs and consider alternative explanations based on the available evidence to support beliefs or thoughts being true.

1.4.3 Cognitive behavioural therapy

CBT is a combination of cognitive therapy and behaviour therapy. It is a structured, problem specific, present oriented, short term therapy which has been adapted for use with a variety of different diagnoses (Hawton *et al*., 1989). A key aspect of CBT is collaborative empiricism. This involves therapist and client forming a collaborative therapeutic alliance and working together to identify and monitor target difficulties and work out potential means to make therapeutic changes. Further to this, clients are encouraged to view their thoughts as scientific hypotheses which can be tested empirically (Toner *et al*., 2000). CBT is a goal oriented therapy and the therapeutic goals are collaboratively chosen (Beck, 1995). CBT is based on a formulation or understanding of a clients difficulties in cognitive behavioural terms such as thoughts, feelings and behaviours related to the current problem. The formulation also includes beliefs and assumptions of the client as related to their early experiences. It is from this collaboratively generated understanding that hypotheses can be generated and tested (Beck, 1995). CBT interventions include challenging thought processes with the use of

thought records and behavioural experiments with the aim of improving mood (Hawton *et al*., 1989). The use of self-help assignments is an important aspect of CBT and the therapist and client work together to generate tasks which can be carried out outside of sessions. These include the monitoring of moods, thoughts and behaviour as well as behaviour experiments (Toner *et al*., 2000). Whilst CBT has various adaptations and is used differently with different diagnoses, the underlying assumption of the approach is that unhelpful thinking influences mood and behaviour and therefore rational evaluation and re-appraisal of thinking may produce an improvement in mood and behaviour (Beck, 1995) and that the use of behavioural interventions such as exposure may produce changes in mood (Hawton *et al*., 1989).

1.5 Understanding of Psychosis

The Oxford English Dictionary (Soanes, Hawker & Elliot, 2005, p.727) defines psychosis as: "a mental disorder in which a person's perception of reality is severely distorted." According to the DSM IV-TR (American Psychiatric Association, 2000) the symptoms of psychosis can be divided in to positive and negative symptoms. Positive symptoms include delusions, hallucinations, disorganised speech and catatonia. Negative symptoms reflect a decrease or loss of regular functioning and include social withdrawal, apathy and emotional flatness.

The understanding of psychosis has changed over the years this will be expanded upon to provide a rationale for the psychological treatment of psychosis. There are three

broad paradigms conceptualising psychosis in the psychiatric literature and each will be considered in turn.

1.5.1 The Disease Model

Morrison *et al*. (2004) describe how the first paradigm can be referred to as the disease paradigm and was outlined by Emil Kraepelin at the turn of the twentieth century. In this paradigm, psychosis was best described in terms of broad diagnostic concepts for example schizophrenia and bipolar disorder which were considered as brain diseases with a biological basis and they were thought of as inherited (Morrison *et al*., 2004). They go on to explain that in this view there is a definite distinction between mental health and mental ill health. As brain disease was considered unresponsive to psychological treatment, this was not considered an option and the only treatment was medication although a course of deterioration was assumed (Bentall, 2003).

1.5.2 The stress-vulnerability model

Challenges to the purely biological basis for psychosis formed the basis of the next paradigm and encouraged new ways of thinking about psychosis. According to Hagen and Turkington (2011), the understanding of psychosis slowly started to change towards a model of stress-vulnerability in the 1960s. In this view they state that a biologically and psychologically predisposed person may become psychotic if they experience stress. Various studies have shown that psychotic symptoms such as hallucinations and delusions are experienced by so called normal populations who do not receive

psychiatric treatment (Meehl, 1962; Chapman, Chapman & Raulin, 1976; Chapman, Edell & Chapman, 1980; Claridge, 1987; Tien, 1991; van Os *et al*., 2000 – cited in Morrison *et al*., 2004). According to Morrison *et al.* (2004) it seems plausible that these people have ways of managing their psychotic experiences that do not make them feel distressed. Therefore a vulnerability to psychotic experiences was considered a plausible alternative to considering psychosis as inherited. Further to this psychotic experiences may be seen to lie on a continuum with ordinary experiences.

Brown (1985) carried out a study looking at psychotic patients leaving hospital to live with family members. He found that if families were critical or over protective, patients were more likely to relapse compared to patients returning to families who were emotionally relaxed. He referred to this as expressed emotion. He concluded that stressful interpersonal relationships could influence the course of psychosis. Bebbington and Kuipers (1994) aggregated data from 25 studies carried out throughout the world and found that high expressed emotion in families is linked to relapse. These studies imply that the environment can have an effect on the course of psychosis.

Ordinary people having psychotic experiences coupled together with the environment having an effect on psychosis suggest that there may not be a purely biological basis for psychosis as the environment plays a role. Morrison *et al*. (2004) outline how in this way of thinking about psychosis, four possible factors interact: personal vulnerability (for example biological factors); personal protective factors (for example coping skills);

environmental precipitants (for example critical family environment or harsh life events) and environmental protective factors (for example a supportive family). Thinking about psychosis in this way allows opportunities for psychological intervention such as manipulating the environment (family therapy) and enhance coping skills (behaviourally orientated psychological therapy and social skills training) (Fowler, Garety & Kuipers, 1995; Morrison *et al*., 2004; McGorry, 2004).

Whilst the stress-vulnerability conceptualisation is an improvement on the disease model of psychosis in terms of considering psychological interventions, it has some limitations. This conceptualisation assumes that psychosis has biological causes which has led researchers to measure cognitive deficits in an attempt to map these on to underlying brain dysfunction but these deficits are not specific to any particular group of psychotic symptoms (Morrison *et al*., 2004; Bentall, 2003). A further limitation of the model is that it does not place emphasis on biases in social cognition which appear to be relevant to positive symptoms. Because cognitive deficits are highlighted and biases in social cognitions are not considered important, the model cannot provide insight into psychological interventions for positive symptoms of psychosis (Bentall, 2003; Morrison *et al*., 2004).

1.5.3 Symptom focussed approach

The third paradigm can be considered as the symptom focussed approach which arose in the late 1980's. It has seen a move away from the concept of diagnosis within

psychosis to looking at individual symptoms such as behaviours and experiences associated with the diagnoses (Bentall, 2003; Morrison *et al*., 2004; Bentall, 2009). This has meant the abandonment of terms such as schizophrenia and bipolar disorder and instead using the umbrella term psychosis. Research within this paradigm has focussed on exploring the psychological processes that may underlie psychotic symptoms. Research has tended to focus on biases in perception and reasoning, for example delusions have been associated with reasoning biases such as jumping to conclusions and auditory hallucinations have been associated with attributing one's own inner speech to outside sources (Morrison *et al*., 2004). Conceptualising psychosis in this way has allowed the development of CBT techniques in the area.

1.6 Cognitive behavioural therapy for psychosis

The changing view of psychosis as outlined above, lends itself well to cognitive behavioural interventions as in the developing view, it is not the symptoms per se that are problematic but rather the perception or interpretation of them that causes emotional distress. CBT for psychosis aims to reduce the distress and impact of functioning related to the experience of psychotic symptoms; further to this it aims to reduce morbidities such as depression and social anxiety (Newton & Cotes, 2010). CBT for psychosis is similar to traditional CBT models in that it is structured, time limited, makes use of collaborative empiricism and involves the use of a formulation of a client's difficulties.

Dow (2003) describes how CBT for psychosis does however differ from traditional CBT in some respects. The duration of treatment is longer to allow the client and therapist to build a trusting relationship and to allow a full assessment of symptoms. The therapist often needs to vary the structure and duration of individual sessions according to the needs of the client. Therapists often need to work within the client's understanding and differences of perspective and goals need to be tolerated by the therapist. Challenging and reappraisal of unhelpful thoughts is often delayed as clients may initially struggle to generate alternative explanations.

CBT for psychosis emphasises the importance of normalising psychotic experiences by viewing them on a continuum with typical experiences as well and the use of psycho-education (Kingdon &Turkington, 1994). It also focuses on developing coping strategies and problem solving; this includes behavioural techniques such as activity scheduling and relaxation methods (Fowler *et al*., 1995). Cognitive behavioural techniques are used to address positive and negative symptoms of psychosis within the context of a collaboratively generated formulation of the client's experience (Newton & Cotes, 2010).

There is evidence that CBT can have an effect on residual positive symptoms as well as depression (Garety *et al*., 1994); it can reduce the severity of delusions (Durham *et al*., 2003); reduce command hallucination compliance (Trower *et al*., 2004); CBT for psychosis has also been shown to be superior to supportive counselling, befriending and

psychodynamic supportive therapy (Tarrier *et al*., 1998; Sensky *et al*., 2000; Durham *et al*., 2003).

The National Institute for Clinical Excellence (2010) recommends CBT should be offered to all people with a diagnosis of schizophrenia or persistent psychotic symptoms. These guidelines are based on evidence of the efficacy of CBT for psychosis.

1.7 Early intervention for psychosis

Penn *et al*. (2005) report that psychotic disorders are among the most disabling of all mental illnesses and there is a poor long-term outcome resulting in great personal adversity and societal cost. Changes in the way psychosis has been conceptualised (as outlined earlier, 1.5) have caused a renewal of interest in treatment and prevention (McGorry, 2000).

There has been a focus on early detection and treatment in psychosis as interventions during this time have a stronger influence over the long-term course of symptoms and function by preventing or limiting the cycle of relapse and recovery (McGorry, 2000; Birchwood, 2000; McGorry, 2004; Birchwood & Spencer, 2001). Birchwood (2000, p.47) states that there is a 'rapid period of progression of psychosis prior to, and following, the first presentation' and that during this time the risk of progression and relapse is strongest and the course of psychosis is predictable by three years. He goes on to say that the first three years of illness provide a window of opportunity to minimise the

possible deterioration and this is referred to as the critical period. It was therefore proposed that treatment during this critical period might alter the course of psychosis and prevent progression (Spencer, Birchwood & McGovern, 2001). These findings have resulted in the National Service Framework for Mental Health in the United Kingdom stressing the need for early assessment and treatment of psychosis and to establish specialist services for early psychosis for the management of this critical period (in Spencer *et al*., 2001).

Spencer *et al*. (2001, p.133) list the aims in the management of early psychosis as:

- 'To reduce the time between onset of psychotic symptoms and effective treatment
- To accelerate remission through effective biological and psychosocial interventions
- To reduce the individual's adverse reaction to the experience of psychosis and to maximise social and work functioning
- To prevent relapse and treatment resistance'.

Spencer *et al*. (2001) discuss the make up of their early intervention service in Birmingham. This was the first specialist early intervention service in the United Kingdom on which other services have been modelled. This service works with clients between the ages of 16 and 35 years and provides comprehensive care over a period of three years which matches with the critical period (Birchwood, 2000). This service

offers interventions in the form of pharmacotherapy, family work, social recovery, work and training schemes and CBT. Their service is based on an assertive outreach model which ensures that staff members have low case loads, guaranteeing that they can be in frequent contact with clients.

Spencer *et al*. (2001, p.134) list the principles for best-practice management of early psychosis as:

- 'A strategy for early detection and assessment of frank psychosis
- A specific focus on therapeutic engagement
- A comprehensive assessment
- An embracing of diagnostic uncertainty
- Treatment in the least restrictive setting using low dose medication'.

Anti-psychotic medication is the mainstay of symptom management in early psychosis and psychological approaches, especially CBT (individual and group) are used alongside pharmacotherapy (Penn *et al*., 2005). Individual CBT for early psychosis will now be discussed.

1.8 Cognitive behavioural therapy for early psychosis

Addington and Gleeson (2005) discuss how CBT for early psychosis should address both the symptoms of illness as well as the impact of psychosis including social functioning, depression and substance misuse. They go on to say that the goals of CBT should be to

increase the clients understanding of their psychosis and to increase their adaptation to it. These suggestions appear to be in line with CBT for psychosis in general (Morrison *et al*., 2004; Chadwick, 2006; Hagen *et al*., 2011).

Valmaggia *et al*. (2008) explored the difference in individual CBT across the stages of psychosis including: prodromal psychosis, early psychosis and chronic psychosis and attempted to fine tune the approach for each. They reported that CBT for early psychosis should have a specific emphasis on engagement and a shared understanding of problems. Engagement in CBT for psychosis is seen as an important precursor to the rest of therapy (Chadwick, 2006) and this will be elaborated on later in this chapter.

To date there is limited evidence for the efficacy of individual CBT for early psychosis (Jackson *et al*., 1998, 2001, 2005; Lewis *et al*., 2002; Tarrier *et al*., 2004; Jolley *et al*., 2003; Haddock *et al*., 2006; Jackson *et al*., 2008; Jackson *et al*., 2009; Penn *et al*., 2011). This evidence will now be reviewed.

1.9 Is cognitive behavioural therapy for early psychosis effective?

A series of trials have been carried out to assess the efficacy of CBT for early psychosis. The studies will be reviewed and critiqued in terms of how they address answering questions about the efficacy of CBT for early psychosis.

1.9.1 Outcome studies of CBT for early psychosis

1.9.1.1 Study of Cognitive Reality Alignment Therapy in Early Schizophrenia (SoCRATES)

In a large randomised control trial known as the SoCRATES (Study of Cognitive Reality Alignment Therapy in Early Schizophrenia) study, Lewis *et al*. (2002) used a sample of 315 clients to compare a five week treatment package of CBT plus routine care with supportive counselling plus routine care and routine care alone in people diagnosed schizophrenia related to their first or second acute admission. The CBT which they used was manualised and aimed to treat auditory hallucinations and delusions, associated problems such as depression, low self esteem and anxiety as well as relapse prevention. Treatment consisted of four stages: assessment and engagement; formulation and the key problem; interventions directed at reducing the severity of key problems and relapse prevention. Cognitive behavioural strategies were employed throughout. They used various outcome measures to compare the positive and negative symptoms of psychosis before and after care. They found that all three groups improved on all measures but that there was no significant differences between the groups. Tarrier *et al*. (2004) carried out an 18 month follow-up to the SoCRATES study and found that both CBT and supportive counselling were significantly better than routine care in reducing symptoms. They found that there were no group differences in relapse rates with high overall relapse across the total study group. They concluded that individual therapy (either CBT or supportive counselling) may have a beneficial long-term effect on symptoms in early psychosis.

As the SoCRATES study was a randomised control trial it is a useful study in attempting to show causality as randomised control trials are an adaptation of the experimental method and are considered the gold standard in research as they can yield the most convincing evidence of efficacy of psychotherapy (Chambless & Hollon, 1998; Roth & Fonagy, 2005). That being said, there are various pitfalls as randomised control trials are often far removed from real life therapy. They screen out patients with co-morbidities and are available only to patients who agree to be randomised for trials, thus creating an unrepresentative group which is far removed from the severity, complexity and diversity of clinical settings (Roth & Fonagy, 2005).

The SoCRATES study employed treatment manualisation. The aim of this is to factor out therapist variables, enhance therapist competence and decrease the differences between therapists (McLeod, 2003). Manualisation is useful in that it helps us to know that treatment has been delivered in a congruent and standardised manner; is essential to minimise variability within the experimental conditions and allows people to know what has been tested (Westen, Novotny & Thompson-Brenner, 2004; Roth & Fonagy, 2005). Manualisation however limits therapist flexibility and reduces the therapeutic strategies available to therapists (Roth & Fonagy, 2005). Manualised treatment is far removed from real world therapy and this makes it hard to generalise the findings (McLeod, 2003).

The SoCRATES trial compared a CBT treatment group to a supportive counselling group and a group receiving treatment as usual. It is useful to compare the CBT group

to the supportive counselling group as this aims to control for non-specific aspects of therapy. The supportive counselling group was matched to the CBT treatment group in terms of therapy time and therapist. This is useful as it shows that the researchers have considered to some extent the influence of therapist factors in initiating change and attempted to control for them (Kazdin, 1986). Controlling in this way assumes that personal traits of the therapist will influence each therapy equally but Bentall (2009) argues that therapists may be more committed to one type of therapy and this may influence how they carry out interventions. Although these two groups were controlled, there was no attempt made to standardise treatment as usual and this may be useful to consider given the lack of statistical significance found between groups as it would increase the likelihood of showing experimental effects (Lewis *et al*., 2002). A further consideration is that therapists received regular supervision during the course of the trial, approximately one hour per week (Haddock *et al*., 1999) which is not usually the case in day to day clinical practice and there is no research into the effect of this supervision (Haaga & Stiles, 2000). This adds to the argument that the results may be difficult to generalise.

This series of studies included follow data which is informative in terms of whether or not changes were maintained over time. However, the longer a patient is followed up, the less change can be attributed to treatment as various other things may have occurred in that person's life and it is also important to note that the original randomisation is lost (Roth & Fonagy, 2005). Because of this, the studies became

naturalistic studies at follow up and they are therefore better at answering questions about immediate outcome (Roth & Fonagy, 2005).

The SoCRATES study focussed on a treatment package offered over five weeks with a mean duration of treatment of 8 hours (Tarrier *et al*., 2004). The short duration of treatment may be linked to the overall high relapse rates shown in all three groups and the authors note that perhaps persisting with CBT for a longer period would be beneficial (Tarrier *et al*., 2004).

1.9.1.2 Cognitively Oriented Psychotherapy for Early Psychosis - COPE

Jackson *et al*. (1996) developed COPE (Cognitively Oriented Psychotherapy for Early Psychosis). COPE is a manualised cognitive behavioural treatment programme aimed at facilitating adjustment after a first episode of psychosis. Cope aims to assist clients in resuming their developmental tasks which may have been interrupted by psychosis for example education, career, relationships and a sense of identity. Further to this, COPE aims to address secondary morbidities of psychosis such as social anxiety and depression. COPE consists of four phases including assessment; engagement; adaptation and secondary morbidity. Cognitive behavioural techniques are of emphasised in the latter two stages.

Jackson *et al*. (1998) carried out a study of 80 individuals experiencing early psychosis. Forty four clients received COPE as part of their outpatient care, 21 refused COPE but received outpatient treatment as usual and 15 clients received inpatient care only

(control group). The duration of therapy was 12 months and there was a median of 19 sessions attended. At the end of the treatment, those who received COPE significantly out performed the control group on measures of insight and attitudes towards treatment, adaptation to illness, quality of life and negative symptoms, but they performed significantly better than the refusal group only with respect to adaptation to illness. There were no significant differences in relapse rates between the three groups. At one year follow-up Jackson *et al*. (2001) reported that the group receiving COPE maintained significantly better adaptation to their psychosis than the group who refused treatment. The other group differences were not maintained at one year follow up and there were no group differences in relapse rates. At four year follow-up there were no significant differences between groups (Jackson *et al*., 2005). Jackson *et al.* (2001, 2005) concluded that there was no advantage to those clients receiving COPE compared to those not receiving therapy.

The COPE studies were not randomised control trials using an experimental design but rather a quasi-experimental design. They do however face similar criticisms to the SoCRATES study discussed above (Lewis *et al*., 2002; Tarrier *et al*., 2004).

Jackson *et al*. (1998, 2001, 2005) compared a treatment group to a refusal group and a control group. In selecting patients suitable for the study, researchers screen out clients with co-morbidities. This can result in a group which may not be representative of that of clinical settings (Roth & Fonagy, 2005). It is unclear in these studies whether the

refusal group and the inpatient care only group were controlled in anyway. There appears little consideration of therapist or client factors in outcome (Kazdin, 1986). In terms of the delivery of COPE, it was a manualised treatment package and as such it is subject to similar criticisms as the SoCRATES studies (Lewis *et al*., 2002; Tarrier *et al*., 2004). Manualisation is useful in that in this case, it helps us to know that COPE has been delivered in a congruent manner, but manualisation can lead to a therapeutic style that does not reflect best practice (Bentall, 2009).

Jackson *et al*. (2001, 2005) noted a low number of patients left at follow up in the refusal and control groups which made it challenging to detect differences between the groups. This also meant that there was more power to detect differences within groups as the COPE group was larger. The absence of patients in the two comparison groups may have made the follow-up scores appear more impressive and impacted negatively on the follow-up scores of the treatment group.

Although the studies carried out by Jackson *et al*. (1998, 2001, 2005) are essential in terms of establishing the efficacy of CBT for early psychosis, they appear to be far removed from clinical practice. They have difficulties with external validity making the findings hard to generalise to clinical practice.

1.9.1.3 Other smaller outcome studies

There are a number of smaller outcome studies evaluating the efficacy of CBT for early psychosis and these will be briefly outlined. They can be critiqued in a similar manner to the two larger studies documented above.

Jolley *et al.* (2003) conducted a small pilot randomised control trial of CBT for early psychosis with 12 clients receiving CBT and 9 clients receiving treatment as usual. Of the 12 clients receiving CBT, only 8 engaged. They reported a high level of disengagement from services. During recruitment, only half of the potential participants who were met agreed to participate. Those who did not agree to participate were not in regular contact with mental health services. They noted further disengagement during the trial. Jolley *et al*. (2003) suggest that failure to engage with services may be related to the study being carried out in inner London as the results to do not corroborate engagement patterns noted in other studies (Lewis *et al*., 2002). They surmise that this group may be difficult to engage in formal therapy. The results showed that both groups improved but that there were no significant group differences. They acknowledge that this is a similar pattern to larger studies (Lewis *et al.,* 2002; Jackson *et al.,* 1998, 2001) and conclude that the evidence suggests that CBT for early psychosis is not strongly indicated as a treatment for all clients.

Haddock *et al*. (2006) report on an aspect of the SoCRATES study (Lewis *et al*., 2002; Tarrier *et al*., 2004) and review the data in relation to age of clients. Outcomes were

evaluated in terms of positive and negative symptoms, social functioning, insight and therapeutic alliance. They divided their sample into two groups based on age with 21 years old being the cut off point. In this way, they measured outcome related to age at 3 and 18 months. They found that younger clients responded better to supportive counselling over 3 months and older clients responded better to CBT over 18 months. The younger clients were more difficult to engage in the CBT group. Haddock *et al*. (2006) report that these results imply that age is a significant factor relating to treatment in early psychosis and that this is not usually addressed in service provision. They considered that younger clients responding better to supportive counselling and being more difficult to engage in CBT may relate to the complex nature of CBT. They put forward that CBT requires higher levels of engagement than supportive counselling as it requires active participation and collaboration which supportive counselling does not. From these findings, they conclude that younger people require more strategies to help them to engage in therapy. These findings point to the fact that younger people have different developmental needs in comparison to older people with psychosis. Life changes relating to their developmental needs may prevent people with early psychosis from engaging in a more structured therapy such as CBT and they suggest that further work is needed to explore this.

The ACE study was a randomised control trial comparing CBT (ACE- Acute Cognitive therapy for Early Psychosis) to befriending carried out by Jackson *et al*. (2008). Sixty two participants were randomly assigned to each group. They measured positive and

negative symptoms and functioning at pre-treatment, middle treatment, end of treatment and one year follow up. They reported that both the ACE group and the befriending group improved significantly over time. The ACE group scored significantly better with regards to functioning but not symptoms at mid-treatment. By the end of treatment and at follow up, there were no significant differences in any measures between the two groups. These results show befriending and CBT to be similar in outcome, suggesting the importance of non-therapy specific factors such as the relationship between client and therapist.

Jackson *et al*. (2009) developed a version of CBT (Cognitive Recovery Intervention - CRI) aimed at addressing adjustment and adaptation to early psychosis. Sixty six clients were randomly assigned to either CRI or treatment as usual. They took measures of trauma symptoms, depression and self esteem at pre-treatment and at 6 and 12 month follow-up. They reported that the CRI group had a lower level of trauma symptoms, especially at six months but there were no differences on the other measures. The concluded that CRI is helpful in adaptation to traumatic aspects of early psychosis but that further research is required.

Penn *et al*. (2011) have devised a version of CBT (Graduated Recovery Intervention Program – GRIP) designed to support functional recovery from early psychosis. In a randomised control trial, 46 clients were randomly assigned to either GRIP with treatment as usual or treatment as usual alone. They examined functional outcomes

including quality of life, community functioning and social skill. The results showed no significant differences between groups but it was noted that both groups improved on various functional outcomes but there was no advantage of GRIP over treatment as usual.

These studies have been briefly mentioned to highlight the inconclusive evidence for the efficacy of CBT for early psychosis. The outcome literature will now be critiqued as a whole.

1.9.2 Overall critique of the outcome studies

These studies, demonstrate the variability in the efficacy of CBT for early psychosis. It is noteworthy that the studies differed in style, focus and duration of therapy making comparison of results difficult. It is important to note that routine care in the treatment of early psychosis generally results in swift remissions and it is therefore difficult to demonstrate the efficacy of CBT (Lewis *et al*., 2002). All of the above studies were carried out from a realist perspective and do not fit into the proposed research framework. These studies rely on the use of outcome measures to produce statistics to show group differences. They pay little attention to individual differences or subjective experience.

Challenges regarding control groups and manualisation have been addressed with regard to the larger studies discussed first (Lewis *et al*., 2002; Tarrier *et al*., 2004;

Jackson *et al*., 1998, 2001, 2005) and this critique is applicable to the other smaller studies.

As is evident from the critique of the outcome studies, they appear to be removed from clinical practice which serves to broaden the science-practice divide (Morrow, 2007). They do however draw attention to some points of interests. CBT is as effective as supportive counselling (Lewis *et al*., 2002; Tarrier *et al*., 2004) and befriending (Jackson *et al*., 2008) which may point to a relationship between people as being integral to outcome. Haddock *et al*. (2006) demonstrated that the needs of younger and older clients may be different which may indicate that a tailored approach to therapy is needed. Attention has also been drawn to the difficulty of engaging young people when using CBT (Jolley *et al*., 2003; Haddock *et al*., 2006).

Whilst the evidence for the efficacy of CBT for early psychosis is limited, it is commonly used in early intervention services and is indicated by the National Institute of Clinical Excellence (NICE) guidelines (2010). Although the guidelines state that all people with schizophrenia should be offered CBT, they do not make specific reference to early psychosis. Newton and Cotes (2010) highlight how across the United Kingdom therapists are using CBT to treat clients in early intervention services. Treatment protocols specify guidelines for clinical practice in early intervention services (for example Birchwood, Fowler & Jackson, 2000; French *et al*., 2010) but to the best of the researcher's knowledge there are no studies which look at how services are actually

delivered within the context of an early intervention service. For this reason, it may be appropriate to look at what happens in day to day clinical practice in the use of CBT for early psychosis and subjective accounts of CBT for early psychosis will be explored.

1.10 Subjective experiences of cognitive behavioural therapy for early psychosis

A literature search did not reveal any studies of client or therapist experiences of individual CBT for early psychosis. O'Toole *et al*. (2004) however looked at clients' perceptions of an early intervention service as a whole which included an element of CBT. They carried out a series of focus group discussions with 12 clients to explore their experiences of the service with an aim of informing future service planning and provision. They analysed their data using interpretative phenomenological analysis (IPA) and found the human approach as being key in service provision as well as the importance of clients being involved in treatment decisions and flexibility. Although not explicitly stated, this study appears to be carried out from a critical realist perspective and takes into account the subjective experiences of clients. It has been helpful in establishing what is valued by service users in an early intervention setting. Focus groups can however tend towards a group consensus and often marginalise some voices within the group (Newton *et al*., 2007). Therefore looking at individual experiences may be important. It would be advantageous to carry out a study looking at how the service providers carry out their interventions. It would be useful to separate the service as a whole into components, for example medication and psychosocial interventions for example CBT.

Newton *et al*. (2007) looked at the experiences of group CBT for young people who reported hearing voices in an early intervention setting. They conducted individual interviews with eight clients and analysed their data using IPA. They appear to take a critical realist position by avoiding either upwards or downwards reduction and staying with the experience of the participants (Rennie, 2007). They hold that the voices, the group and the CBT are real but they focus on the subjective experience of these. The results yielded a rich account of the young people's experiences of group CBT showing the value of having a place to explore shared experiences. Newton *et al.* (2007) have linked their findings to clinical practice in the development of support for young people who hear voices.

To provide contextual information, the literature search was broadened to review studies looking at CBT for psychosis in general (not specific to early psychosis). McGowan, Lavender and Garety (2005) looked at factors affecting outcome in CBT for psychosis. They interviewed four therapists and eight of their clients about their experiences of CBT for psychosis and analysed the data using grounded theory. They appear to adhere to a critical realist approach, valuing subjective experiences but linking them to what they consider as real structures (whether clients progress in therapy or not). They reported how both therapists and clients valued and benefitted from therapeutic contact outside of a structured CBT style. This shows the value placed on the personal approach in CBT for psychosis and draws attention to the importance of the therapeutic relationship.

Messari and Hallam (2003) looked at clients' understanding and experience of CBT for psychosis. The data was analysed using a discourse analytic method focusing on the way clients positioned themselves in relation to their therapist. These findings point to the importance of the therapeutic relationship. Their participants construed 'the relationship with their therapists as a personal relationship between two equal human beings, who respected and trusted each other' (Messari & Hallam, 2003, p.13). Although this study was beneficial in potentially informing clinical practice and showing the centrality of the therapeutic relationship, it was carried out from a relativist perspective and relied on an upward reduction of experience to language and culture (Rennie, 2007) which does not fit with the proposed research framework.

The evidence discussed shows the variability in the efficacy of CBT for early psychosis and suggests that CBT is as effective as supportive counselling (Lewis *et al*., 2002) and befriending (Jackson *et al*., 2008) which may indicate the importance of the therapeutic relationship. There appears to be no studies exploring either clients' or therapists' experiences or accounts of individual CBT for early psychosis but studies in the wider literature have drawn attention to the importance of the therapeutic relationship.

1.11 Engagement and the therapeutic alliance

As outlined earlier (1.8) engagement is an essential aspect of CBT for early psychosis. Although engagement in treatment is regarded as vital to outcome, there appears to be little agreement on the definition of the term and it is difficult to say what it is (Tait, Ryle

& Sidwell, 2010). However, there is some consensus about the constructs that relate to the concept of engagement which include: treatment adherence and the alliance between client and therapist (Dearing *et al*., 2005). This shows the link between the concept of engagement and the therapeutic alliance. The therapeutic alliance will be briefly outlined followed by a discussion on engagement. The concept of engagement will be discussed in depth as it is considered to include the therapeutic alliance.

1.11.1 The therapeutic alliance

Norcross (2010, p.120) describes the therapeutic alliance as: 'the quality and strength of the collaborative relationship between therapist and client'. Bordin (1979) devised a pantheoretical model of the therapeutic alliance which includes the positive emotional bond between the therapist and client, the agreement about the goals of therapy and consensus on the tasks of therapy needed to attain the goals. Rogers' (1957) core conditions of empathy, unconditional positive regard and genuineness are considered as generic relational skills used by the therapist in forming the positive emotional bond with the client.

Horvarth and Greenberg (1989) developed a measure of the therapeutic alliance based on Bordin's (1979) model called the Working Alliance Inventory. This is commonly used across therapy modalities and diagnoses. Consistent evidence has shown the quality of the therapeutic alliance, measured using the Working Alliance Inventory, to predict treatment outcome (Horvath & Symonds, 1991; Martin, Garske & Davis, 2000). The

importance of the therapeutic alliance in therapeutic outcome is well documented in the broader psychotherapy literature (Horvarth & Luborsky, 1993; Norcross, 2010; Cooper, 2008) and this is mirrored in the psychosis literature (McCabe & Priebe, 2004; Priebe & McCabe, 2006). Further to this evidence linking the therapeutic alliance to outcome, explorations into what clients consider to be helpful in therapy have revealed the importance of the therapeutic alliance (Bohart & Tallman, 1999, cited in Cooper, 2008; Najavits & Strupp, 1994; Johansson & Eklund, 2003). This was also evident in the studies of subjective experiences of CBT for psychosis reviewed earlier (1.10) (McGowan *et al*., 2005; Messari & Hallam, 2003). This suggests the centrality of the therapeutic alliance in therapy in general as well as CBT for psychosis.

Although both therapists and clients contribute to the therapeutic alliance, Baldwin, Wampold and Imel (2007) found that therapeutic outcome related to how well the therapist formed a positive relationship with the client and they suggest that therapists should consider their own part in forming relationships instead of concentrating on client characteristics. Kazdin (1986) emphasised how, in outcome studies treatment is seen as the independent variable but that little attention is placed on therapist or client factors in initiating change, and these are attempted to be minimised. He goes on further to say that usually no difference is found between different treatment methods which points to therapist variables and he suggests that perhaps this should be the focus of research. Outcome studies measure treatment variables but it is hard to disentangle treatment variables from client variables and therapist variables (Krause &

Lutz, 2009). They elaborate this by saying that treatment is nested within clients and clients are nested within therapists leaving the therapist ultimate professional responsibility for managing the process of therapy, irrelevant of the type of therapy and type of client. For this reason Krause and Lutz (2009) propose that treatment outcome depends on the therapist, how they do therapy and how they engage the client. This suggests that the therapist plays an important role in forming the therapeutic alliance or engaging clients. Engagement will now be discussed and further elements of the therapeutic alliance related to CBT for psychosis will be drawn upon.

1.11.1.1 The therapeutic alliance in cognitive behavioural therapy

Whilst the construct of the therapeutic alliance proposed by Bordin (1979) is a pantheoretical concept, it does differ slightly within different modalities. Within the model of CBT, collaboration is emphasised and therapy involves active participation of both client and therapist (Toner et al., 2000). The therapist and client work together to observe and comment on the client's thoughts, feelings and behaviours in order to offer solutions to the client's difficulties; they work together to help the client to reach their goals (Sanders & Wills, 2005). Within a collaborative therapeutic alliance, the therapist does not have hidden agendas or hypotheses about the client but rather makes all aspects of therapy explicit (Sanders & Wills, 2005). Rogers' (1957) core conditions of empathy, genuineness and unconditional positive regard are often seen as relevant despite the modality and are therefore important in CBT. CBT however has a tendency to place an emphasis on specific techniques and therefore relational qualities can often

be overlooked (Leahy, 2008). Within CBT, whilst a positive affective bond is seen as necessary for therapeutic change, it is not considered sufficient (Beck et al., 1979). Leahy (2008) describes how therapeutic tasks and goals in CBT may differ from other therapies in that they are focussed on present time, problem solving, behavioural change and a rational approach.

1.11.2 Engagement

The aims of early intervention services are likely to be diminished by poor treatment adherence and disengagement. The rates of disengagement in specialised early intervention services have been estimated at between 18% and 25% (Conus *et al*., 2010). It is therefore essential that engagement is addressed. Engagement will be reviewed in terms of general service engagement and therapeutic engagement.

1.11.2.1 Service engagement

Engagement involves developing trusting and collaborative relationships with clients and is seen as key to delivering support and services (Tait, Birchwood & Trower, 2002). Engagement of people with psychosis has been suggested as a priority as they can often be challenging to engage (Sainsbury Centre for Mental Health, 1998; Tait *et al*., 2002; Tait *et al*., 2010). Bertolote and McGorry (2005) discuss the importance of service engagement in early psychosis and point to the necessity to make services youth friendly and non-stigmatising to encourage young people to engage. Spencer *et al*. (2001) state that for a client to form a trusting relationship with services, a single key

worker or care coordinator should be allocated to each client as soon as they enter the service and that this worker should be allocated to them for their entire care within the early intervention service. They explain that adopting an assertive outreach model encourages engagement. This ensures that each member of staff has a low case load allowing frequent contact to establish trusting relationships. The model emphasises the importance of the team so that each member of the team knows every client to allow for matching of staff and clients and continuity of care in staff absences. Although engagement is seen as a process of forming a relationship or alliance between two people, the responsibility for forming and maintaining the relationship is seen as the responsibility of the clinician (Tait *et al*., 2010). Engagement is seen as key to working with people with early psychosis and clinicians have to attempt 'to overcome barriers to engagement by thinking of creative ways to make services more acceptable and relevant' to clients with early psychosis (Tait *et al*., 2010, p.35). In making services more useful to clients, they suggest helping clients with practical aspects of life for example accompanying a person to a leisure activity or playing football with them or any other things that may tap into the personal interests of clients.

'Keys to engagement' (Sainsbury Centre for Mental Health, 1998) highlights the reasons that some clients do not engage with services. This may be due to both characteristics of the client as well as of the service. Clients may be suspicious of services because of their upbringing, attitudes or experiences. Clients may experience staff attitudes such

as racism or sexism which effects engagement. Services can lack skilled and sensitive staff.

1.11.2.2 Measuring service engagement

Various scales have been developed to measure service engagement. For example Tait *et al*. (2002) developed the Service Engagement Scale to measure engagement with community mental health services. This is a scale on which the clinician rates the client according to availability, collaboration, treatment adherence and help seeking. This scale may be useful in thinking about whether a client engages with services or not but it places the onus of engagement on the client instead of seeing it as a process that occurs between two people. The scale is rated by the clinician and his or her view may be biased.

O'Brien *et al*. (2009) have developed an engagement scale which is rated by the client. The scale is focussed around the client's acceptance of the need for treatment and their perceived benefit of treatment. The scale has predictive validity. They suggest the need for such a scale as research shows poor concordance between clinician and client ratings of alliance and that this may be the case with engagement. O'Brien *et al*. (2009) note that alliance measures rated by clients are better predictors of outcome than those rated by clinicians. Although this is a useful measure, it does not do justice to engagement as a process between two people and does not say how people engage.

These measures look at whether a client engages or not, from either the clinician or client point of view but they do not look at the complexity of engagement and how it happens (or does not happen) in clinical practice.

1.11.2.3 Engagement and beliefs about mental health

Williams and Steer (2011) have linked engagement to beliefs about mental health problems. They base their work on the Self-Regulation Model which proposes that illness perceptions influence emotional responses such as treatment adherence. They suggest that investigation of illness perceptions may shed light on engagement in mental health services. They carried out a study investigating the relationship between participants' ratings on the Illness Perception Questionnaire for Schizophrenia and a self report version of an engagement measure. The results showed the two concepts to be partially related in people with psychosis. The constructs of illness perception related to engagement included: coherence and treatment control. This supports the hypothesis that people who hold a greater belief in treatment and have a coherent understanding of their psychosis will engage better with services. They use these findings to suggest that clinicians can improve engagement by helping clients to develop a coherent understanding of their psychosis and that they have some level of control over their symptoms. They link these findings to CBT for psychosis with its aims of developing a collaborative explanation of symptoms and to increase client control and autonomy. This study is useful in linking the concepts of illness beliefs and engagement but uses measures to examine the concepts and does not pay attention to the process of

engagement. Whilst the study draws attention to a collaborative understanding, it appears to imply that to some degree the client must adopt or partially adopt a medical model of understanding in order to see the relevance of treatment and therefore wish to engage. This in a sense goes against the idea of giving a client control.

1.11.2.4 Engagement and recovery style

Using the Service Engagement Scale (Tait *et al*., 2002), ratings of engagement have been linked to client recovery style (Tait, Birchwood & Trower, 2003). During recovery, clients can either integrate their psychotic experiences into their life experience or try to keep them separate and these different ways of recovering are referred to as integration and sealing over respectively (Tait *et al*., 2003). They have shown that recovery style and engagement are related, with sealing over recovery style related to lower service engagement than an integrative recovery style.

Thompson, McGorry and Harrigan (2003) linked recovery style and outcome in early psychosis, finding that clients with an integrative recovery style had a better outcome and functioning. They attribute this to clients being more open to discussing their psychosis and trying to understand it and therefore being more compliant with treatment as the benefits were apparent to them. They also found that recovery style changed over time and over a 12 month period most clients tended towards an integrative style. They therefore suggest the implementation of therapies that may influence recovery style to improve outcome and functioning. It does not seem

surprising that a client who wants to attempt to understand their psychosis would engage well with services but it is useful to have data showing this as it gives us an indication of the clients who may struggle with engagement. It is however important to note that measures used to assess recovery style and outcome were clinician and researcher rated. This means that whilst some of the constructs and ideas raised in this research may be useful, the research does not account for the subjective experiences of clients or clinicians. The scales may capture an aspect of their experience but do not do justice to the complexity of recovery. McGowan *et al*. (2005) in a qualitative study of therapists' and clients' experiences of CBT for psychosis gave examples of where therapists had considered clients to not be progressing in therapy but the client had reported benefitting from therapy. This shows how perhaps clinician ratings of outcome may not be the same as client ratings meaning that the results of the Thompson *et al*. (2003) study should be viewed with this in mind.

Because of the complex nature of engagement, it is necessary to look at it in a more detailed manner rather than using a measure of engagement. In doing this it is useful to review studies exploring client and therapist accounts of the process of engagement. This fits with the proposed research framework.

1.11.2.5 Subjective experiences of engagement

Priebe *et al*. (2005) carried out a study using grounded theory and thematic analysis to explore clients' accounts of engagement and disengagement in assertive outreach

services. They interviewed clients who had disengaged from services and then later re-engaged. They reported that clients spoke about a need for independence, a poor therapeutic relationship and loss of control related to the effects of medication as accounting for disengagement from services. In terms of engagement, clients drew attention to the importance of social support without a focus on medication, the commitment of clinicians as well as a partnership model of the therapeutic relationship. This study raised useful information and considers engagement as a process from the clients' perspective. The results draw attention to the importance of the therapeutic relationship in the process of engagement and disengagement. The study focuses on an assertive outreach model of working and Priebe *et al*. (2005) suggest further research to explore whether these results apply to other settings and they suggest an exploration of the views of clinicians in the process of engagement. The study focuses on the service as a whole, and not specific elements of it such as individual therapy.

James, Cushway and Fadden (2006) carried out a grounded theory study looking at engagement in family therapy with the aim of constructing a model of engagement from the therapists' perspective. They found a core category of humanity running through the accounts of the engagement process. Therapist qualities that they considered to fall into the category of humanity were professional integrity, treating a client as a person above anything else, honesty about who they were and being transparent about this at all times. James *et al*. (2006) used their results to show the importance of the human element of contact in family therapy as opposed to manualised treatment, showing the

centrality of the therapeutic relationship in engagement. They do note that the study was not carried out in real time and therefore cannot establish links between process and outcome. This study appears to provide a useful resource for family therapists on what might be important in attempting to engage families and it captures the complexity of the engagement process.

To the best of the researcher's knowledge, there are no studies looking at subjective experiences of engagement in early psychosis.

1.11.3 The importance of the therapeutic alliance and engagement in CBT for early psychosis

The literature specific to early psychosis is sparse and it is necessary to also review the broader literature of CBT in general and CBT for psychosis.

Álvarez-Jiménez *et al*. (2009) have carried out a study looking to build up a profile of clients who do not engage in CBT so as to be able to predict adherence or non-adherence to CBT for early psychosis. They found that a longer duration of untreated psychosis and a lower level of insight emerged as the strongest predictors of poor adherence to CBT. These findings point to the importance of treating psychosis early. Lowered insight indicates people may be less likely to want to try to understand their psychosis and this may mean that they may not wish to engage with a therapy which attempts to try to explain their psychosis. They use these findings to highlight the

importance of early intervention and strategies to promote insight in improving adherence to treatment and therefore potentially outcome. Whilst this study is useful in showing areas to focus on in service provision and therapy, it is does not take into account clients' or therapists' subjective experiences of therapeutic engagement. Nor does it explain how therapists can actually go about engaging clients in CBT or overcome the challenges involved in promoting insight.

Treatment non-adherence in CBT for psychosis was studied in relation to working alliance and recovery style (Startup, Wilding & Startup, 2006). They used rating scales to measure working alliance and recovery style. They found that clients who dropped out of treatment had a sealing over recovery style and showed less agreement with their therapists but did not differ from those who stayed in treatment in terms of their therapeutic bond. They deduce that the drop outs were not due to the therapists but to the clients' lack of curiosity about their psychosis (sealing over recovery style). This study may be helpful in building up profiles of clients who do not engage. However, it does not do justice to the complexity of the process of engagement and problematises the client.

Factors associated with the therapeutic alliance in CBT for psychosis were investigated by Evan-Jones, Peter and Barker (2009). They measured a series of client, therapist and therapy variables in relation to a measure of the therapeutic alliance rated by both therapists and clients on the Working Alliance Inventory. They found no client variables

to be related to the therapeutic alliance but that many therapist and therapy variables were related to a better therapeutic alliance. They found therapists' empathy, expertness and trustworthiness as well as the presentation of a formulation related to a stronger therapeutic alliance. They use these results to suggest that therapists *can* develop relationships with people with psychosis and that empathy is of importance. They also report some non-significant findings suggesting that confidence, experience and collaborative goals are important in therapeutic alliances. These results suggest that therapists have a greater influence than clients in determining the quality of the therapeutic relationship or alliance in CBT for psychosis. This study is useful in looking at elements of the therapeutic encounter and trying to link them to outcome. It focuses on the role of the therapist in forming the therapeutic relationship but it does not explain how a therapist may actually go about forming that relationship. The study is not specific to CBT in early psychosis.

Relationship building is a more useful term than engagement in CBT for psychosis as it emphasises both participants of therapy: the therapist and the client and therefore addresses the complexity of the process (Chadwick, 2006). There are several threats to the therapeutic relationship including: 'therapist failure in empathy, therapist beliefs, client beliefs…, a therapist being too anxiety provoking and the way therapists address delusions' (Chadwick, 2006, p.21; Chadwick, Birchwood & Trower, 1996). Chadwick (2006) describes how the factors with the greatest impact on relationship building are

therapists' beliefs and assumptions. These could be negative beliefs, also referred to as anti-collaborative beliefs. Examples of these are listed in table 1.1.

Table 1.1: Anti-collaborative beliefs and assumptions (Chadwick, 2006)

Belief	**Example**
Therapist failure	I am responsible for keeping this client in therapy
Risk to the therapist	People with psychosis are dangerous, they may harm me
Fear of harming the client	Therapeutic work may cause clients to commit suicide
Beliefs about the service	I can't ask others for help

Chadwick (2006, p.33-35) discusses positive assumptions which can help relationship building:

- 'The core of people with psychosis is essentially positive…
- Psychotic experience is continuous with ordinary experience…
- Therapists' responsibility is to radical collaboration and acceptance…
- Effective therapy depends on understanding sources of distress not sources of psychosis…
- Therapists aim to be themselves more fully with clients.'

Chadwick (2006) discusses these beliefs and assumption in detail and bases his model of CBT for psychosis on them. He does however state that the assumptions are not intended to be original and that he makes no attempt to back them up empirically. This approach to therapy highlights the importance of the therapist in building relationships.

The above discussion posits the importance of engagement or relationship building in CBT for psychosis and early psychosis as well as the role the therapist plays in this. The work of Chadwick (2006) further emphasises the importance of the therapist in forming a therapeutic relationship but there is little research in this area.

From the above discussion, it can be concluded that the therapeutic alliance is an essential element in therapy. Furthermore therapists play a crucial role in forming the alliance. For this reason, it may be important to focus research on therapists in terms of how they engage clients and conduct therapy.

1.12 Conclusion and research question

The above discussion has positioned the researcher as a critical realist and counselling psychologist. This has provided the framework for the critique of the literature and current research. The concepts of CBT and psychosis have been introduced and linked to form a rationale for CBT for psychosis. The area of early intervention for psychosis has been discussed. Individual CBT for early psychosis was reviewed as a potential intervention. Although the evidence for the efficacy of CBT for early psychosis is currently limited, it is a widely used form of therapy. The literature search did not reveal any studies researching experiences of CBT for early psychosis. Engagement was considered as key in early intervention services and in CBT for early psychosis. The role of the therapist in engaging and establishing a good therapeutic alliance with the client was reviewed. From this it has been concluded that the therapist is important in

establishing and maintaining a therapeutic alliance in CBT for early psychosis but it is not clear exactly how therapists may do this in clinical practice. Research into therapists' accounts of engaging people with early psychosis within the proposed research framework would therefore be a useful contribution to the literature.

- Research question: How do therapists engage people with early psychosis when working within a CBT perspective?

Chapter two: Methodology

2.1 Introduction

This chapter will outline and expand on the position of critical realism taken in the literature review (chapter one). This will be linked to the choice of grounded theory as a methodology to collect and analyse data. The participants, recruitment, an explanation of the interview design, data collection and the ethics involved in conducting this research will be discussed. An account of the analysis procedure and related process of evaluation, including a section on personal reflexivity will follow.

2.2 Critical realism

Ontology concerns the nature and reality of being whilst epistemology addresses the nature and acquirement of knowledge and the relationship between the knower and what can be known (Denzin & Lincoln, 2005). Axiology concerns the role of the researcher's beliefs and values in the process of research (Ponterotto, 2005). Ontology, by its nature informs epistemology, axiology and methodology, it therefore seems logical to take the philosophical understanding down to the basics of ontology.

Ontology exists on a continuum from realism to relativism and critical realism is positioned between the two, accommodating aspects of both (Willig, 2008). According to Ponterotto (2005) realism posits that there is an observable, measurable reality which exists independently of human existence. He goes on to say that relativism considers there to be multiple, constructed versions of reality rather than a single reality

and that these can only be accessed through subjectivity between people. Relativism acknowledges the role of the researcher's values and beliefs in shaping the research process and therefore any construction of reality is relative to the researcher (Ponterotto, 2005).

Stickley (2006) explains that in critical realism there are real structures that exist independently from people's experiences but that these structures can only be known imperfectly through subjectivity, construction and interpretation. He elaborates, saying that in critical realism all knowledge is local, provisional and context specific. From this description, it can be concluded that critical realism allows a researcher to hold a notion of reality that is separate from constructions or interpretations of it. It also allows the emphasis of the impact of the social context on the production of knowledge. The researcher has made the assumption that the data will reflect the participants' internal categories of understanding and can therefore be used to account for how the participants go about engaging people with early psychosis, this in part subscribes to a level of realism (Reicher, 2000). The researcher is also placing importance on the subjective experience of participants, the social context and the role of the researcher, this subscribes to a level of relativism (Ponterotto, 2005). For this reason, the researcher can be seen to be attempting to reconcile or accommodate realism and relativism. The researcher takes the position that knowledge acquisition involves subjectivity and interpretation of the meaning of real structures within context and that the results will be relative to the researcher. As critical realism acknowledges the

impact of the researcher on the research process, in terms of axiology, the researcher will attempt to outline and explain her personal and ontological reflexivity. This will be done by reviewing how the researcher's own values and beliefs as well as the position of critical realism have impacted on the research. Although the research is not focussed on the use of language, the researcher will give some consideration to the language that has been used in shaping the research.

2.3 Critical realism, the research question and grounded theory

In choosing a method to collect and analyse data, it was necessary to find a methodology which was suited to answering the research question and fitted the position of critical realism.

The research question of: 'How do therapists engage people with early psychosis when working within a CBT perspective?' was considered to fit with critical realism in that it requires a notion of reality. The concepts of engagement, CBT for psychosis and the service they worked in were considered to relate to real structures which the therapists had experienced. How therapists portray and interpret these experiences relies on a more relativistic approach of using interpretation and subjectivity to access meaning and to construct a theory. The research question therefore requires an accommodation of realism and relativism, making the stance of critical realism appropriate.

Grounded theory was considered a suitable methodology as it fits in with critical realism and is suited to answer questions related to social processes such as engagement. There is much debate within the grounded theory literature about the philosophical underpinnings of the approach resulting in various forms of grounded theory being developed ranging from naïve realist to radical constructionist versions (Madill *et al*., 2000). In this section a critical realist version of grounded theory will be argued for (Rennie, Phillips & Quartaro, 1988; Rennie, 2006). This is referred to by Madill *et al*. (2000) as a contextualist grounded theory.

Grounded theory relies on interpretation and an acknowledgement that although the researcher tries to bracket off their own values this can never be done completely, the theory constructed will therefore always be relative to the researcher (emphasising relativism) but it will also be grounded in the participants accounts (emphasising realism) (Rennie, 2000). According to Rennie (1998) analysing data involves interpretation which can be referred to as hermeneutics. The researcher is interpreting the participants interpretation of their experience, this is referred to as the double hermeneutic. Hermeneutic activity itself is considered relativist as it relies on the perspective of the researcher. Some obvious or manifest meanings merely require description which is objective (realism) and some of the meanings will be latent and require deeper level interpretation as well as drawing on shared language and culture and this entails relativism (Rennie, 1998). There is also an assumption in grounded theory that the interpretations of the data map onto the experiences of participants. It

is only through this assumption that it can be said that a theory is grounded in the accounts of participants and this assumes a notion of reality (Reicher, 2000).

2.4 Grounded theory

Grounded theory is a qualitative methodology with an emphasis on theory generation through inductive examination of information (Rennie *et al*., 1988). The method requires: data collection, constant comparison, categorising and memo writing leading to the determination of a core category resulting in the write-up of a theory (Glaser, 1978).

Psychologists were interviewed on a one-to-one basis and the interviews were transcribed and analysed using Rennie's version of grounded theory (Rennie *et al*., 1988; Rennie, 2006). The text of each interview was broken down into meaning units. To decide what a meaning unit is, the main point or theme of a given passage is interpreted. Each meaning unit was studied carefully and every meaning interpreted was represented by a category.

Categorising was done straight away from one meaning unit to the next rather than using the intermediate step of coding used by other grounded theorists (Charmaz, 2006). This prevented the data from being de-contextualised which kept the categories grounded in the data. Each new meaning unit was compared to all of the categories; this is known as constant comparison. Categories were constantly compared to each

other and if they were considered similar they were subsumed into one category. Subsumed categories were then referred to as properties meaning that categories are made up of properties. Theoretical sampling is when more data is gathered to focus on a category and its properties. This was carried out by recruiting further participants and through adjustment of the interview schedule. Further participants were recruited to explore categories already interpreted from the data. Questions for subsequent interviews were tailored to take into account the analysis of previous interviews so that categories could be explored further. Data analysis and collection continued until saturation of categories occurs. This means that the analysis of more data revealed no new categories, properties or links between categories.

Memo writing occurred alongside data analysis and collection serving to remind the researcher of thoughts and ideas about categories, their properties and definitions as analysis proceeded.

The categories, their links to each other and the memos were used to form the theory or model. The theory interpreted was considered to be grounded in the data.

2.5 What is meant by theory?

Theory needs to be considered within the proposed framework of critical realism with its emphasis on interpretation and subjectivity. Positivist definitions of theories are 'statements of relationships between abstract concepts that cover a wide range of

empirical observations' (Charmaz, 2006, p.125). In the current study, the term theory was not considered in the realist or positivist sense of trying to produce a universal, generalisable theory. The theory produced was the end product of the process of analysis and provided an explanatory framework for how therapists engage people with early psychosis.

2.6 Participants and recruitment

Participants in this study were psychologists with experience of working with people with early psychosis using a cognitive behavioural approach. The British Psychological Societies website was used to recruit participants. The search facilities were used to identify psychologists, using the criteria: accredited psychologist and experience of working with early psychosis. From this search, a list was compiled. The names of psychologists working within the field already known to the researcher were added to this list.

An email invitation was sent out to potential participants (Appendix A). Once a participant had agreed to be interviewed, an introductory letter (Appendix B) was sent to them, outlining the aims of the research and providing them with contact details of the researcher and the research supervisor. A suitable time and place to meet was agreed. All interviews were carried out in a private room at the participant's place of work. At the start of the meeting, the participants were asked to re-read the information sheet (Appendix C) which had been sent out with the introductory letter.

They were given the opportunity to ask any questions and then requested to sign the consent form (Appendix D).

In total, eight psychologists were recruited and interviewed although one of the participants served as the pilot and was used as a means of checking the interview schedule. Seven interviews were analysed. There were five male and two female participants. They were all chartered clinical psychologists registered with the Health Professions Council and British Psychological Society, working in the National Health Service in London. All of them had at least two years experience of working with people with early psychosis.

In line with the concept of theoretical sampling in grounded theory, two participants were specifically recruited for their known expertise in CBT for psychosis. One participant was recruited based upon the location of their work. This will be considered in more detail in the description of the analysis (2.9.3).

Notably, all participants were clinical psychologists whilst only the pilot interview was a counselling psychologist. Although this is an area that is relevant for counselling psychologists as more are entering the field, it is an area predominated by clinical psychologists as reflected in the participants used in this study. The reason for this may have related to recruitment stopping when saturation was reached as well as it being a time limited study. Two participants were recruited for their specific expertise and one

was recruited based on the location of their work. Notably, there was an interest in the study and various psychologists contacted me after I had completed the study, many of which were counselling psychologists. Collectively, these factors may have prevented the inclusion of counselling psychologists.

2.7 Semi-structured interviews

Semi-structured interviews were used to collect data as they allowed an open exchange but still allowed some guidelines in order to answer the research question. The interviews allowed subjectivism and interpretation but were still grounded in the research question, this is in line with the researcher's position of critical realism.

As the research followed a grounded theory methodology, each interview was informed by the analysis of previous interviews resulting in the interview schedule changing with each interview. The interviews were recorded using a digital dictaphone.

Appendix E shows the initial interview schedule. This interview schedule was based on the research question which was in turn based on the literature review, specifically the work of Chadwick (2006) in terms of how the client, the therapist and the therapy may influence engagement. This schedule was reviewed by a research tutor, a research supervisor and two peers. The following changes were made as a result of this review:

- It was decided that it would be beneficial to focus only on clients that therapists had worked well in case participants felt in some way judged or assessed by being asked about clients they were not able to engage.
- It was decided that the interview should open with a broader question about working with the client group instead of asking specifically about engagement at the start.

To accommodate these changes, interview schedule 2 was devised (Appendix F) and the pilot interview was carried out using this. During this interview it became clear that certain changes could be made to facilitate easier interviewing. The questions asking directly about the process of engagement seemed to be difficult to answer and the pilot participant suggested it may be useful instead to ask about specific challenges relating to engagement. Therefore, questions related to engagement were based on challenges that participants worked with and following the pilot interview, the schedule was amended to include questions about these challenges. These included:

- Sticking to the model of CBT
- Difference and diversity
- Diagnosis
- The service the participant worked in
- Recreational drug use

Questions about these challenges were framed in terms of how each impacted on engagement and based on the feedback following the pilot interview allowed

participants to reflect on the process of engagement in different circumstances to help provide a fuller picture. From this, interview schedule 3 (Appendix G) was produced. This schedule was used in the first interviews. As the interviews progressed, the questions altered slightly based on categories interpreted from the data. Appendix H shows the final interview schedule which includes all possible questions asked to participants throughout the data collection process.

The questions used in the research interviews were therefore based on the research question, the literature review as well as feedback from research tutor and the pilot participant. The questions were further amended to explore categories which had been interpreted from the data.

2.8 Ethics

All procedures were carried out in line with the British Psychological Society's Code of Ethics and Conduct (2009) so that at all times the four key ethical principles of respect, competence, responsibility and integrity were kept in mind and there was no deception throughout the research. An ethics application was submitted to the University of East London Ethics Committee and approval was granted (Appendix I).

Participants signed an informed consent (Appendix D) to participate in the study and were reminded of their right to withdraw at anytime. Following the interview,

participants were given the opportunity to ask the researcher any questions relating to the nature of the research and given a debriefing sheet (Appendix J).

The transcribed interviews were made anonymous by using a number rather than a name to indentify participants. All potential identifying material was removed from the transcripts. For example if the participant mentioned the area they worked in, this was referred to as 'an inner London borough'. If they mentioned a specific ethnic minority group which was germane to the area they worked in, the group was referred to as 'ethnic minority'.

All electronic documents and digital recordings pertaining to the research are stored on a password protected computer. All hard copies of documents are stored in a locked filing cabinet. The transcripts will be shredded and electronic copies of transcripts will be permanently deleted from the computer once they are no longer required.

Although all participants worked in the NHS, NHS ethics was not sought as recruitment was carried out independently of the NHS. As the BPS website was used to recruit participants, whether they worked privately or solely in the NHS was not known to the researcher until meeting individual participants. NHS ethics was therefore not deemed necessary for this study.

2.9 Analysis

The analysis of the transcripts followed Rennie's version of grounded theory (Rennie *et al*., 1988; Rennie, 2006). The steps include breaking the data into meaning units, categorising and linking categories with the help of memos to create a theory which is grounded in the original meaning units. Although this process is presented in a linear fashion, it is a circular process with a constant backwards and forwards between data collection and analysis.

2.9.1 Transcription

The recorded interviews were transcribed. It was not necessary to transcribe prosodic (rhythm, stress, intonation), paralinguistic (non-verbal vocal nuances) or extra-linguistic (outside the realm of language e.g. ums and ahs) parts of the interview as the focus of the study was not on the language used by participants but instead on the interpretation of meaning (Oliver, Serovitch & Mason, 2005). The transcription was carried out by the researcher which helped to familiarise the researcher with the transcripts before analysis. Each transcript was read several times to gain familiarity and an understanding of the participants' accounts.

2.9.2 Meaning units

Each transcript was broken down into meaning units. Each meaning unit described a particular point which the participant was making. The meaning units varied in length from one line to a page. Each meaning unit was described on an index card which

contained details to identify the exact text (transcript number, page number and line numbers). A short summary or one-liner of the meaning unit was also written onto the card. This was used to indentify the meaning unit but not for analytical purposes. An example of a meaning unit index card is shown in figure 2.1.

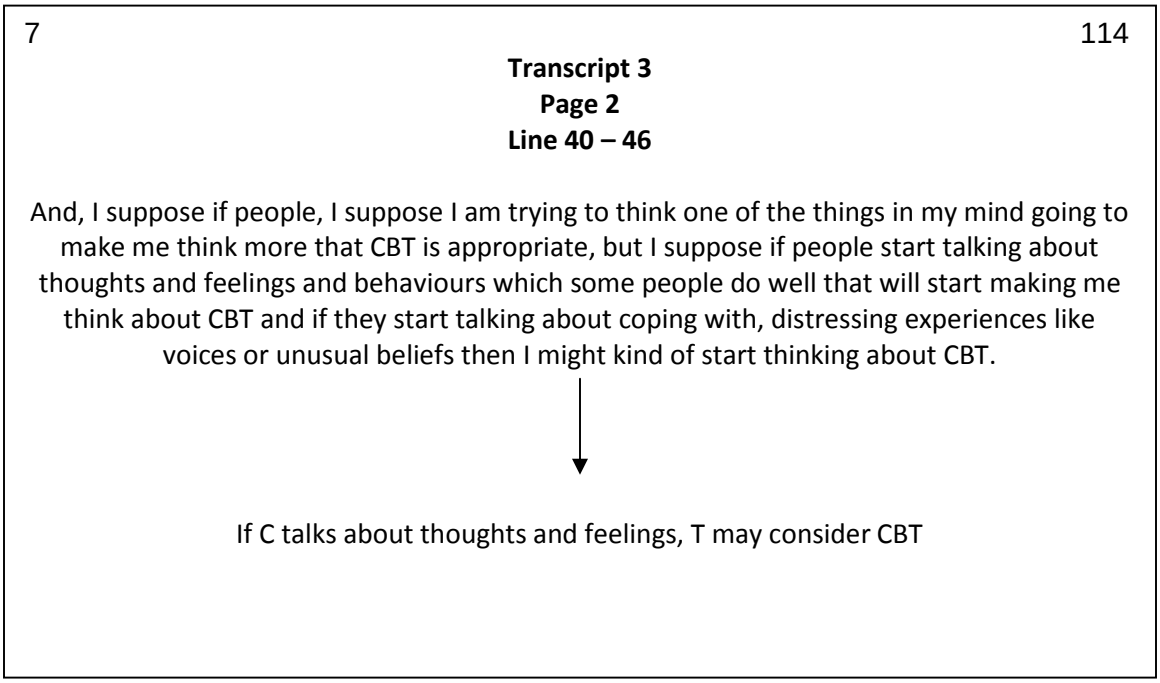


Figure 2.1: Example of a meaning unit index card

C denotes client, T denotes therapist. The number in the left top corner is the meaning unit number within this transcript and the number on the right is the meaning unit number in the entire analysis.

2.9.3 Categories, constant comparison and theoretical sampling

Each meaning unit was interpreted and given as many meanings as possible. Each meaning was considered a category. The categories that a meaning unit was assigned to were written on the back of the index card. For example the above meaning unit (Figure 2.1) was interpreted to mean that the therapist talking about being client led, being

flexible and discussing CBT/therapy. The meaning unit was therefore assigned to the categories: *therapy*, *flexibility* and *client led*.

A new set of cards was made to depict each category. Each category was represented on a different card. They contained the name of the category, the one-liner reminders of meaning units assigned to the category as well as references to the full transcript details. A category card therefore contains all references to meaning units which depict the category. An example of a category card is shown in figure 2.2.

Category: Client led

Transcript	***Page***	***Line***	***Condensed Meaning Unit***
T3	2	40 - 46	C talks about thoughts and feelings, T may consider CBT
T8	17	499 – 510	T adjusts to C
T6	3	70 – 72	T goes with what she brought
T5	3	70 – 80	T not an expert, guided by C
T4	7	209-211	T helps C to go in direction of what is important to C

Figure 2.2: Example of a category card

C denotes client, T denotes therapist. (This figure does not show all meaning units assigned to the category client led.)

Each new meaning unit was compared to all categories. If the meaning was similar, they were assigned to the same category and if different, a new category was created. The meaning units were assigned to as many categories as possible; this is referred to as open categorisation and differentiates grounded theory from content analysis. A category card therefore consisted of a selection of different meaning units from the transcripts.

The categories were kept quite open for example, the category *understanding* also consisted of examples of misunderstandings and this allowed for rich categories and helped to inform the properties of the categories. Keeping the meanings of categories open allowed the number of categories to be kept within manageable limits. Categories were compared to each other and if there were similarities, categories could be subsumed by another category or an all encompassing category and the subsumed categories were referred to as properties of the new category.

As categories were interpreted, these were used to inform the subsequent interviews as a means of theoretical sampling. For example, early in analysis, participants mentioned sometimes positioning themselves differently to others in the team to help engage clients. This was interpreted as flexible use of their identity and informed the category *flexibility* and its property *identity*. In subsequent interviews, participants were asked how they might position themselves in relation to others. This allowed the researcher to explore how psychologists may or may not use their identity flexibly.

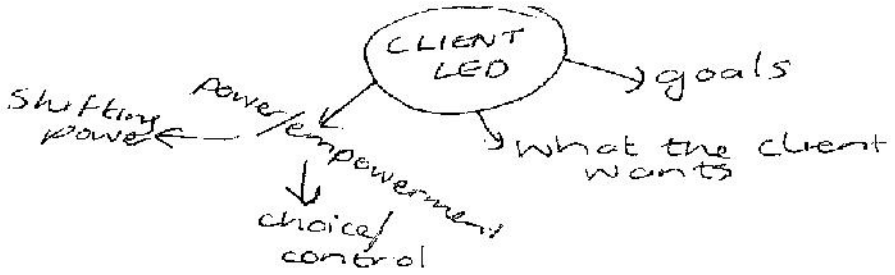
As a further means of theoretical sampling, analysis informed recruitment. For example ideas about the flexible use of CBT became apparent early in analysis. Some participants said that they felt no need to adhere strictly to CBT as they had not received specialist CBT for psychosis training or did not identify strongly with the model, despite claiming to work in this way. Two participants were then recruited, one who was known to have undergone the specialist training and one who was considered to be an expert in the field of CBT for psychosis. The analysis of these interviews yielded similar data in terms of the flexible use of CBT. Recruiting in this way helped to define the categories and added depth to the categories, confirming the emerging model. Another example is that various ideas about engaging people from ethnic minority groups emerged and informed the category *difference and diversity*. A further participant was recruited who was known to work in a less diverse area to explore this category further.

2.9.4 Memos

Memos were written with ideas about categories and how they may link up. Figure 2.3 is an example of a memo.

15/2/11 Memo re: category - client led

I think that 'what the client wants', 'power' and 'goals' can all be joined together as they all seem to be about being client focussed + client led. The term client led seems appropriate and the best label for the category as it was used by participants and seems to capture the essence of what they were conveying to me. I may also be influencing the label as I like to be client led as a therapist + value it as helpful.



This category seems to be in constant interplay with flexibility. At the same time, therapists were client led in a tender way. Being client led is also influenced by the context/outside influences as well as therapists experience.

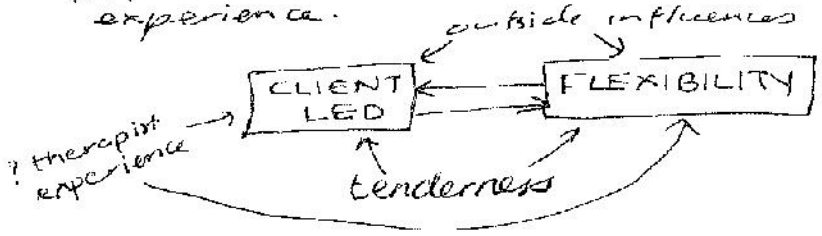


Figure 2.3: An example of a memo

2.9.5 Saturation and theory construction

Data was collected and analysed until no new categories or properties of categories were interpreted. This was a decision made by the researcher and the implications of this will be explored in the discussion (chapter four, 4.5.1). Categories were linked by looking at commonalities between them. Due to open categorisation, each meaning unit could appear in a number of categories. Therefore if two categories shared a number of meaning units, they were considered to be linked in some way. The links between all categories were considered and the categories, their links and the memos were used to form a theory or understanding of engagement grounded in the data.

2.10 Personal reflexivity

Guidelines for the publication of qualitative research recommend that the researcher be open about any background experiences, interests or values related to the research as this allows the reader to decide if this has impacted on the interpretation and analysis of the data (Elliot *et al*., 1999; Rennie, 2000; Harper, 2008). Being reflexive fits in with critical realism as outlined earlier. In contrast to the rest of the thesis, this section has been written as a first person account for ease of reading.

I am a 34 year old white, middle class female. I am currently a final year Counselling Psychologist in Training at the University of East London and have been working on this research for the past four years. As part of my training, I have spent three years

working clinically from a CBT perspective. I am therefore both a researcher and clinician but in a trainee capacity.

Prior to commencing training, I worked in an early intervention service and therefore have some knowledge of the client group and the work involved. I thoroughly enjoyed working in this service and thought highly of all the staff I was in contact with. I have a family member who has suffered with psychotic experiences and has found it challenging to engage in services.

These issues will be revisited in the discussion (chapter four, 4.5.3) and each will be looked at in terms of potential impact on the process of research.

2.11 Quality and evaluation

There are various guidelines for quality in qualitative research (Elliot *et al*., 1999; Madill *et al*., 2000; Morrow, 2005). In accordance with these guidelines, the researcher's philosophical position and personal reflexivity have been made clear and the research has been conducted in a manner consistent with the position taken. In addition to the above, a reflexive journal of the progress of the research and personal reflections of the analysis has been kept. The process of analysis was also carefully documented through memo writing. As a measure of quality control, the analysis was read by three colleagues who agreed with the researcher's interpretations. The final fit of the analysis and the data will be judged by the reader as to whether the theory appears to account

for the data – whether the theory is in fact grounded in the data. The researcher has aimed to be transparent about the analytic process throughout in order to aid the reader.

Chapter three: Results

3.1 Introduction

The interpretation of the data highlighted the process of engaging people with early psychosis being influenced by the categories: *tenderness*, *client led*, *flexibility*, *therapist influences* and *outside influences*. *Tenderness* is the core category and permeates through the other categories. The model as a whole will be introduced followed by a description of each category using sample quotations to illustrate these. In some instances quotes or part of quotes may be repeated in different categories due to open categorisation. The links between categories will be demonstrated throughout this chapter. Quotations are referenced in the following format: (therapist number: page number: line number).

3.2 Overview of therapists' accounts of relationship building in early psychosis

The therapeutic qualities of flexibility and client led are in continuous interplay to engage clients. Being client led focuses on what the client brings to sessions, their goals and empowerment. The therapist can be flexible in terms of their identity, the therapy they offer, their understanding and time. This process is permeated by *tenderness* which forms an essential part of engagement with people with early psychosis, influencing *flexibility* and *client led*. Therapist influences informed how client led or flexible therapists were and included: personal factors, experience and ideas about engagement. *Outside influences* have been conceptualised to surround the entire

process as they are the context within which engagement takes place. Figure 3.1 shows the model and Table 3.1 provides a summary of the categories and their properties.

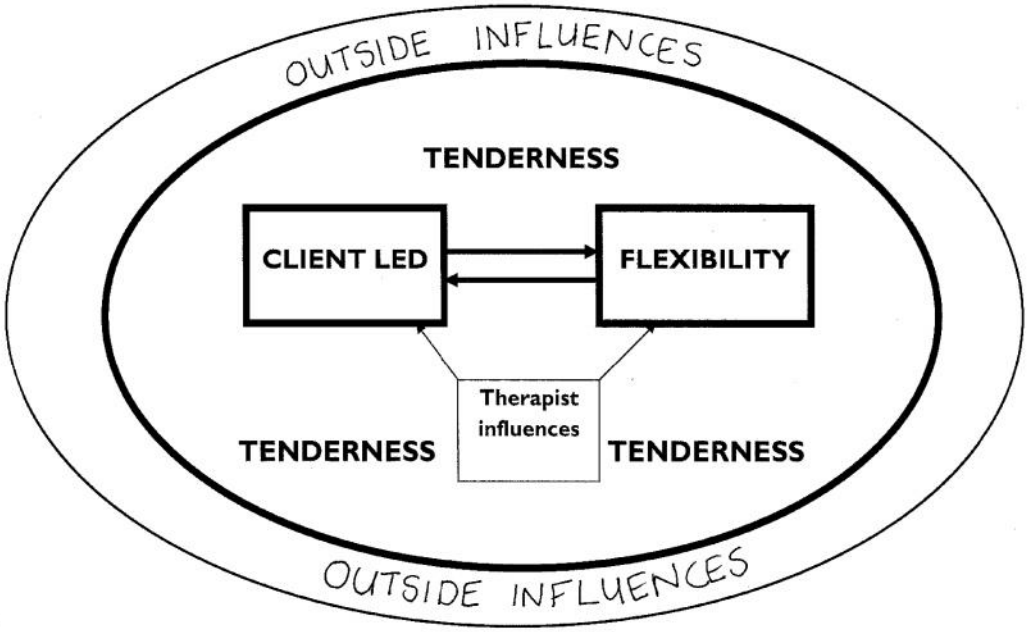


Figure 3.1: A model of engagement or relationship building in early psychosis from the therapists' perspective

Table 3.1: A summary of main categories and their properties

Tenderness
Compassion
Respect as an equal
Humility
Everyday things
Acceptance
Comfortable and relaxed
Trust
Client Led
Going with what the client wants
Client goals
Empowerment
Interplay between client led and flexibility
Flexibility
Identity
Understanding
Time
Therapy
Therapist influences
Personal influences
Experience
Ideas about engagement
Outside influences
Difference and diversity
Families
Team/service
Diagnosis
Recreational drugs

3.3 Tenderness

Tenderness is the core category and permeates all of the other categories interpreted from the data. Tenderness in this instance refers to being gentle, kind and humane, showing concern for the welfare of another person. In addition, the researcher has included aspects of the therapists' accounts related to being a person, treating other people as such and not treating them differently because of their mental health struggles as these qualities were seen to demonstrate tenderness. The properties of *tenderness* include: compassion, respect as an equal, humility, everyday things, acceptance, comfortable and relaxed and trust.

3.3.1 Compassion

Compassion can be defined as care and empathy for the feelings and suffering of others as well as a desire to alleviate suffering. Compassion was of utmost importance to the therapists when working with this client group:

> *"…generally, even with that group, if you keep talking and smiling and generally being nice, you can't go too far wrong." (7:1:28-29)*

Being compassionate with clients involved therapists being empathic:

> *"Well I think it's a lot of just general you know therapists' qualities that you know are sort of empathy, unconditional positive regard, you know the kind of, just the kind of generic sort of counselling type skills." (6:10:308-311)*

3.3.2 Respect as an equal

An intrinsic part of working with people with tenderness for the therapists was respecting their clients as an equal. This involved holding clients in esteem or admiration and regarding clients as people:

> *"…being a kind of normal human being and treating them like a normal human being." (3:4:119-120)*

> *"…there is something about being able to speak to people in non-patronising ways as an equal which has helped me…" (2:9:274-276)*

3.3.3 Humility

*Humility refer*s to the quality of being modest. Therapists in this study tended not to place great importance on their own opinions but rather tended to listen to and respect what others had to say. They were humble about what they know about their clients and about psychosis:

> *"I don't know everything, I will do my best when I don't know something I will seek some advice and I will be honest with you about what I think we can do together and being a real professional is being able to admit you don't know something" (5:22:655-658)*

When the therapist was unable to understand or empathise with the client, showing humility by saying that he/she did not understand appeared to encourage engagement:

> *"…maybe a lot of what they say doesn't make much sense or I find it hard to follow what they are saying, I tend to apologise for finding it hard to follow them. I try and reflect back the emotion at least that I think is behind what they might be saying, trying to validate that…" (5:2:32-36)*

3.3.4 Everyday things

Everyday things refers to activities unrelated to therapy that typical people would engage in on a regular basis. Therapists often did everyday things to help build relationships. This has been interpreted as *tenderness* as it involved treating clients as people:

> *"I have to (be) prepared to go off piste for sometimes two, three, four sessions, talking about all sorts of other stuff doing a bit of well intentioned tea and biscuits sometimes if it maintains engagement." (2:5:156-159)*

> *"…scope to do things with guys there's lots there on ward like play pool or going out and kicking a football around or going and doing things and once that is started and once that is there, there are a lot of opportunities there to go further with stuff." (4:12:396-399)*

3.3.5 Acceptance

Acceptance has been taken to mean therapists taking onboard and tolerating the opinions of their clients, even if different to their own. This was seen as a quality of tenderness:

> *"…not being too directive, not taking an expert position, not being you know trying to impose things on people…" (3:5:125-127)*

> *"…being open to different ways of looking at things and different ways of thinking about things and trying not to make assumptions about what the meaning of something might be but checking that out with the person so being ready for them to tell you about what things matter and what things work in their world and in their system rather than having a presupposed idea…" (8:4:102-107)*

Acceptance often involved not making a judgement or assumptions about what the client had to say:

> *"…not make assumptions about what sounds normal and what's not and how there is often quite a grey sort of patch in the middle there for people that may sound quite odd and bizarre to me but actually within the family, actually within the cultural context, actually not so much." (4:6:186-190)*

3.3.6 Comfortable and relaxed

Comfortable and relaxed refers to how the therapists behave and how they feel about themselves. *Tenderness* involved therapists being comfortable and relaxed about themselves and how they work:

> *"I have got a laid back style and I think that can sometimes help, being laid back with people and having an easy going approach, I think that helps with younger people and with people with psychosis as well potentially, yeah here we are a little less formal, just a little bit more easy going, I think that would help, it can help. Yeah being flexible I guess can help but some people need things a little bit more structured and a little bit more formalised that can help as well." (4:19:629-635)*

> *"…we could meet for a few times and you can see what I am like as a person and whether I am the sort of person that you could do some work with" (3:3:67-70)*

Therapists were able to be relaxed and comfortable in all situations, particularly when clients become distressed:

> *"Yeah I definitely I think yeah being able to tolerate confusion and quite a high level of distress and being able to kind of remain calm in the face of…. and hear and listen to people when they are very, very distressed and very frightened I mean people tend to have some very frightening experiences and sort of just*

yeah being able to just remain grounded with all of that going on I think is important." (6:19:597-602)

Being comfortable and relaxed involved the ability to use humour about themselves and in general:

"Therapist:…I have kind of always thought of it as my fault and not their fault if they are not engaging and trying harder I suppose.

Researcher: when you try harder, what do you do to try harder?

Therapist: More crap jokes, more smiling, self depreciation" (7:26:755-758)

Being relaxed seemed to spill into therapists' attitudes in that they were comfortable with who they were and how they worked and did not worry about fitting into specific therapist criteria. This may have made them appear more confident:

"..I don't feel any, what is the word, need to comply with the model, and I still feel that I am doing CBT." (3:10:306-307)

This level of comfort was also evident in the therapists' descriptions of the teams that they worked in:

"…the team in general, including the psychiatrist are very comfortable working with open diagnosis" (3:21:632-633)

3.3.7 Trust

Trust refers to therapists relying on clients' strength, integrity and ability in terms of things like making decisions or their behaviour. Therapists' ability to trust their clients was interpreted as an element of *tenderness*. Therapists had to trust clients to make decisions. Therapists also had to trust that the client's behaviour, no matter how confusing, had some meaning to the client. This trust is what enabled therapists to be *client led*:

> *"…we have group of people who decide not to take medication that does not mean that they are out of the service, we just try to engage them in other ways. The idea of a service is support, recovery and help in general. So if you have people engaged someway in the service then you know we have the opportunity to provide various things that might support their recovery. You know like taking medication is a good idea however, taking medication also exposes you to side effects and again people can make an informed choice..." (5:6:165-172)*

> *"…don't get lost in these hypothetical constructs about how people behave and actually look at the behaviour in front of you, the person is behaving for a purpose. You may not understand that purpose and frequently the people I see I don't initially understand why they behave the way they do but I am assuming that there is some purpose, there is something workable there…" (5:22:673-677)*

3.3.8 Interactions/links

Tenderness can be seen to permeate through and influences all of categories interpreted from the data; hence it is the core category. Therapists' ability to be client led and flexible to encourage engagement depends on their ability to show tenderness in their interactions with clients. How they allow their own personal influences to impact on engagement is reliant on their tenderness. Outside influences impact on the context in which therapists can demonstrate tenderness and therapists' tenderness in turn influences how they negotiate outside influences. Examples of the influence of tenderness are described throughout.

3.4 Client led

Fundamental to engagement was the therapists' ability to work in a client led manner. *Client led* refers to the therapy being guided by the client and an emphasis being placed on the clients' understanding of their experience, giving the client power and working towards client chosen goals. Allowing the client to feel at the centre of their own therapy encouraged engagement. The properties of *client led* include: going with what the client wants, client goals and empowerment.

3.4.1 Going with what the client wants

Client led is about working with whatever the client brings to therapy:

> *"…I suppose it is about trying to, find out what they are interested in working on really…" (3:3:87-88)*

Going with what the client wants may not always be apparent and it may take some time to figure this out:

> *"Possibly by not holding back a little bit and I suppose trying to tune into what they value." (2:16:510-511)*

Sometimes clients may not wish to engage in therapy at all and the therapists respected this decision. This shows overlap with the category *tenderness*:

> *"But ultimately, if they've come in to the room with you like within that position that I don't want to talk about it, that kind of does it with me you know, I can't really do anything that can change their mind" (3:6:165-168)*

By respecting a client's decision to disengage may make future engagement more likely:

> *"…quite often you know, well people will say I am not interested but then, down the line they will then come back to me and I think, I think that by allowing them to make that decision in the first place it then makes it much more likely that they will come back in the future."(3:4:101-104)*

All therapists were client led but in varying degrees:

> *"…really just went with whatever she brought…" (6:2:70)*

> *"…over the years I have become more strict with myself, I like to lead more and say what I think I can help with…" (7:2:51-52)*

3.4.2 Client goals

Being client led ties in with the clients' goals of therapy in that the client chooses their own goals to work towards. This helps to facilitate engagement:

> *"…psychology sessions are about the person themselves, it is about what they want to get out of sessions. It is not about what I want, what the team wants but that it is really personal and individual to what the person wants…" (4:4:100-104)*

> *"…thinking of it as always about getting them to go in a direction of what is important for them, you know do more of what is important." (4:7:209-211)*

Therapists attempted to relate client goals to the bigger picture of their life and then see how workable the goals were, but always letting the client make the decision about what is important to them:

> *"I guess I explore with people their goals about what, extending part of the goal, are they about personal gain or are they about a form of control over their experiences and whether that is workable so exploring whether these goals are actually workable for them and finding more workable goals if that is the case. And, sort of exploring all of the outcomes so if the goal, if someone came with the goal, I don't want to feel scared when I go to college. Well what is the ultimate outcome, you know like the miracle question if you woke up tomorrow and you weren't scared and you went to college, what would you be doing there?*

What is this about for you? And more broadly in your life is this the direction you want to go in? What is important about that for you? So that you know the means goal of getting rid of anxiety is about what actual end and we can focus on, there might be various ways of focusing on the end if too much focussing on the means is the problem." (5:15:432-445)

The same therapist focussed on how goals can sometimes be negative as they can keep people in a state of deprivation until the goal is attained and that this can be de-motivating, this therapist attempted to keep client goals positive:

"What do you want to approach that is good, not what do you want to get away from that is bad. So I am interested in helping the person to construct goals that are reinforcing each step that you make towards, so it is not like you are waiting and waiting and waiting and struggling with the anxiety and then one day you are at college, you discover you are not anxious anymore, hooray you have achieved your goal. It is like well, in going to college tomorrow, think about how you are going to be there and what is going to college about and trying to reinforce going to college is actually about something bigger than my anxiety and it is something I have chosen…" (5:15:454-463)

It was seen as important to link goals to homework or between session tasks:

"But then that kind of is working hard to think about making homework or stuff that is done outside of sessions relevant, applicable, interesting, fun and then

trying to really get a sense of what is it that stops people doing it. If it is simply that they forget, well then I might call them during the week and text them and remind them and stuff and do things like that. If it is just that they, you know, not even the word homework is a good way to start but thinking about how can I just translating stuff outside and making sense of what we talk about and thinking about getting people to be doing more I guess kind of linking it a lot with goals like thinking about what are we doing here, what is this for, what is this talking we are doing here" (4:17-18:561-570)

3.4.3 Empowerment

Empowerment refers to therapists giving strength, confidence and power to their clients. Being client led can empower clients to allow them to have choice and control over their lives:

"I think trying to give them the power to make the decision themselves and trying to give them enough information in order for them to make informed choices is the way to do it" (3:4:96-98)

"…giving people choice and letting people know what they are in for and letting them be in control of whether they engage in psychology." (5:5:147-149)

"…helping people to self regulate, to have personal control in their lives and so you know there might be a lot of working within what they believe and not really

sharing what I think has happened, it is not that relevant to them." (5:10:299-302)

Empowering clients allowed clients to take back some control:

"But I guess in the end, underneath it is still a sense of maybe we can have control over our behaviour, maybe we can decide where we go, what we have contact with out in the world – to a degree but not in our heads, a lot of, it seems to me like psychology says well actually we are not really in control of our minds very much at all. Well not the automatic parts of our, you know what ever pops into our head and actually if you can help people to notice that, that maybe you never really had that much control over your mind, as much as what you do with your hands and your feet, where you go, what you decide you want your life to be about. Those are all things that are within your control, typical choices to continue to make. ." (5:11-12:333-342)

The clients were often seen as having been stripped of their power by the system or their families and the therapy was often about giving them back some power to allow them control and choice in their lives:

"Researcher: It sounds quite important to be giving them a lot of power and…. Therapist: Yeah … working with young adults who may not have a lot of control in their lives for different reasons and who have recently got involved in a system

that often takes away power from people then you know I think that is very important." (3:5:128-133)

Services as a whole were sensitive to issues of authority and power with this client group:

"I think that is also because a lot of people have had difficult experiences with authorities when they were young that made them very sensitive to you know being subject to authority and I think early intervention teams generally kind of think about that quite a lot…" (6:19:574-577)

If therapists did not give clients power to make decisions, it could be detrimental to engagement:

"I think that if you try to push, try to cajole if you like and encourage too much then what tends to happen is that they will agree and then they will come for a few sessions and then they'll stop coming and then they won't come again sort of thing." (3:4:104-108)

Giving a client power involves the therapist not taking an expert position which is related to *tenderness* as the psychologist is humble:

"I certainly don't take the point of view that I am an expert and I understand this problem. So you could say, say there is someone who hears voices, I would say well I have worked for over ten years with people who hear voices and what I

have learned in that time is that everyone is different, you know there are some things that are similar in terms of what those experiences are like to cope with but I will be guided by you as to what you tell me about that." (5:3:71-77)

Empowering clients often means putting aside what the therapist thinks:

"…identifying with the client what the difficulty is, and trying to get how the client understands it and how it is not working for them, that is how you get into working with those kind of issues and whatever your presupposed agenda is, stays at the back of your mind as a presupposed agenda and not actually what your working on." (8:5:137-141)

Letting clients tell their own story can be empowering as they may not have been allowed to do so before. The following therapist described this in relation to assessments:

"I think the longer the assessment process the better. I think it is an interesting way of engaging someone, you know you are allowing someone to do in a way what they are a world expert at which is tell you about themselves. You know they are the world expert on themselves and there is something quite empowering I think for them to have a good, sufficiently, lengthy period of talking about themselves to you and telling you who they are and why they think the way they do." (2:25-26:802-808)

3.4.4 Interplay between client led and flexibility

Client led is in constant interplay with *flexibility.* Therapists are *flexible* in the way that they carry out their therapy in a *client led* manner. Further to this by being client led in their work, therapists have to be flexible and adaptable in their approach. These two categories therefore have a reciprocal relationship which forms a crucial part of the model:

> *"… tailoring it to what the person wants to work on so you would find out what their problems and goals are and then talk about CBT strategies that might help with that, so how could they get from where they are to where they want to be, what is the problem facing them and then suggest some strategies that might help with that." (8:3:69-74)*

3.5 Flexibility

Flexibility refers to the therapists' adaptability within their work and not working in a rigid or fixed manner. Therapists may have to work in a variety of different ways to suit the needs of their clients. *Flexibility* is essential when building relationships with people with early psychosis. The therapist has to be flexible to work with what is important to the client and is therefore in constant interplay with *client led*. The therapist constantly adjusts themselves and their therapy to the needs of the client. Therapists described themselves being flexible in terms of their identity, understanding, time and the therapy they offer.

3.5.1 Identity

Therapists juggled different identities in order to build relationships with clients. They took on various identities or roles to encourage engagement and used varying degrees of each.

They identified as a psychologist but also as a team member. They alternated between these two identities to encourage engagement depending on the needs of the client:

> *"…talking a lot about what a psychologist does and people ask what is the difference between a psychologist and a psychiatrist, occupational therapist, drama therapist, dance therapist and all the other kind of therapists there is so taking some time to explain to people what psychology is about and how it works…" (4:16:513-517)*

> *"I am a member of the team and I am broadly responsible for the decisions the team makes, just like any other members of the team…" (5:7:193-195)*

Male therapists were able to use their identity as a male to encourage engagement but also acknowledged that this was not always helpful and were therefore flexible in how they used this identity:

> *"Yeah I think that's probably a double edged sword. I don't know, I am kind of assuming I think in some respects it does help in that some guys you can kind of use the football metaphor and things that are blokey and that kind of thing can*

really help and just maybe helping them normalise stuff a little bit, helping them open up about things. The flip side is that if it is taken too far, it can maybe push some guys away they feel less comfortable opening up about feelings and then talking about difficult emotions and what's going for them. There has to be a set balance with that and I guess me being really flexible and not always doing the same thing with every guy I meet." (4:12:384-393)

Balance and flexibility in terms of the roles identified with by therapists appeared important in engagement, especially in terms of being friendly to clients:

"It is showing that you're sort of with them without wanting to be their best mate. So being friendly without wanting to be their friend if you see what I mean? Because if you look like you want to be their friend in a lot of cases, people are going to go running but if you are friendly then they might actually warm to you a bit more." (2:16-17:516-520)

"I am a psychologist, this is what I can offer and kind of being quite clear about the role but still kind of doing the other friendly stuff if that makes sense" (7:9:254:256)

Most of the therapists positioned themselves as different to others to help to build relationships:

> *"And so I suppose I am trying to set myself apart to some extent from other professions in the team if you like. Trying to say that you maybe actually coming and talking to me is different than talking to your psychiatrist or talking to your care coordinator where it is more likely that they will take a position that they think that this is what you should be doing you know, we think you should be taking medication or we think you should be talking it over or whatever. I think I don't have, my role is different to that as if it doesn't have to involve that so I am very tentative about imposing other things, like a model of working on them I think." (3:5:133-142)*

> *"So people getting a bit of a feel maybe a bit of a sense that a psychologist isn't all about, I don't know maybe a bit different from other people on the ward, in that we have got a bit of a different role." (4:2:43-46)*

> *"I may present psychology as a slight alternative to the other things that might be happening in their care…" (5:4:110-112)*

Sometimes therapists used their identity as a psychologist to stay away from some controversial issues which other team members may have to be more opinionated on:

> *"I think as a psychologist you can stay away from diagnosis quite easily." (6:12:382)*

> *"Yeah I mean I suppose again I would try to stay out of that, I would leave that to the care coordinator or the psychiatrist to see the person, you know if someone comes to me and they specifically want to work on their cannabis or reduce their cannabis then fine I will do it but if they come to me and say you know this isn't what I want to work on but I want to work on X, Y, Z then I generally wouldn't see it as a sort of exclusion criteria for psychology." (3:13:369-375)*

Therapists also tended to position their team as different to other services to encourage engagement:

> *"…being a separate community team you know, as we were saying before, not being so intimately connected with the hospital or with some of the other services even though obviously we do liaise with them a lot but I think that can help in those cases where people have had an admission and it hasn't been a particularly positive experience you know we can position ourselves as different to them. You know we can work with people on the ward about what we need to be doing to get this client out which I guess the ward should be doing as well but*

it might be harder for people to accept or understand the fact that the ward would want that." (3:7:195-203)

3.5.2 Understanding

Flexibility in understanding involves the therapist being open to different ways to make sense of things, depending on what the client brings and how they perceive their psychosis. Therapists' flexibility in understanding allows the client to be able to develop their own flexible and workable understanding about their psychosis and their experience. It means not imposing a way of thinking on the client, and in this way it is connected to *client led:*

"…framing it in a way that is acceptable for the person so it becomes something like dealing with the effects of the magic rather than the effects of mental health problems if that will allow them to accept services if indeed services are going to be able to address their needs …" (8:6:167-170)

"Even if people have kind of quite specific cultural explanations, I think it is still possible to either work within their model of understanding or sometimes, even though people may have a view they are happy to entertain different perspectives and different possibilities" (3:15:441-445)

Being flexible in understanding means not expecting a client to follow the same model of understanding that the therapist does and being open to different options and explanations, especially family and cultural explanations:

> *"…to suddenly expect them to sit down and demonstrate any insight into what on earth is going on for them when actually they are going through frightening, potentially frightening experiences and their cultural belief structure is providing them with a set explanations, an explanatory model that is about gin, black magic and depression and or the family who live down the road who's son didn't get into that school are jealous of you because you did get into that school they have put a spell on us. They are very, very powerful explanations for individuals who have been brought up within that frame of thinking. Why would they think any other way?" (2:5:130-139)*

> *"I think on a more broad level there is a notion about working with people with psychosis and their different explanations for making sense of what they're going through and then I guess a subset of that is that people have their cultural explanations so part of it I guess to me is, particularly in terms of like cultural explanations is trying to kind of, as I would do anyway, is to try and come at it with an open mind and where I felt like I didn't know something or it was out of my area of knowledge and like asking about it and just checking out with the person and just trying to help them to help me to understand where they are coming from." (4:6:176-185)*

Being flexible in understanding aims to create a shared understanding or collaboration but from within the client's frame of reference. One therapist acknowledged how essential this was but doubted that CBT was collaborative enough:

> *"I mean I think collaboration is absolutely vital, I mean I don't necessarily buy into the fact that CBT is collaborative, you know I think it is up to a point, at the end of the day, the model is the model and it is you know very much about socialising the person to the model, so I have some doubts about how truly collaborative it is. So yes, I think you need to be collaborative but sometimes I think you need to be more collaborative than actually the CBT model allows you to do or with you know. I suppose it comes down to how rigidly you feel you need to be doing CBT for psychosis you know." (3:9:269-277)*

Developing a shared and flexible understanding with clients did not involve changing clients' beliefs or ideas or attempting to convince them of the medical model of psychosis or a CBT based formulation. Therapists suggested that it was about being client led in developing understandings:

> *"So, you know sometimes people don't agree that it is a mental illness and don't agree that they need medication but can have a lot of insight into what their difficulties are and what causes them or how they come about without necessarily buying into that medical model. Sometimes people have cultural explanations which are completely appropriate for their culture but don't agree with the western scientific view so I don't agree that that they would be thought*

of as having insight. Sometimes people, I suspect have great insight into what is happening to them but they just don't want to talk to professionals about it so they say they don't want to talk about it or I don't know or whatever and then that then gets interpreted as a lack of insight." (3:14-15:427-437)

Although therapists did not try to change the beliefs and understandings of clients, they did explore how workable these understandings were. Therapists were mindful to keep their own understandings to themselves. The following quote highlights how this still may fall within a CBT framework:

"….there is this slightly ridiculous idea that CBT has its own agenda that you somehow impose on the client and if the client thinks it is black magic well that is a terrible difficulty for CBT isn't it because CBT of course thinks it is thoughts and behaviour and I think by identifying with the client what the difficulty is, and trying to get how the client understands it and how it is not working for them, that is how you get into working with those kind of issues and whatever your presupposed agenda is, stays at the back of your mind as a presupposed agenda and not actually what your working on. So if someone is explaining it is black magic and that is working for them, there is no problem with that. If someone is explaining it as black magic and that is getting in the way for them then you might want to look at what it is getting in the way and what it is about it that is getting in the way and how they might be able to tweak it to be able to do what they want to be able to do." (8:5:133-146)

By being flexible in their understanding, the therapists aimed to create a shared understanding with the client. This often meant helping the client to make a decision about the usefulness of psychology by helping them to understand it:

> *"Other things I might do is sometimes talking about psychology as using coaching metaphors especially for the young fellows and talking about, not necessarily, like that to have psychology doesn't necessarily mean there is something majorly wrong but that psychology can be something that is a bit like helping you get up to speed with things or brush up on stuff. I use the coaching metaphor quite a lot, particularly like with football for young guys and that seems to help a bit…" (4:11:344-350)*

Having flexibility in understanding often involves being confused and uncertain. Therapists placed emphasis on being able to tolerate this uncertainty and communicate it to their clients. This links to the category *tenderness* with being comfortable as a person and humility:

> *"I don't know everything, I will do my best when I don't know something I will seek some advice and I will be honest with you about what I think we can do together and being a real professional is being able to admit you don't know something …. There are lots of times when we don't have the answers ….And I say this to people I am working directly with, you know I didn't quite follow that or you know I am sorry I didn't quite get that. And I am not trying to do a*

Colombo technique or something I am just plain old confused. Yeah it is not giving up but it is also not thinking I have all the answers" (5:22:655-670)

There were some instances where therapists could not be flexible in their understanding. This was if a client presented an unreasonable or dangerous idea:

"I mean there are some things that are just so out there that I think it would be unhelpful to pretend it doesn't sound weird to me." (7:6:157-159)

3.5.3 Time

Flexibility with time was important to all therapists. They were flexible in terms of the time it may take to start to see a client and allowing the client time to build a relationship:

"…that engagement process can take quite a while, quite a fair amount of flexibility in terms of meeting times and maybe compared to other services, not letting people go if they don't turn up a few times, you know, getting on the phone and texting them and trying to work harder just even just meeting face to face without necessarily doing anything more than having a fairly low key chat kind of thing and then over time, hopefully as the client discovers that I am hopefully not that threatening and I am trying to be helpful then they might start to open up." (5:1:20-27)

Therapists also had to be conscious of timings around sessions offering shorter sessions or breaks where appropriate. They did this by being client led:

> *"…being flexible about timings and length of sessions and taking breaks in sessions and that kind of thing so I have met with people before where I have had to meet for ten minutes before we needed a cigarette break but then they have a five minute break and come back…" (8:17:489-493)*

3.5.4 Therapy

Therapists were flexible about the type of therapy they used. All identified as CBT therapists, but none of them adhered to a rigid CBT structure for their therapy:

> *"…what we mean by CBT would have to be much more elastic…" (2:5:144-145)*

When they did use CBT elements in their therapy, they had to be quite flexible over the use of these, very often simplifying CBT but to the needs of the client:

> *"…very diluted version, very very simple terms, again, depending on which population I am working with or which individual I am working with from whatever population" (2:6:162-164)*

Therapists saw their work as integrative rather than purely CBT and found this approach most helpful to engagement:

> *"…when I found it most helpful was when I could sort of integrate CBT ideas into a kind of general work when it fitted with the person…" (6:22:671-673)*

Therapists valued the role of the relationship over CBT techniques:

> *"I think building relationships is the key part really, I think it is much more about relationships than it is about techniques and CBT is probably only a part of what I do, I understand from books you have to be prescriptively CBT to get a clear message across and actually in real practice it is not like it is in the manuals and the conference presentations and things. It is much more integrative of other techniques and there is much more thinking on the hoof as well." (7:1:10-17)*

One therapist felt that some clients would not understand the model and that a structured form of CBT may not be appropriate for all clients in this client group:

> *"In terms of formally teaching the model, my experience is that clients generally don't get it with psychosis. Some of them do, the ones that do generally try it a bit and they really like it as well. That isn't to say that CBT doesn't work, it is more to say that a structured focus on logic and reason doesn't always work." (7:3:67-71)*

Therapists tended to focus on the behavioural aspects of CBT as this could tie in more easily with clients' needs:

> *"…maybe you do CBT with a big B. So you focus more on behaviours and strategies or you might do a bit more work on trying to identify …if that seems relevant I mean I think if you can get the person to where they want to get to..." (8:16:465-470)*

This was especially evident in relation to between session tasks. CBT often advocates written work between sessions, but therapists said that clients' found this difficult and did not do it. For this reason, the written work was either simplified or behavioural tasks related to goals were given importance. Therapists had to be flexible in their use of between session tasks to suit the needs of individual clients:

> *"..think about making homework or stuff that is done outside of sessions relevant, applicable, interesting, fun and then trying to really get a sense of what is it that stops people doing it. If it is simply that they forget, well then I might call them during the week and text them and remind them and stuff and do things like that. If it is just that they, you know, not even the word homework is a good way to start but thinking about how can I just translating stuff outside and making sense of what we talk about and thinking about getting people to be doing more I guess kind of linking it a lot with goals like thinking about what are we doing here, what is this for, what is this talking we are doing here, what is this for" (4:17:561-571)*

3.6 Therapist influences

Therapist influences included personal influences, experience and therapists' ideas about engagement. These were interpreted to influence how client led and flexible a therapist could be thus showing the connection between these three categories.

3.6.1 Personal influences

Most of the therapists were reluctant to talk about personal aspects of their life and how these may influence their therapy although two therapists were open and described their personal background and personal values to be important in their work:

> *"I think yeah my own individual, sort of social rearing and my early academic professional background I think have contributed to the way I approach my work and I think to some success with that." (2:10:305-308)*

> *"Probably in terms of my values, at heart I am a liberal, small l liberal, so even though I do think that our society is made up of forces of people and groups of people and all of this sort of stuff, at the end of the day, as an individual, can you exercise as much freedom as you can? So, my interest is how is it that we end up stuck as human beings? I don't think my job is to help people adjust to really crap social circumstances. I think as a therapist, my job is to help people notice the things they can change and the things that they can't…" (5:20:589-596)*

3.6.2 Experience

Experience refers to the experience a therapist has had working in the field. All therapists mentioned experience as influencing their work:

> *"…the more you work with a client group, the more experience you have, the more you know things you know to try, experience you have of what works and what doesn't work…" (3:19:585:588)*

"It is mainly confidence, I suppose I am much more confident to just launch into doing what I do and when I am with a trainee you can see that they head in and are very, very cautious which is right and a good thing but the more experience you get the easier it gets. It does help." (7:27:800-803)

"…the more you experience, the less anxious you are going to be about engaging people…" (2:21:670-671)

3.6.3 Ideas about engagement

Therapists talked about their ideas of the concept of engagement and emphasised that this was a process between people and it was the responsibility of the therapist to engage the client. It was seen as fundamental to working with this client group and the implication of this is that it is an ongoing process, not an obstacle that needs to be overcome at the beginning of therapy:

"I suppose I don't see it in that way, I see it as a process anyway and I see the onus as being on the therapist to present things in such a way so the person wishes to engage." (8:22:666-668)

"…it is just being nice, getting on with people. It is fundamental to what we do, it shouldn't be an issue it should be a given in all cases really." (7:21:623-625)

One therapist reported that engagement could be seen as a process between two people. It was however noted that when engagement was discussed as a team setting, the role that therapists played in the process was not always considered:

> *"…it is a two way street and if someone is not able to engage as it were it is not really a reflection of them. I know we talk about it as a team when we have the team meeting and I don't really think about so much how we as practitioners, what we offer and bring to the table." (4:20:649-653)*

It was suggested that the word engagement may not be helpful as it places the onus on the client to engage instead of seeing it as a process:

> *"I mean it definitely sets up a particular paradigm and it doesn't really sit with the kind of ethos of you know meeting people where they're at. I don't think it's a very helpful term but I don't think, I don't think it's something that I've ever used the word with a client and I think it's quite important to be aware of it and connotations when using it but it is used so widely in therapy and it communicates something." (6:20-21:634-640)*

3.7 Outside influences

The therapists described how outside influences impacted on the client, the therapist and the therapy. The category *outside influences* places engagement in context; it is the backdrop in which it occurs. Therapists negotiated outside influences using *flexibility*, being *client led* and showing *tenderness*. This category is represented diagrammatically

in figure 3.2 as not all elements of this category have been reported and expanded on due to its size.

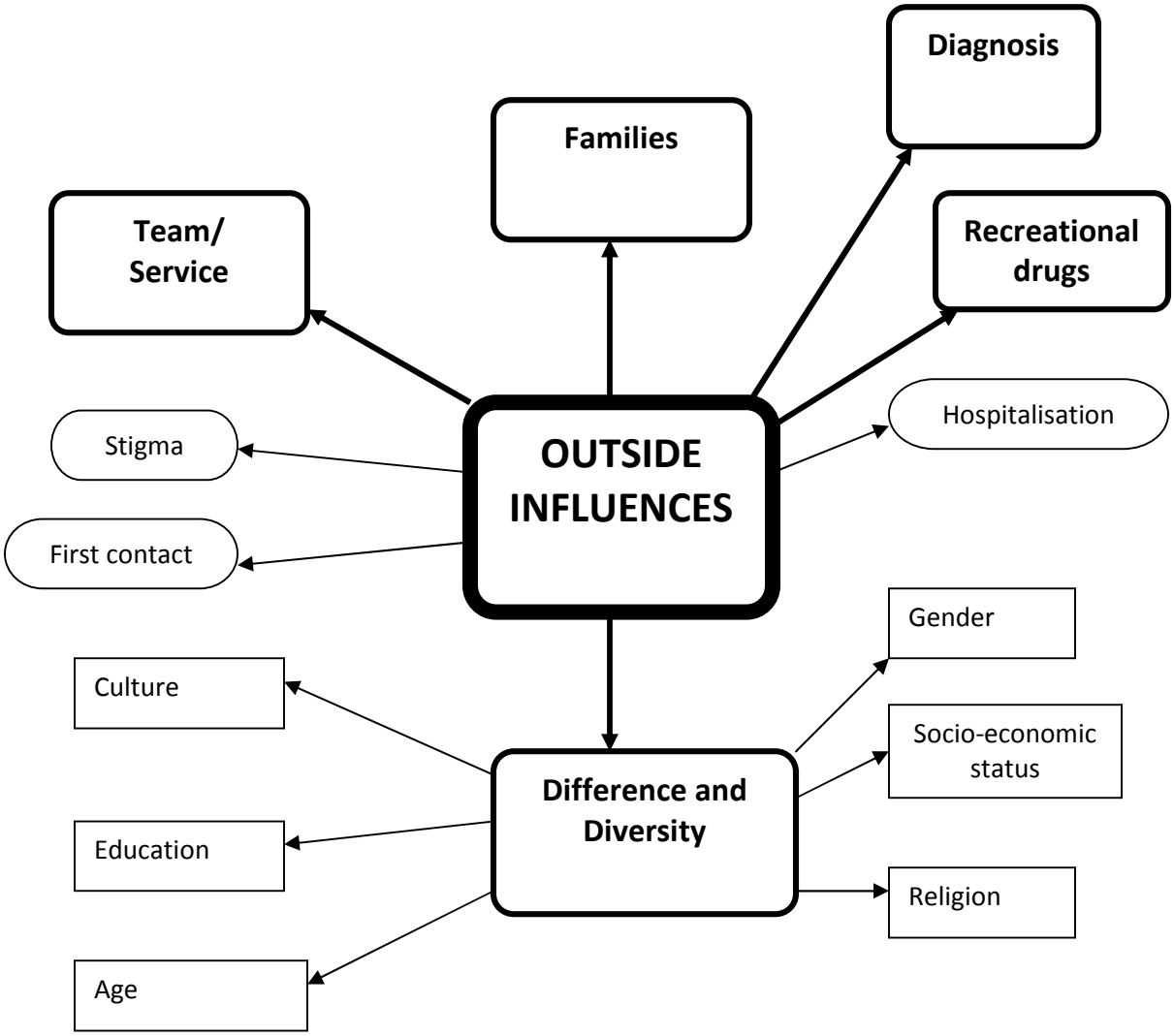


Figure 3.2: Diagrammatic representation of the category outside influences

Stigma, first contact and hospitalisation have not been discussed in the text

3.7.1 Difference and diversity

Difference and diversity encompasses all of the ways in which the therapist and the client may be different or the same including: culture, education, religion, socioeconomic status, age and gender. The therapists worked with this using flexibility and a client led approach to their work to invite conversations about difference and diversity:

> *"What I have found always works well and I try to make sure I always do with clients, if there is cultural difference there, is invite them to tell me about their culture and say look, I don't know what it is like for you sitting here talking to some you know forty year old white guy who has been to uni, you know, what do you think of that? What do you think of me? What would worry you or concern you about talking to me? You're a 19 year old 'ethnic minority' young lady. I can tell from your dress that you come from quite a traditional background you know you have got the veil on etcetera what is it like talking to me and what would you want me to know about you and what might be difficult for you to talk about and how are we going to work with that? Can you tell you a bit more about your culture, you know, what are you into?" (2:17:525-536)*

When therapists talked about cultural differences, it raised the idea of differences in beliefs about mental illness and how to manage that. All of the therapists spoke about being open to different beliefs and not trying to convince people to change their beliefs. Therapists described how it was important to focus on the clients' goals when thinking

about beliefs and looking at what was or was not helpful. This links with *flexibility* (*understanding)* and *client led (goals)*:

> *"I would be always sort of coming into it with you know a sense of curiosity and openness and not and trying to be thinking about how they are understanding of that problem and in ways in which it might be unhelpful for them and or also helpful at the same time. So not coming into it with an angle of obviously that I know better or that you're a psychotic and you need to think more rationally or clearly about it. Not that at all, but more about helping them get the space to kind of talk through and explain what's going on for them and in thinking about their understanding them I guess in terms of relevance to their goals and what is important to their life." (4:6-7:193–202)*

In thinking about different beliefs about mental illness, all of the therapists were flexible in their thinking and encouraged clients to consider different explanations:

> *"You know people are generally I think quite good at juggling different perspectives and different understandings I think. Certainly if people do have a very fixed cultural view, I wouldn't see it as my job to try and change that or try and get them to believe a different model." (3:15-16: 463-466)*

In some instances difference and diversity presented difficulties to engagement. Therapists suggested some groups did not engage for various reasons:

> *"I am thinking particularly of black, afro Caribbean men, you know there are ideas that are quite well founded that they don't get treated fairly, they are more likely to be medicated, they are more likely to be put on section and things like that which are all born out by facts. So there is a reluctance to get involved in services, there are other communities which are reluctant to involve anyone from outside the communities…" (3:17:509-515)*

One therapist talked about the importance of the team in helping to overcome challenges arising from difference and diversity in relation to culture:

> *"…the team increasingly began to reflect on its own cultural or ethnic make up to reflect the population that we were serving and that was incredibly helpful for us as a team when people thought and thought it is not just a bunch of white people trying to do good for the local community, these people are actually, some of them are of the local community and understand therefore you know they are part of it you know, they know the score." (3:10:318-324)*

There was an agreement between most therapists that white middle class clients posed less of a challenge to engagement than ethnic minority groups. The therapists varied on whether they accounted this to the nature of CBT or to the familiarity of this group with the structure of health services and perhaps their educational advantages:

> *"I think my own experience has been that the middle classes, the Caucasian middle classes have an existing understanding of and relationship to social structures and structures of help in society which put them at an advantage compared to other groups which means that where engaging is concerned they are in my experience much easier to engage." (2:3:71-76)*

> *"…people who are, have many full advantages in life and you know those sorts of folks tend to engage really easily in talking therapy." (5:1:11-13)*

3.7.2 Families

Due to their age, this client group often live at home with their families. Therefore there can be family involvement in treatment. They can be involved in individual work as well as family therapy. The category f*amilies* has some overlap with *difference and diversity* as often therapists talked about engaging families from other cultures. Engaging families was considered by therapists as essential in getting the client on board with the therapy:

> *"I probably, there are quite a few that are so chaotic but there is no real way of contacting them in the morning of the appointment, I generally ring their mums*

or their dads and they will be the ones that make sure that the client turns up on time." (7:14:401-405)

Therapists approached the involvement of families in a client led and flexible manner:

"Yeah, it kind of varies with different people. Some people from the outset, it is really clear they just want individual sessions and they really want to keep their families separate and stuff. Then other times it might be a case that it is really clear that the family needs to be involved from the outset, it is more a systemic problem or issue and it can kind of go that way. But often times it is more of a combination, maybe starting to see someone individually, do some family work, meet the family and incorporate some of the stuff there and then go back to meeting individually and sort of doing things a little bit organically if that is the way to put it, kind of a little bit as the need kind of comes up." (4:13: 416-425)

"If you go to someone's home and the family are there you have got a better chance of getting an individual on board with you if you have got their family on board with you too…" (2:17:539-541)

Whilst it is seen as helpful to engage families and involve them in treatment, therapists acknowledged that they often did not manage to engage all families and that this was perhaps an area for further work:

> *"So we tend to, where family members are involved they tend to be more over involved than under involved with services. We probably, we need to do a lot more with those sorts of families that we don't get to engage. If it comes up in the course of therapy that I think it would be useful then I will try to insist on having a family meeting or three and there is sort of a fifty-fifty record of getting them up and running for therapy and sometimes they do and then it works really well when they do." (7:14:413-420)*

On some occasions, families could also pose challenges to engagement:

> *"…there are families with high expectations of sort of recovery and what the person is going to do. So the family can put pressure on the service, understandably, you know it has been three months now and they are not back at work or whatever so there is that kind of issue that can make the person feel you know, not want to engage with services either because they are also thinking well services haven't fixed anything yet. Or it can make them feel a bit despondent that they are not doing sufficiently well or as well as their family expect and I think that is probably more of an issue in early psychosis than further down the line where people have come to some degree of acceptance,*

even if that might be quite upsetting, that things aren't going to change very quickly." (8:8:217-227)

When families posed challenges to engagement, therapists considered that this may be related to perceived stigma for the family. The following therapist gave an example of this related to ethnic minority groups:

"I think because of the concerns about the stigma that will attach to the family in general which I don't think are necessarily, well they can still come up in white middle class western families but for instance the idea that if the young person is involved in services it will then become impossible to organise marriage for them, you know that kind of idea is not going to, probably not going to come up in a white British family. There are times when the young person themselves is very happy to work with us and to look at thing from a western medical view point but the family is reluctant to do that and reluctant to let the person do that. Sometimes working with the family, as well as CBT, one of the main psychological therapies that we offer is family work, sometimes you can overcome that with family work and sometimes you can't. We at this service only work with people who are over 18, so to some extent there is the possibility of working with the person individually if their family are reluctant, but for some people they are not going to want to do that, they are not going to want to go against their family." (3:18:548-564)

3.7.3 Team/service

The service or team within which the therapists worked was vital for engagement. The team played an important role in engaging clients and in all cases the client would be well engaged with the team in general before seeing a psychologist. The work of the team was seen as laying the foundations for later work:

> *".....the process of engaging them in psychology and CBT perhaps ultimately, starts right at the beginning really and there may have been all sorts of ground work done if you like by the care coordinator and by other people in the team before they even sort of get to see me…" (3:8:242-245)*

The location of the team was seen as important by all therapists as well as having a relaxed, youth focussed attitude to work in order to relate to clients and to help to reduce stigma:

> *"Yes and I think that is also because a lot of people have had difficult experiences with authorities when they were young that made them very sensitive to you know being subject to authority and I think early intervention teams generally kind of think about that quite a lot in terms of you know not being in the hospital buildings I mean definitely you know we dressed more casually there than I do in this job and you know I wore my jeans you know and that kind of rather than looking a bit smarter like in an adult psychology service" (6:19:574-581)*

All of the therapists spoke about their services offering an open door policy in terms of psychology. People could attend whenever they wanted for the duration that they were with the service and there were no waiting lists:

> *"Anyway, it is not a one shot deal either I mean they can try seeing me or one of the other psychologists here, you know, they can drop out, they can always come back, the door is always open while they are seeing the team." (5:5:151-154)*

Therapists valued groups run by the team which helped with engagement and normalised the experience of psychosis:

> *"So for example sitting around in groups and hearing other people say yeah I hear voices as well and people probably haven't heard of people that had any kind of mental health issues before ever and to hear other people say it and these other people who are relatively normal and look ok and I think that can have a benefit…" (4:10-11:331-336)*

3.7.4 Diagnosis

Early intervention services encourage diagnostic uncertainty and try to withhold diagnosis for as long as possible but often this is not the case and can impact on engagement:

> *"…as a team we tend not to diagnose people and I think that is a really important thing in terms of engagement. However, we work in a system where we are almost forced to give diagnoses to people which is fine because sometimes that*

can kind of be contained in the bureaucracy and doesn't actually have to impact on the work that you are doing with a client but interestingly sometimes it can filter out." (3:20: 598-604)

The therapists approached diagnosis in a *flexible* and *client led* way. Some clients were happy to have a diagnosis and others find it stigmatising and the therapist would explore this with them and give them information about diagnoses if necessary:

"…depends on their position, some people are quite comfortable with the idea of diagnosis and accepting of it in which case, it is not something I would see as something to kind of work on whereas other people are very much questioning of the diagnosis, their specific diagnosis and the whole idea of diagnosis and with those people I am more than happy to embark on some exploration of what diagnosis is and what is good and what is bad about the idea I suppose." (3:20:608-614)

"…it would depend on the person but my usual way of working is to talk about diagnosis for what it is, it is a medical label and it comes from fitting a set of criteria and that is what it is. You know I usually, depends on the person and what they are able to take on board but I talk openly about what diagnosis is, so you know it is just a label but within that people have very different presentation and very different pathways and we talk about it from that point of view and I think very much in the recovery oriented way…" (8:12:354-360)

3.7.5 Recreational drugs

All therapists described recreational drug use to be an issue when working with clients with early psychosis. It was seen to be expected of this client group:

> *"One of the things I think about the team is partly because of where it is, in a sense I think we can be a little bit blasé about it (laughs) we can almost sort of…. expect it and therefore maybe sometimes not focus in on it as much as, it may or may not be helpful to do. So it is something we just sort of roll with if you like, so we expect it and we work despite it." (3:13:394-401)*

The therapists tried to take a non-judgmental and flexible approach to recreational drug use so as not to encourage disengagement. They generally tried to explore the positive and negative aspects of this from the client's perspective:

> *"So it is more useful to maybe talk about workability or again to talk about this activity in the broader context of their life and what is workable, you know certainly for some people they don't see, their substance misuse is maybe part of their culture…." (5:17:509-513)*

Therapists try to work flexibly to overcome the difficulties recreational drug use may present to the sessions:

> *"…making sense of why someone is doing that. Does that point towards the need to do something different in sessions, to kind of tone things down a little bit and*

make it so it's not so anxiety provoking so I would suggest that and doing that kind of stuff, making sessions shorter." (4:19:605-609)

"…are there other ways of getting around it because they smoke their spliff an hour earlier then they are not quite so foggy when they come to the session…" (8:9:264-266)

Chapter four: Discussion

4.1 Introduction

This chapter will briefly summarise the findings of the study by discussing how they have answered the research question. The findings will then be reviewed in relation to the position taken by the researcher and the literature. This will be followed by a critical review of the research including: limitations, evaluation and reflections of the researcher. The practical and research implications will be outlined.

There is much debate in grounded theory as to whether the literature should be reviewed before data collection as this may direct the collection of data around points of interest to the researcher (Charmaz, 2006). With this in mind, the literature around the concept of therapeutic engagement was initially reviewed in order to justify the study. After the data was collected and analysed the literature was then reviewed with respect to the categories that emerged. Therefore the results of this study will be discussed in relation to the literature review (chapter one) and new literature will be considered in view of the findings.

4.2 Answering the research question

This study aimed to explore how therapists engage people with early psychosis when working from a cognitive behavioural perspective. The analysis showed some aspects of what therapists contribute to engagement as well as some of the challenges involved. The results showed therapists focussing on the therapeutic alliance in working to

engage people. Therapists demonstrated the importance of working in a tender, client led and flexible way to form this relationship. Tenderness was at the heart of the model and was evident in all aspects of the therapists' work and was thus conceptualised as the core category. The model shows how in engaging and working with clients with early psychosis, therapists tended to use the model of CBT flexibly; they often did not seem to operate along their professed CBT guidelines. Flexibility in the use of CBT was something that came about early in data analysis and was therefore explored through the use of theoretical sampling. Firstly all participants were asked about the use of CBT and sticking to the model. As most participants seemed to not adhere to CBT, two participants were sought to understand this further. The analysis of these subsequent interviews yielded similar data and added depth to the categories by confirming the emerging model. The model showed the importance of working in a client led way when engaging and working with this client group. Therapists demonstrated that they were perhaps more client led than collaborative further supporting the notion that they may not adhere to a cognitive behavioural way of working.

4.3 Findings in relation to the position of the researcher

4.3.1 Critical realism

The researcher has taken the position of critical realism. In line with this position the study has focussed on subjective accounts of therapists in engaging people with early psychosis. The service participants worked in, CBT and engagement were considered as real structures and the results showed therapists' subjective accounts of these. The

model interpreted from the data is coherent with the position of critical realism. It is important to note that this is not an outcome study and therefore no claims about therapeutic outcome can be made. The possible limitations of taking this position as well as the reflections of the researcher related to critical realism will be discussed in the critical review section (4.5) of this chapter.

4.3.2 Counselling psychology

The literature review (chapter one, 1.3) outlined the importance of research in counselling psychology. By focussing on subjectivity the researcher has worked within the values of counselling psychology. In doing this, it is hoped that this research will be meaningful to practitioners and help to narrow the science-practice divide. Counselling psychology places emphasis on the value of the therapeutic relationship in practice and research. Similarly, this study has shown the centrality of the therapeutic relationship when working with people with early psychosis.

There have been no other studies exploring therapists' experiences of engaging people with early psychosis when working from a cognitive behavioural perspective. This research is therefore an original contribution to counselling psychology and to the literature around early psychosis. There are an increasing number of counselling psychologists working in early intervention services and this research may therefore be useful to counselling psychologists.

4.4 How the findings relate to the literature

4.4.1 The therapeutic alliance

This section will outline the importance of the therapeutic alliance in the process of engagement. It will then go on to consider how the findings are in line with the work of Rogers (1957) and Chadwick (2006). The concepts of expressed emotion and compassion will be considered as the findings of the current study can be linked to these in terms of qualities a therapist may use to foster engagement. Therapists' ideas about engagement will then be considered.

4.4.1.1 The importance of the therapeutic alliance in the process of engagement

The model highlights how therapists viewed engagement or relationship building as fundamental to what they do in CBT for early psychosis. Although the model included aspects of CBT, it was mainly based on non-CBT specific factors or relational factors. The model interpreted from the data maps on to Bordin's (1979) pantheoretical model of the therapeutic alliance. The core category *tenderness* could be linked to what Bordin (1979) considered the positive emotional bond. This category was seen to permeate all others categories. It is plausible that when working with people with early psychosis, this positive emotional bond may be integral to any therapeutic work, or perhaps precede it. The category *client led* can be linked to the mutually agreed goals and tasks of therapy outlined by Bordin (1979). The model as a whole therefore emphasises the therapeutic alliance as an integral part of the engagement process and CBT.

The literature regarding the importance of the therapeutic alliance is well documented in the psychotherapy literature (Horvarth & Luborsky, 1993; Cooper, 2008; Norcross, 2010) and is mirrored in the psychosis literature (Johansson & Eklund, 2003; McCabe & Priebe, 2004; Priebe & McCabe, 2006). The current study provides further support for this.

The lack of significant results in the outcome studies explored in the literature review (chapter one, 1.9) may be related to the therapeutic alliance. The SoCRATES study (Lewis *et al*., 2002; Tarrier *et al*., 2004) used supportive counselling as a control group and the ACE study (Jackson *et al*., 2008) used befriending as a control group. Both studies found very few significant differences between the groups. Common to CBT, supportive counselling and befriending is the relationship between two people. The current study corroborates these findings with its focus on the therapeutic alliance.

The results of this study can be linked to qualitative studies of CBT for psychosis. Client experience studies of CBT for early psychosis are currently absent from the literature, therefore the wider literature will be drawn upon to provide contextual information.

O'Toole *et al*. (2004) looked at client perceptions of early intervention services and described the human approach to be valued by clients and discussed the importance of clients being involved in treatment decision and service flexibility. In the current study,

the categories *tenderness*, *client led* and *flexibility* demonstrate how the way the therapists worked was in line with what is considered important by clients.

In exploring factors affecting outcome in CBT for psychosis McGowan *et al*. (2005) reported that both therapists and clients valued and benefitted from therapeutic contact outside of strictly CBT criteria. The current study supports this finding in that therapists' primary focus was working in a tender way. Working in this way appeared more important to therapists than the model of CBT and this appears to encourage engagement.

Messari and Hallam (2003) explored clients' understanding and experience of CBT for psychosis. They reported how clients viewed the relationship with their therapists as a trusting and respectful relationship. The current study shows how therapists attempt to create the relationship which is valued by clients. The properties *respect as an equal* and *trust* suggest this.

The similarities between the findings of this study and the others outlined above gives validity to the current results as they fit in with findings in the wider literature of CBT and psychosis. Whilst this study shows the importance of the therapeutic alliance in the engagement process, it goes further and considers how therapists may go about forming this relationship. It is in this way that the current study is adding to the knowledge base.

4.4.1.2 Rogers' core conditions

Within the therapeutic alliance literature, Rogers' (1957) core conditions are seen as relational skills used by therapists in creating a positive emotional bond with clients. Rogers (1951, 1957) advocates the core conditions necessary for building relationships with clients to be: genuineness, offer unconditional positive regard and being able to feel and communicate empathy to enable change. Within Rogers Person Centred Approach, there is a central premise that the client knows best (Mearns & Thorne, 1999). They go onto say that the approach values the subjective experiences of clients and encourages clients to take responsibility for their own lives by trusting in themselves.

In the current study, the category *client led* could be linked to the client centred approach advocated by Rogers (1951, 1957). The property *going with what the client wants* emphasises the value therapists placed in their clients' accounts and experiences. The property *empowerment* involved allowing clients to have power so that they can have control in their own life which is related to allowing clients to take responsibility.

The therapists in this study showed empathy in that they talked about trying to understand things from the clients' point of view and not making assumptions. This is evident in the category *tenderness*. The importance of empathy in therapy is well established across different therapy modalities and client groups (Ackerman & Hilsenroth, 2003; Norcross, 2010). There is however, limited research examining the

construct of empathy in CBT for psychosis (Hoaas *et al*., 2011). The findings of this study therefore add to the literature on CBT for psychosis. The findings support those of Evan-Jones *et al*. (2009) who found that empathy was important in forming therapeutic relationships with people with psychosis when working from a cognitive behavioural perspective.

Therapists in the current study demonstrated genuineness. In the category *tenderness*, the properties *comfortable and relaxed*, and *humility* show the therapist being genuine. By being relaxed, open and humble, therapists were able to be themselves and were present and available to the clients as people to relate to and this seemed to foster good relationships. Mearns and Thorne (1999) suggest that being genuine encourages the client to trust the therapist as it removes the mysteriousness of the therapist and therapy often present. They go on to say that by removing the mystery, the therapist can be seen as more of an equal than as an authority figure with power. Genuineness therefore encourages trust and helps the client to feel more powerful in relation to the therapist. Dr Brabban (personal communication, 16th April 2011) explained that genuineness is a vital element of engagement in CBT for psychosis. She posits that people understand the world based on how other people react and therefore therapists' genuine responses to clients and their experiences aids clients in understanding their psychosis. Dr Brabban stressed that she was speaking from her own clinical experience and that there was limited research exploring genuineness in CBT for psychosis. The current study therefore adds to the literature.

Unconditional positive regard is the attitude of the therapist to the client; the therapist is warm and accepting to all aspects of the client (Rogers, 1957). The category *tenderness* shows how therapists in the current study exhibited unconditional positive regard by trusting clients, being compassionate and accepting them. Therapists respected their client's input and opinions. Unconditional positive regard seems to empower clients, thus linking with the category *client led*.

Overall the participants in the current study demonstrated the core conditions of therapy advocated by Rogers (1951, 1957). Within the therapeutic alliance and CBT literature, these contribute towards building a positive emotional bond with the client and are considered important in terms of outcome and the current study corroborates this.

4.4.1.3 Relationship building model of Paul Chadwick

Chadwick (2006) suggests that therapists' beliefs and assumptions may impact on engagement in CBT for psychosis. In the current study the category *tenderness* highlights how all of the therapists engaged clients based on positive assumptions. For example, treating people with respect and as equals implies that therapists may view psychosis and ordinary experience on a continuum and that they do not think of people with psychosis as being dangerous which would hinder engagement. Therapists' compassion, trust, acceptance and respect towards clients was evident in the analysis.

This suggests that therapists may believe that the core of people with psychosis is positive and this encourages relationships building.

In the current study therapists did not appear to have any negative beliefs and assumptions which hindered engagement. They did not feel it was their responsibility to keep clients in therapy and they all respected a client's decision to disengage from therapy; this links to Chadwick's (2006) anti-collaborative beliefs about therapist failure. This assisted engagement in the long run as the client would be more likely to come back as they had been given the power to make the decision and were respected for their decision. The categories *client led* and *tenderness* could therefore be seen as helping therapists to overcome assumptions and beliefs that may hinder engagement. Whilst linking the findings of the current study to the work of Chadwick (2006) it is important to note that therapists did not explicitly refer to beliefs and assumptions either negative or positive, these have been inferred from the interpretation of the data.

4.4.1.4 Expressed emotion

Expressed emotion has been shown to be a powerful predictor of outcome in schizophrenia. Kuipers (2006) suggests that clients who return to families displaying high expressed emotion have a higher rate of relapse. She discusses that high expressed emotion includes families being critical, hostile and emotionally overly involved. Further to this, the concept of expressed emotion can also be evident in clinicians. Whilst high

expressed emotion has been found to be predictive of relapse, a calmer and more tolerant environment is conducive to recovery (Kuipers & Bebbington, 2005, cited in Kuipers, 2006). The category *tenderness* appears to be the opposite of the characteristics of high expressed emotion as it incorporates acceptance, compassion and respect. It is possible that by therapists forming a therapeutic alliance without high expressed emotion, clients may be encouraged to engage and better outcomes may be achieved.

4.4.1.5 Compassion

Therapist compassion can be defined as non-judgmental openness and connection to the suffering of clients with an aspiration to relieve this suffering (Gilbert, 2005 cited in Vivino *et al*., 2009). Vivino *et al*. (2009) explored therapists' accounts of compassion in psychotherapy. They found that compassion may be important in psychotherapy as it has the potential to influence therapeutic outcome by providing a positive emotional experience for the client. Therapists' compassion enables clients to feel understood and listened to. They postulate that therapists showing compassion may help clients to be more compassionate towards themselves resulting in them being less self critical. Paranoia has been associated with self critical thinking (Mills *et al*., 2007). It may therefore be possible that a compassionate approach may be useful when working with clients with paranoid experiences, including people with psychosis. The therapists in the current study demonstrated compassion in their accounts and this may have encouraged clients to be less self critical.

4.4.1.6 Therapists' ideas about engagement

Therapists' ideas about engagement echoed the research described in the literature review (chapter one) in that engagement is seen as an ongoing process with the onus placed on the therapist to engage the client (Sainsbury Centre for Mental Health, 1998; Tait *et al*., 2010). Taking this view appears to allow therapists to effectively build relationships and work therapeutically with clients. Conversely, if therapists placed the onus on the client and saw engagement as a one off process at the beginning of therapy, this may hinder successful relationship building and any potential therapy. One therapist did point out that this view was not always taken by the team. The team did not tend to always consider the therapists' contribution to engagement and this could mean that the client was problematised and labelled either an engager or non-engager. Qualitative studies of engagement suggested the importance of the therapeutic relationship (Priebe *et al*., 2005; James *et al*., 2006) and client autonomy (Priebe *et al*., 2005) in engagement and the results of the current study are in agreement this.

4.4.2 Cognitive behavioural therapy

The results of the current study suggest that the therapists do not adhere to a CBT way of working. This will be discussed in terms of the model of CBT as well as collaboration which is an important element of CBT. The concept of power in CBT will be considered.

4.4.2.1 The model of CBT

The model interpreted from the data suggests that therapists do not rigidly adhere to their professed cognitive behavioural ways of working. Flexibility in terms of therapy used seems to suggest the importance of not always adhering to a strict model of CBT with this client group but rather going with what the client brings. This shows that a strict model of CBT may not always be essential and that other factors are considered by therapists as important such as the therapeutic relationship as outlined above. The results of this study indicate that it was important for therapists to be integrative in their work. Being flexible in the use of CBT may add to the explanations for the inconclusive results presented in the outcome studies in the literature review (Chapter one, 1.9) of CBT for early psychosis. The CBT offered in these studies was manualised and time limited and therefore was not always able to be flexible or client led (Roth & Fonagy, 2005). This study, although not related to outcome, shows how flexible use of CBT may be beneficial in engaging client which has the potential to influence outcome.

4.4.2.2 Collaboration in CBT

Therapists in this study highlight the importance of working in a client led way and often putting aside their own ideas and understanding of what may be going on for the client. This way of working is not inline with the collaborative relationship preferred in CBT (Toner *et al*., 2000). The results of this study suggest that perhaps shifting the balance of collaboration by empowering the client or going with whatever the client brings rather than the therapist having an agenda encourages engagement.

In the current study, therapists showed flexibility in understanding. The literature generally advocates creating a shared collaborative understanding involving both client and therapist views. Some studies mention attempting to shift the clients' views to that of the therapist. For example, McGowan *et al*. (2005) emphasised the need to change existing understandings of psychosis and provide new understandings in order to achieve a favourable outcome. The current study places more emphasis on listening to the clients' perspectives and trying to enter their explanatory framework rather than imposing anything on the client. This can be linked to the literature regarding insight in psychosis, recovery style and illness perceptions.

Insight can be referred to as: 'the patient's awareness of having a mental disorder, of the social consequences of the disorder, and of the need for treatment' (McGorry & McConville, 1999 cited in Mintz, Addington & Addington, 2004). Álvarez-Jiménez *et al*. (2009) found that a lowered level of insight predicted poor treatment adherence in CBT for early psychosis. They postulated that having low insight may be linked to a sealing over recovery style and therefore poor adherence to CBT. The results of the current study do no confirm this. The therapists placed emphasis on helping clients to develop an understanding of their psychosis but did not see it as necessary for that understanding to be related to having a mental illness. In this way, therapists appeared to challenge the concept of insight. These findings are in line with the writing of Bentall (2009). He posits that the concept of insight privileges clinicians' views and understanding of psychosis over those of the client and denies clients a voice.

Participant three highlighted how people can have insight without buying into the medical model or a CBT based understanding. Rather than encouraging clients to take on board an illness based understanding of their psychosis, therapists in the current study tried instead to enter into the client's frame of reference and help them to develop a workable understanding of their psychosis. Participant eight gave an example of how if a client explained their psychosis as the result of magic and this explanation was not getting in the way of their life, then there would be no point in them changing it. This participant suggested that the therapy could be about dealing with the effects of magic rather than the effects of a mental illness. The results of this study suggest that even if clients have what clinicians may term as low insight, they can still integrate their psychotic experiences into their daily life (integrative recovery style) within their own frame of reference and that this is what therapists encouraged.

Flexibility in understanding can be linked to the recovery literature. Clients who use an integrative recovery style are likely to be more flexible in their thinking in order to incorporate their psychosis and its meaning into their lives (Thompson *et al*., 2003). The accounts given by therapists in the current study suggest that therapists are flexible in their understanding and thinking. It is possible that this encourages clients to be flexible in their own understanding of their psychosis. In this way, the therapists interviewed in this study could be seen to be encouraging an integrative recovery style. As an integrative recovery style has been linked to outcome (Thompson *et al*., 2003) it is

possible that the style demonstrated by therapists in the current study may result in better outcome.

Williams and Steer (2011) linked engagement to illness perceptions and suggested that therapy should focus on developing a meaningful understanding of psychosis and increasing client autonomy. The current study corroborates these findings as therapists were flexible in their own understanding of clients with a potential aim of helping clients to develop a coherent and workable understanding. Williams and Steer (2011) do however suggest clients adopting a medical model of understanding which this study does not corroborate. Therapists were client led in their work and attempted to empower clients to allow them to have more control and choice in their life which links to increasing client autonomy. Therapists' ideas about what works in engagement predominantly support the ideas proposed by Williams and Steer (2011).

4.4.2.3 Power and CBT

In the broader literature, powerlessness has been argued to be associated with psychological distress (Proctor, 2008). Proctor (2008) argues that to deal with this difficulty it is essential not to impose further power and control over people. She presents an argument in which power is inherent in CBT. She posits that CBT makes the assumption that the therapist is in an objective position to decide what is best for the client. She argues further that although CBT aims to be collaborative, it attempts to get the client to think along the same lines as the therapist.

The present study does not confirm this in relation to CBT for early psychosis. The therapists' accounts showed an awareness of the power dynamics inherent in therapy. Therapists attempted to overcome this by empowering clients. The analysis showed therapists going with whatever the client experienced and understood and keeping their own understanding to themselves. The therapists claimed to have been working from a CBT perspective, although there was some doubt from the participants as to whether they were strictly adhering to the model or not. These results demonstrate that CBT is not always caught up in power dynamics as indicated by Proctor (2008) and that by being client led and flexible therapists attempted to overcome the power dynamic inherent in CBT.

4.4.3 Psychosis

4.4.3.1 Critique of the medical model of psychosis

Bentall (1993, 2003, 2009) has written extensively critiquing the understanding of psychosis. He disagrees with the treatment of psychosis having a purely biological focus. He advocates seeing psychotic experiences on a continuum with ordinary experiences. He views diagnostic categories as mainly unhelpful and instead promotes a view which aims to understand the events which may have caused a person's psychosis and what makes recovery challenging. He sees client autonomy as essential in health care. He goes on further to suggest that 'what is needed is a more compassionate approach that places the therapeutic relationship at the centre of clinical practice' (Bentall, 2009, p.265). The results of the current study appear to be in line with his

suggestions, emphasising a tender and client led way of working. Further to this the therapists' accounts suggested a way of working which stayed away from diagnoses and did not considered psychotic experiences as dissimilar to ordinary experiences. The similarities between the results of this study and the accounts of Bentall (2003, 2009) are not necessarily surprising as the concept of early intervention in psychosis was born out of a shift in the conceptualisation of psychosis as discussed in the literature review (1.5, 1.7). Bentall (2003, 2009) however, insinuates that a biological perspective is still privileged but these results suggest otherwise. This may indicate that the medical model of psychosis is indeed being successfully challenged in some services.

4.4.3.2 Identity and power in early psychosis

Empowerment and control were important aspects of the category *client led* and these constructs relate to the literature regarding development and early psychosis. McGorry *et al*. (1996) discusses how the period for maximum risk of onset for early psychosis is in late adolescent and early adult stages of development. He goes on to say that this is a critical developmental stage as it involves the consolidation of identity and the process of separation and individuation from parents and families, construction of a peer group and important choices in terms of education and vocation. A psychotic episode during this time may cause disruption in this developmental stage. This may mean that clients feel like they lack independence and control in their lives and they may wish to attempt to regain this (McGorry *et al*., 1996).

Perry, Taylor and Shaw (2007) carried out a qualitative study into the experience of hope in early psychosis. They emphasised how the experience of mental health services and hospitalisation in particular left clients feeling they did not have any control over what was happening to them and feeling powerless to their psychosis and the mental health system.

Boydell *et al*. (2010) carried out a descriptive review of qualitative studies in early psychosis. They reported that achieving identity is important for this client group. They suggest that interventions focussing on the clients' meaning of their experiences may help to encourage a client centred model of care by placing value on a clients' sense of self and their sense of control and agency in their health and potential recovery.

Collectively, this literature highlights the importance of identity, power and control to this client group. The present study showed how therapists placed emphasis on working in a client led way by empowering clients thus allowing them to have control and responsibility in their lives and health care. Working in this way potentially enables clients to work towards achieving their own sense of identity and thus encourages engagement.

4.4.4 Addressing difference and diversity

The results of this study point to some difficulties engaging people in ethnic minority groups. Therapists were sensitive to difference and diversity and spoke of encouraging

a culturally sensitive service. Participant three did however note how some ethnic groups may be reluctant to get involved in services due to ideas and beliefs about getting treated unfairly which participant three believed to be true. The majority of the therapists' accounts reported their respective services as culturally sensitive but there was a sense that more can be done. 'Keys to Engagement' (Sainsbury Centre for Mental Health, 1998) describes how there may be racism in mental health services and the need for this to addressed. A recent report from the British Psychological Society (2010) emphasises the importance of having culturally sensitive services and suggests an urgent need for staff training in cultural sensitivity.

4.4.5 Therapist experience

Therapists mentioned the importance of experience and from their descriptions of their work; their levels of experience were evident. Experience was described as helping to improve confidence which appeared to help relationship building with this client group. Confidence and experience allowed the therapists to be more client led and flexible in their work thus encouraging engagement. These results are in line with Evan-Jones *et al*. (2009) who highlight the importance of therapist confidence and experience in forming therapeutic relationships within the context of CBT for psychosis.

4.4.6 Grounded theory literature

There are few studies considering therapists' perspectives regarding therapy in the area of psychosis. James *et al*., (2006) explored therapists' experiences of engagement in

behavioural family therapy and McGowan *et al*., (2005) looked at client and therapist accounts of factors associated with outcome in CBT for psychosis. These studies have been discussed in detail in the literature review and drawn upon in the discussion in terms of the importance of the therapeutic relationship. It is however useful to review the findings of the current study in relation to other grounded theory studies carried out in a similar area. Similar to James *et al*., (2006), the current study constructed a process model of engagement from the perspective of the therapist. In common with both studies is the value placed on the therapeutic relationship rather than technical therapeutic factors. The similarity of the results of the current study to other grounded theory studies in the literature adds validity to the current findings.

4.5 Critical review

4.5.1 Limitations

As has been made apparent throughout the research, the position of critical realism has been adopted and informed the research question, methodology and analysis of the research. In terms of the research question, critical realism limited what could be asked about the phenomena of engagement in early psychosis and therefore limited what could be found. The results are only relevant to the research question and cannot answer more positivist concerns such as the factors associated with therapeutic engagement. Although the study also did not aim to link any therapeutic processes to outcome, some speculative attempts have been made.

Whilst the researcher has endeavoured to reconcile realism and relativism using grounded theory, this method does not specifically examine discourses or more social constructionist concerns which could shed further light on the accounts of therapists by examining how they use language in relation to the experience of engagement. It is therefore important that the results only be reviewed, interpreted and evaluated with the researcher's position of critical realism in mind.

The study was retrospective in nature and does not capture engagement in real time. It is therefore not possible to know whether therapists are doing what they say they are doing. The study focuses on therapists' accounts of engagement and what they think is important. It does not provide any understanding of how clients experience engagement. James *et al*. (2006) used family accounts to corroborate the views of family therapists in engagement and this may have been a useful addition to the current study by adding richness to the categories.

The small number of participants means that the results can not be generalised. It is however important to note that within the framework presented, this is not a limitation as it is not a goal for grounded theorists. Therapists recruited for this study worked in London and therefore the results may not be relevant to other areas. It may be the case that engagement in rural areas may have a different focus to it. The study is historically located by the therapists' current accounts and therefore may not be relevant to past or future therapists.

When using grounded theory, the concept of saturation is important to consider. A category is considered to be saturated when no more new properties are interpreted through constant comparison and theoretical sampling. Although this was attempted, it seems impossible to know if a category can ever be saturated as any new participant interviewed may shed further light on a topic. The lack of new properties interpreted from the data may also point to the study becoming more focussed in its data collection and analysis as it progressed (Dey, 1999). With this in mind, a level of saturation has been assumed but the researcher is also aware of the limitations of such assumptions. The model presented is therefore captured in a moment in time and it is acknowledged that were more participants interviewed or data reanalysed, the model may have shown added or different categories.

Of note, there was a large response to recruitment attempts in this study. Over twenty therapists agreed to participate in this study. It was not possible to interview all potential participants. Therapists outside of London were excluded from the study for pragmatic reasons. This limits the relevance of the study as mentioned early. It also means that not all therapists' voices were heard. The unexpected response to recruitment could indicate that therapists have a great deal to say about engagement in CBT for early psychosis and is an area of interest to therapists who work with this client group.

Although there was a good response to recruitment attempts, a large group of potential participants did not agree to participate in the study and it is not possible to know the reasons why. It is possible that those people who did not participate may not have presented the account of engagement shown in this study. It seems feasible that therapists who responded to the recruitment attempts had positive experiences of engagement and this should be considered when interpreting the results.

As mentioned in the methodology section (chapter 2) all of the participants were clinical psychologists. This may mean that the results may be more relevant to clinical than counselling psychologists working in the field of early intervention for psychosis. As clinical and counselling psychologists work in the same role but with slightly different backgrounds and orientations it is possible that the results would differ but it is not possible to say exactly how they would be different or the same.

4.5.2 Evaluation

As outlined in the methodology section (chapter two, 2.11), the research can be evaluated by owning one's own perspective in terms of: openness regarding philosophical position and personal reflexivity. The research should be carried out in a manner which is consistent with these positions. Other evaluation criteria include grounding categories in examples, situating the sample and coherence. These will allow the reader to judge whether the results fit the data (Elliot *et al*., 1999; Madill *et al*., 2000; Morrow, 2005)

The researcher's personal position was outlined in the methodology section (Chapter two) and will be revisited in the next section (4.4.3) to make clear the role played by the researcher in the findings. The philosophical assumptions of the researcher and how these have impacted on the research have been made explicit throughout.

A detailed account of how the analysis was undertaken has been presented and numerous examples of quotes to support categories have been provided. An attempt has been made to include as many therapist examples of categories as possible to ground the theory and to give a rich description. This should allow the reader to see the fit between the data, the categories interpreted and the model presented. In terms of situating the sample, the recruitment process and the sample have been described.

The researcher has attempted to provide a clear and structured thesis in order to provide a coherent account of the research process. An attempt has been made to be concise and succinct and to use figures and tables where appropriate.

The findings have been linked to current research and add to the literature regarding CBT for early psychosis and the importance of the therapeutic alliance as well as some potential ways in which therapists can form the alliance. As it is important to disseminate research findings to the populations to which they apply the researcher plans to publish aspects of this thesis.

4.5.3 Reflections of the researcher

This section is written in the first person for ease of reading. My personal position and biases were outlined in the methodology section (chapter two, 2.10) and will be revisited.

I am aware that as a researcher I shared many similarities with the therapists interviewed. I am a white middle class psychologist with experience of CBT and experience of working in an early intervention service. Based on this it is probable that we shared many assumptions and that I may have missed opportunities to explore categories further as I felt I understood the therapists. We also had a shared language in terms of CBT terminology and this may have meant that sometimes I did not clarify what a participant meant which may have resulted in some further missed meanings. Being a trainee psychologist, participants seemed to expect me to know certain things. For example when I asked about the homework in relation to the client group, I was sternly told to never call it homework. Although as a CBT therapist I have never used the term homework with a client, it has been common language within circles of other therapists. This experience may have made me more cautious with other questions that I asked. That being said, I generally build up a good and friendly rapport with all therapists interviewed.

My own experience as a CBT therapist has led me to form various opinions about CBT. I have at times found the model very structured and challenging to use. I have especially

found the work on thoughts or cognitions complicated to apply in clinical settings. In my practice, I have found it difficult to adhere to a rigid model of CBT and instead have used a more integrative approach. I am sure that my ideas about CBT have influenced and shaped the interviews and analysis. Although I do think it is clear that the participants voiced their own opinions of CBT and the use of the model, I think I may have tended to focus on this aspect of what they said as this supported my own ideas about CBT. I may have limited the questions that I asked to some extend as I felt sure I understood the concept of adhering to the model but this is perhaps something that could have been explored more thoroughly. Although I am aware that my own ideas may have influenced both data collection and analysis, I hope that by grounding my categories in the data with numerous examples will show how I attempted to bracket off my own ideas.

My previous work in an early intervention service was something that was not known to the participants. It did however afford me knowledge of the client group and the way that teams work. This knowledge may have been conveyed to participants during the interviews and they may have made assumptions that I knew certain things about their services. Having worked in an early intervention service has informed me of how committed the staff members are in their attempts to engage this client group and this may have influenced me in that I may have wanted to highlight their commitment. I hope that by being explicit about this and by grounding my categories in the data, through the use of examples, this will not detract from the evaluation of the research.

Having a family member with psychosis will have influenced this research. The reports of my family's dealings with services were not positive and may have swayed me towards some negative aspects of the services. The interview schedule however was predominantly aimed at eliciting positive accounts of engagement.

I was acutely aware during most of the interviews of the power dynamic set up between myself and the participants. They were the expert who in various cases was teaching me as I was a trainee. This may have been different were I a postgraduate researcher. Therapists may have only told me what they thought I wanted to hear or what would be considered the correct way to work with this client group. They may have felt like I was evaluating them and their work and therefore only portrayed positive aspects of their work.

Throughout the research process I became increasingly intrigued by the ideas about black magic as an explanation for psychotic experiences, raised in the interviews. Although I was initially interested in how therapists engaged clients with these beliefs, my personal interest in this topic may have influenced my questioning around it.

I have positioned myself as a critical realist throughout this research and still value that philosophical standpoint but through listening to the interviews various times I have developed an interest in the use of language and discourses, especially those evident in mental health services. In this way, the research process has influenced me and I have

perhaps shifted my position on the realist-relativist continuum slightly more towards the relativist stance than I was at the start. I have started to develop a social constructionist interest in phenomena but within a critical realist framework.

My personal position, views and experience of the research as outlined above have influenced the language I have used in the interviews. This will have shaped how the participants answered the questions and therefore the data collected. My use of language will also have influenced my interpretation of the data and the language I used in the labels of categories. In turn, the labels I used for the categories potentially influenced subsequent data analysis.

I cannot say with certainty that I do not have any other assumptions or biases outside of my awareness which may have influenced the current study. I feel that all of the factors discussed may be relevant to my interpretation of the data and I hope that this level of reflexivity will add to the trustworthiness and quality of my research.

4.6 Implications of findings

4.6.1 Practical

The results of this study highlight that the therapeutic alliance is key to engagement in CBT for early psychosis and attention should be paid to this by therapists working with this client group. This study suggests that working in a tender, client led and flexible way may help to build the therapeutic alliance and therefore foster engagement. These

results may be relevant to all clinicians who work with this client group. As discussed earlier, the findings corroborate those of other studies and therefore add to the knowledge base that the therapeutic alliance is important in working therapeutically with clients with early psychosis. In addition to corroborating current literature, the current study adds to the knowledge base by considering the way in which therapists may go about developing this relationship.

In light of the links between the current study and the work of Chadwick (2006), it may be useful for therapists to consider their own beliefs and assumptions about working with people with psychosis as these may influence engagement.

The results suggest the importance of not attempting to change clients' beliefs but instead trying to step into their frame of reference; this may be more in line with a person centred way of working than a CBT way of working. The study also advocates not strictly adhering to a model of CBT but working in a more integrative way. Considering this in clinical practice this may assist with engagement in clinical practice. The accounts of therapists in this study point to the importance of providing a culturally sensitive service and this may be an area for further consideration in service provision.

4.6.2 Research

As discussed earlier (4.5.1), client accounts of engagement would supplement and add richness to the categories interpreted from the data. It would be useful to carry out

similar style studies in different geographical locations. It may be useful to explore engagement in settings working with chronic psychosis. This could provide useful comparisons between the two groups from the perspective of therapists. The idea of therapists using their identity flexibly appeared to be a novel concept and may benefit from further research. The study was a retrospective study and it may be useful to capture the therapeutic encounter in real time. This could be done by recording therapy sessions and interviewing therapists and clients about their experiences.

4.7 Summary and conclusion

The current study has reported a qualitative, grounded theory study of engagement in CBT for early psychosis from the perspective of the therapist. It was carried out from a position as a critical realist and counselling psychologist. The results suggest the importance of the therapeutic alliance in the engagement process and that therapists work in a tender, client led and flexible way to form the alliance. The results show the importance of outside influences or the context in which they worked and how this could sometimes be helpful and sometimes challenging. The model indicated that therapists do not stick to the model of CBT and this may encourage engagement. Overall the model presented highlighted how important relationships are in therapeutic work and provides an initial account of how therapists might go about building relationships. The results have been linked to the literature relating to CBT for early psychosis and the broader psychosis literature as well as the literature regarding the

therapeutic relationship. The researcher has reflected on her role in the research and practical and research implications have been explored.

References

Ackerman, S.J. & Hilsenroth, M.J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance [Electronic version]. *Clinical Psychology Review*, *23*(1), 1-33.

Addington, J. & Gleeson, J. (2005). Implementing cognitive-behavioural therapy for first-episode psychosis [Electronic version]. *British Journal of Psychiatry*, *187*(48), 72-76.

Álvarez-Jiménez, M., Gleeson, J.F., Cotton, S., Wade, D., Gee, D., Pearce, T. *et al*. (2009). Predictors of Adherence to Cognitive-Behavioural Therapy in First-Episode Psychosis [Electronic version]. *Canadian Journal of Psychiatry*, *54*(10), 710-718.

American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.). Washington DC: American Psychiatric Press Inc.

Baldwin, S., Wampold, B. & Imel, Z. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance [Electronic version]. *Journal of Consulting and Clinical Psychology*, *75*(6), 842-852.

Bebbington, P. & Kuipers, L. (1994). The clinical utility of expressed emotion in schizophrenia [Electronic version]. *Acta Psychiatrica Scandinavica, 89* (382), Suppl, 46-53.

Beck, A.T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Beck, A.T., Rush, A.J., Shaw, B.F., and Emery, G. (1979). *Cognitive therapy of depression*. New York: Guildford.

Beck, J.S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press.

Bentall, R.P. (1993). Deconstructing the concept of `schizophrenia'. *Journal of Mental Health*, *2*(3), 223-238.

Bentall, R.P. (2003). *Madness explained: Psychosis and human nature*. London: Penguin Books Ltd.

Bentall, R.P. (2009). *Doctoring the mind: Why psychiatric treatments fail*. London: Penguin Books Ltd.

Bertolote, J. & McGorry, P. (2005). Early intervention and recovery for young people with early psychosis: Consensus statement [Electronic version]. *British Journal of Psychiatry*, *187*(48), 116-119.

Birchwood, M. & Spencer, E. (2001). Early intervention in psychotic relapse. *Clinical Psychology Review*, *21*(8), 1211-1226.

Birchwood, M. (2000).The critical period for early intervention. In M. Birchwood, D. Fowler & C. Jackson (Eds.) *Early Intervention in Psychosis a guide to concepts, evidence and interventions* (pp.28 – 63). West Sussex: John Wiley & Sons Ltd.

Birchwood, M., Fowler, D. & Jackson, C. (Eds.) (2004). *Early Intervention in Psychosis: A Guide to Concepts, Evidence and Interventions.* West Sussex: John Wiley & Sons Ltd.

Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252-260.

Boydell, K.M., Stasiulis, E., Volpe, T. & Gladstone, B. (2010). A descriptive review of qualitative studies in first episode psychosis [Electronic version]. *Early Intervention in Psychiatry*, *4*(1), 7-24.

British Psychological Society. (2010). *Understanding bipolar disorder: What some people expereince extreme mood states and what can help.* Leicester: British Psychological Society.

British Psychological Society. (2005). Division of Counselling Psychology. *Professional Practice Guidelines.* Leicester: British Psychological Society.

British Psychological Society. (2009). *Code of ethics and conduct.* Leicester: British Psychological Society.

Brown, G.W. (1985). *The discovery of expressed emotion: induction or deduction*. New York: The Guilford Press.

Chadwick, P. (2006). *Person-based cognitive therapy for distressing psychosis*. Chichester: John Wiley & Sons Ltd.

Chadwick, P.D., Birchwood, M.J. & Trower, P. (1996). *Cognitive therapy for delusions, voices and paranoia*. Oxford: John Wiley & Sons Ltd.

Chambless, D. L. & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal Of Consulting And Clinical Psychology*, *66*(1), 7-18.

Charmaz, K. (2006). *Constructing Grounded Theory: A practical guide through qualitative analysis.* London: Sage Publications Ltd.

Conus, P., Lambert, M., Cotton, S., Bonsack, C., McGorry, P. & Schimmelmann, B. (2010). Rate and predictors of service disengagement in an epidemiological first-episode psychosis cohort [Electronic version]. *Schizophrenia Research*, *118*(1-3), 256-263.

Cooper, M. (2008). *Essential research findings in counselling and psychotherapy: the facts are friendly*. London: Sage Publications Ltd.

Dearing, R.L., Barrick, C., Dermen, K.H. & Walitzer, K.S. (2005). Indicators of Client Engagement: Influences on Alcohol Treatment Satisfaction and Outcomes [Electronic version]. *Psychology of Addictive Behaviors*, *19*(1), 71-78.

Denzin, N.K. & Lincoln, Y.S. (2005). Introduction: The discipline and Practice of Qualitative Research. In: N.K. Denzin & Y.S. Lincoln (Eds) *The Sage Handbook of Qualitative Research* (3rd edn., pp.1-42). California: Sage Publications Inc.

Dey, I. (1999). *Grounding grounded theory guidelines for qualitative inquiry*. San Diego: Academic Press.

Dow, R.M., (2003). *First sessions of cognitive behaviour therapy for psychosis: A description of process and a report on the development and validation of a measure of affective response.* Unpublished Clinical Psychology Doctoral Dissertation: The University of East Anglia.

Durham, R. C., Guthrie, M., Morton, R., Reid, D. A., Treliving, L. R., Fowler, D. & MacDonald, R. R. (2003). Tayside-Fife clinical trial of cognitive-behavioural therapy for medication-resistant psychotic symptoms: Results to 3-month follow-up. *The British Journal Of Psychiatry*, *182*(4), 303-311.

Elliott, R., Fischer, C.T. & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*(3), 215-229.

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

Fowler, D., Garety, P. & Kuipers, E. (1995) *Cognitive Behaviour Therapy for Psychosis*. Chichester: Wiley.

French, P., Smith, J., Shiers, D., Reed, M. & Rayne, M. (Eds.) (2010). *Promoting recovery in early psychosis: a practice manual*. West Sussex: Blackwell Publishing Ltd.

Garety, P. A., Kuipers, L. L., Fowler, D. D., & Chamberlain, F. F. (1994). Cognitive behavioural therapy for drug-resistant psychosis. *British Journal Of Medical Psychology*, *67*(3), 259-271.

Glaser, B.G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* California: The Sociology Press.

Haddock, G. G., Tarrier, N. N., Morrison, A. P., Hopkins, R. R., Drake, R. R. & Lewis, S. S. (1999). A pilot study evaluating the effectiveness of individual inpatient cognitive-behavioural therapy in early psychosis. *Social Psychiatry & Psychiatric Epidemiology*, *34*(5), 254.

Haddock, G., Lewis, S., Bentall, R., Dunn, G., Drake, R. & Tarrier, N. (2006). Influence of age on outcome of psychological treatments in first-episode psychosis [Electronic version]. *British Journal of Psychiatry*, *188*(3), 250-254.

Haaga, D. A. F. & Stiles, W. B. (2000). Randomised Clinical trials in psychotherapy research: Methodology, Design and Evaluation. In C.R. Snyder and R.E. Ingram (Eds.), *Handbook of Psychological Change: Psychotherapy processes and practices for the 21st century*. New York: John Wiley & Sons Inc.

Hagen, R. & Turkington, D. (2011). Introduction: CBT for psychosis: A symptom based approach. In R.Hagen, D. Turkington, T. Berge, & R.W. Gråwe (Eds.) *CBT for psychosis: A symptom based approach* (pp.3-11). East Sussex: Routledge.

Hagen, R., Turkington, D., Berge, T. & Gråwe, R.W. (Eds.) (2011). *CBT for psychosis: A symptom based approach*. East Sussex: Routledge.

Harper, D. (2008). Clinical Psychology. In C. Willig & W. Stainton-Rogers (Eds) *The Sage Handbook of Qualitative Research in Psychology* (pp.430-454). London: Sage Publications Ltd.

Hawton, K., Salkovskis, P. M., Kirk, J. & Clark, D.M. (1989). The development and principles of cognitive-behavioural treatments. In K. Hawton, P.M Salkovskis, J.Kirk, & D.M. Clark, (Eds.) *Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide* (pp.1-12). Oxford: Oxford University Press.

Hoaas, L.E.C., Lindholm, S.E, Berge, T. & Hagen, R. (2011). The therapeutic alliance in cognitive behavioral therapy for psychosis. In R. Hagen, D. Turkington, T. Berge & R.W Gråwe (Eds.) *CBT for psychosis: A symptom based approach* (pp.59-76). East Sussex: Routledge.

Horvath, A. O. & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal Of Counseling Psychology*, *36*(2), 223-233.

Horvath, A. O. & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38,* 139–149.

Horvath, A.O. & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy [Electronic version]. *Journal of Consulting and Clinical Psychology*, *61*(4), 561-573.

Jackson, C.C., Trower, P.P., Reid, I.I., Smith, J.J., Hall, M.M., Townend, M.M. *et al*. (2009). Improving psychological adjustment following a first episode of psychosis: A randomised controlled trial of cognitive therapy to reduce post psychotic trauma symptoms. *Behaviour Research and Therapy*, *47*(6), 454-462.

Jackson, H. J., McGorry, P. D., Edwards, J., & Hulbert, C. (1996). Cognitively oriented psychotherapy for early psychosis (COPE). In P. Cotton, H. Jackson (Eds.) , *Early intervention & prevention in mental health* (pp. 131-154). Carlton South VIC Australia: Australian Psychological Society.

Jackson, H., McGorry, P., Edwards, J., Hulbert, C., Henry, L., Francey, S. *et al*. (1998). Cognitively-oriented psychotherapy for early psychosis (COPE): Preliminary results. *British Journal of Psychiatry, 172*(33), 93-100.

Jackson, H., McGorry, P., Edwards, J., Hulbert, C., Henry, L., Harrigan, S. *et al*. (2005). A controlled trial of cognitively oriented psychotherapy for early psychosis (COPE) with four-year follow-up readmission data [Electronic version]. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences*, *35*(9), 1295-1306.

Jackson, H., McGorry, P., Henry, L., Edwards, J., Hulbert, C., Harrigan, S. *et al*. (2001). Cognitively oriented psychotherapy for early psychosis (COPE): A 1-year follow-up [Electronic version]. *British Journal of Clinical Psychology, 40*(1), 57-70.

Jackson, H.J., McGorry, P.D., Killackey, E.E., Bendall, S.S., Allott, K.K., Dudgeon, P.P. *et al*. (2008). Acute phase and 1-year follow-up results of a randomized controlled trial of CBT versus befriending for first-episode psychosis: The ACE project. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences*, *38*(5), 725-735.

James, C., Cushway, D. & Fadden, G. (2006). What works in engagement of families in behavioural family therapy? A positive model from the therapist perspective [Electronic version]. *Journal of Mental Health*, *15*(3), 355-368.

Johansson, H. & Eklund, M. (2003). Patients' opinion on what constitutes good psychiatric care [Electronic version]. *Scandinavian Journal of Caring Sciences*, *17*(4), 339-346.

Jolley, S., Garety, P., Craig, T., Dunn, G., White, J. & Aitken, M. (2003). Cognitive therapy in early psychosis: A pilot randomized controlled trial. *Behavioural and Cognitive Psychotherapy, 31*(4), 473-478.

Kazdin, A.E. (1986). Comparative outcome studies of psychotherapy: Methodological issues and strategies [Electronic version]. *Journal of Consulting and Clinical Psychology*, *54*(1), 95-105.

Kingdon, D. & Turkington, D. (1994). *Cognitive Behavioural Therapy of Schizophrenia*. Hove: Lawrence Erlbaum.

Krause, M. & Lutz, W. (2009). Process transforms inputs to determine outcomes: Therapists are responsible for managing process [Electronic version]. *Clinical Psychology: Science and Practice*, *16*(1), 73-81.

Kuipers, E. (2006). Family interventions in schizophrenia: evidence for efficacy and proposed mechanisms of change. *Journal of Family Therapy*, *28*(1), 73-80.

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

Leahy R., L. (2008). The Therapeutic Relationship in Cognitive-Behavioural Therapy [Electronic version]. *Behavioural & Cognitive Psychotherapy*, *36*(6), 769-777.

Lewis, S., Tarrier, N., Haddock, G., Bentall, R., Kinderman, P., Kingdon, D. *et al*. (2002). Randomised controlled trial of cognitive-behavioural therapy in early schizophrenia: Acute-phase outcomes. *British Journal of Psychiatry, 181*(43), 91-97.

Madill, A., Jordan, A. & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist, and radical constructionist epistemologies [Electronic version]. *British Journal of Psychology, 91,* 1–20.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting & Clinical Psychology, 68,* 438–450.

McCabe, R. & Priebe, S. (2004). The therapeutic relationship in the treatment of severe mental illness: A review of methods and findings. *International Journal of Social Psychiatry*, *50*(2), 115-128.

McGorry, P.D. (2000). The scope for preventive strategies in early psychosis: Logic, evidence and momentum. In M. Birchwood, D. Fowler & C. Jackson (Eds.) *Early intervention in psychosis: A guide to concepts, evidence and interventions* (pp.3-27). West Sussex: John Wiley & Sons Ltd.

McGorry, P.D. (2004). An overview of the background and scope for psychological interventions in early psychosis. In J.F.M Gleeson & P.D. McGorry (Eds.) *Psychological interventions in early psychosis: A treatment handbook* (pp.1-21). West Sussex: John Wiley & Sons Ltd.

McGorry, P.D., Edwards, J., Mihalopoulos, C., Harrigan, S.M. & Jackson, H.J. (1996). EPPIC: An evolving system of early detection and optimal management. *Schizophrenia Bulletin*, *22*(2), 305-326.

McGowan, J., Lavender, T. & Garety, P. (2005). Factors in outcome of cognitive-behavioural therapy for psychosis: Users' and clinicians' views [Electronic version]. *Psychology and Psychotherapy: Theory, Research and Practice*, *78*(4), 513-529.

McLeod, J. (2003). *Doing counselling research*. London: Sage Publications Ltd.

Mearns, D. & Thorne, B. (1999). *Person-centred counselling in action* (2nd edn). London: Sage Publications Ltd.

Messari, S. & Hallam, R. (2003). CBT for psychosis: A qualitative analysis of clients' experiences [Electronic version]. *British Journal of Clinical Psychology*, *42*(2), 171-188.

Mills, A.A., Gilbert, P.P., Bellew, R.R., McEwan, K.K. & Gale, C.C. (2007). Paranoid beliefs and self-criticism in students. *Clinical Psychology & Psychotherapy*, *14*(5), 358-364.

Mintz, A.R., Addington, J. & Addington, D. (2004). Insight in early psychosis: a 1-year follow-up [Electronic version]. *Schizophrenia Research*, 67, 213-217.

Morrison, A.P., Renton, J., Dunn, H., Pollack, K. & Bentall, R. (2004). *Cognitive therapy for psychosis: a formulation-based approach.* East Sussex: Brunner-Routledge.

Morrow, S.L. (2005). Quality and trustworthiness in qualitative research in counseling psychology [Electronic version]. *Journal of Counseling Psychology*, *52*(2), 250–260.

Morrow, S.L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *Counseling Psychologist*, *35*(2), 209-235.

Najavits, L.M. & Strupp, H.H. (1994). Differences in the effectiveness of psychodynamic therapists: A process-outcome study [Electronic version]. *Psychotherapy: Theory, Research, Practice, Training, 31*(1), 114-123.

National Institute for Clinical Excellence. (2010). *Core interventions in the treatment and management of schizophrenia in primary and secondary care (updated edition).* London: British Psychological Society and The Royal College of Psychiatrists.

Newton, E. & Cotes, E. (2010). Cognitive behavioural interventions in early intervention services. In P.French, J. Smith, D, Shiers, M. Reed & M. Rayne (Eds.) *Promoting recovery in early psychosis: a practice manual* (pp.53-65). West Sussex: Blackwell Publishing Ltd.

Newton, E., Larkin, M., Melhuish, R. & Wykes, T. (2007). More than just a place to talk: young people's experiences of group psychological therapy as an early intervention for auditory hallucinations [Electronic version]. *Psychology & Psychotherapy: Theory, Research & Practice*, *80*(1), 127-149.

Norcross, J.C. (2010) The therapeutic relationship. In B.L. Duncan, S.D. Miller, B.E. Wampold & M.A. Hubble (Eds.) *The heart and soul of change* (2nd edn., pp.113-141). Washington: American Psychological Association.

O'Brien, A., White, S., Fahmy, R. & Singh, S.P. (2009). The development and validation of the SOLES, a new scale measuring engagement with mental health services in people with psychosis [Electronic version]. *Journal of Mental Health*, *18*(6), 510-522.

Oliver, D.G., Serovich, J.M. & Mason, T.L. (2005). Constraints and Opportunities with Interview Transcription: Towards Reflection in Qualitative Research [Electronic version]. *Social Forces*, *84*(2), 1273-1289.

O'Toole, M., Ohlsen, R., Taylor, T., Purvis, R., Walters, J. & Pilowsky, L. (2004). Treating first episode psychosis – the service users' perspective: a focus group evaluation [Electronic version]. *Journal of Psychiatric & Mental Health Nursing*, *11*(3), 319-326.

Penn, D.L., Uzenoff, S.R., Perkins, D., Mueser, K.T., Hamer, R., Waldheter, E. *et al*. (2011). A pilot investigation of the Graduated Recovery Intervention Program (GRIP) for first episode psychosis [Electronic version]. *Schizophrenia Research*, *125*(2-3), 247-256.

Penn, D.L., Waldheter, E.J., Perkins, D.O., Mueser, K.T. & Lieberman, J.A. (2005). Psychosocial treatment for first-episode psychosis: A research update [Electronic version]. *The American Journal of Psychiatry*, *162*(12), 2220-2232.

Perry, B., Taylor, D. & Shaw, S. (2007). "You've got to have a positive state of mind": an interpretative phenomenological analysis of hope and first episode psychosis [Electronic version]. *Journal of Mental Health*, *16*(6), 781-793.

Ponterotto, J.G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of Science. *Journal of Counseling Psychology*, *52*(2), 126-136.

Priebe, S., Watts, J., Chase, M. & Matanov, A. (2005). Processes of disengagement and engagement in assertive outreach patients: Qualitative study [Electronic version]. *British Journal of Psychiatry, 187*(5), 438-443.

Priebe, S.S. & McCabe, R.R. (2006). The therapeutic relationship in psychiatric settings [Electronic version]. *Acta Psychiatrica Scandinavica*, *113*(429)69-72.

Proctor, G. (2008). CBT: the obscuring of power in the name of science. *European Journal of Psychotherapy & Counselling*, *10*(3), 231-245.

Reicher, S. (2000). Against methodolatry: Some comments on Elliott, Fischer, and Rennie [Electronic version]. *British Journal of Clinical Psychology*, *39*(1), 1-6.

Rennie, D.L. (1998). Grounded theory methodology: The pressing need for a coherent logic of justification [Electronic version]. *Theory & Psychology, 8,* 101-119.

Rennie, D.L. (2000). Grounded theory methodology as methodical hermeneutics: reconciling realism and relativism [Electronic version]. *Theory and Psychology*, *10*(4), 481-502.

Rennie, D.L. (2006). The grounded theory method: application of a variant of its procedure of constant comparative analysis to psychotherapy research. In C.T. Fischer (Ed.) *Qualitative research methods for psychologists: Introduction through empirical studies* (pp.59-78). California: Elsevier Academic Press.

Rennie, D.L. (2007). Methodical hermeneutics and humanistic psychology [Electronic version]. *The Humanistic Psychologist, 35,* 1-14.

Rennie, D.L., Phillips, J.R. & Quartaro, G.K. (1988). Grounded theory: A promising approach to conceptualization in psychology? [Electronic version]. *Canadian Psychology*, *29*(2), 139-150.

Rogers, C.R. (1951). *Client-centered therapy*. London: Constable and Company Ltd.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95-103.

Roth, A. & Fonagy, P. (2005). *What works for whom? : a critical review of psychotherapy research* (2nd edn). New York: Guilford Press.

Sainsbury Centre for Mental Health (1998). *Keys to Engagement: Review of Care for People with Severe Mental Illness who are Hard to Engage* [Electronic version]. London: Sainsbury Centre for Mental Health.

Sanders, D. & Wills, F. (2005). *Cognitive therapy: an introduction* (2nd edn). London: Sage publications.

Sensky, T., Turkington, D., Kingdon, D., Scott, J., Siddles, R., O'Carroll, M. & Barnes, T. (2000). A randomised controlled trial of cognitive behavioural therapy for persistent symptoms in schizophrenia resistant to medication [Electronic version]. *Archives in General Psychiatry, 57*,165-172.

Soanes, C., Hawker, S. & Elliot, J. (Eds.) (2005). *Pocket Oxford English dictionary* (10th edn). Oxford: Oxford University Press.

Spencer, E., Birchwood, M. & McGovern, D. (2001). Management of first-episode psychosis. *Advances in Psychiatric Treatment, 7*, 33-140.

Startup, M., Wilding, N. & Startup, S. (2006). Patient treatment adherence in cognitive behaviour therapy for acute psychosis: The role of recovery style and working alliance. *Behavioural and Cognitive Psychotherapy*, *34*(2), 191-199.

Stickley, T. (2006). Should service user involvement be consigned to history? A critical realist perspective [Electronic version]. *Journal of Psychiatric and Mental Health Nursing*, *13*(5), 570-577.

Tait, L., Birchwood, M. & Trower, P. (2002). 'A new scale (SES) to measure engagement with community mental health services [Electronic version]. *Journal of Mental Health*, *11*(2), 191-198.

Tait, L., Birchwood, M. & Trower, P. (2003). Predicting engagement with services for psychosis: Insight, symptoms and recovery style [Electronic version]. *British Journal of Psychiatry*, *182*(2), 123-128.

Tait, L., Ryles, D. & Sidwell, A. (2010) Strategies for engagement. In P.French, J. Smith, D, Shiers, M. Reed & M. Rayne (Eds.) *Promoting recovery in early psychosis: a practice manual* (pp.35-44). West Sussex: Blackwell Publishing Ltd.

Tarrier, N., Lewis, S., Haddock, G., Bentall, R., Drake, R., Kinderman, P. *et al*. (2004). Cognitive-behavioural therapy in first-episode and early schizophrenia: 18-month follow-up of a randomised controlled trial [Electronic version]. *British Journal of Psychiatry, 184*(3), 231-239.

Tarrier, N., Yusupoff, L., Kinney, C., McCarthy, E., Gledhill, A., Haddock, G., & Morris, J. (1998). Randomised controlled trial of intensive cognitive behaviour therapy for patients with chronic schizophrenia. *BMJ: British Medical Journal (International Edition)*, *317*(7154), 303-307.

Thompson, K.N., McGorry, P.D. & Harrigan, S.M. (2003). Recovery style and outcome in first-episode psychosis. *Schizophrenia Research 62*(1-2), 31-36.

Toner, B.B., Segal, Z.V., Emmott, S.D. & Myran, D. (2000). *Cognitive Behavioural Treatment of Irritable Bowel Syndrome, The Brain – Gut Connection*. New York: The Guildford Press.

Trower, P., Birchwood, M., Meaden, A., Byrne, S., Nelson, A., & Ross, K. (2004). Cognitive therapy for command hallucinations: Randomised controlled trial. *The British Journal Of Psychiatry*, *184*(4), 312-320.

Valmaggia, L., Tabraham, P., Morris, E. & Bouman, T. (2008). Cognitive behavioral therapy across the stages of psychosis: Prodromal, first episode, and chronic schizophrenia [Electronic version]. *Cognitive and Behavioral Practice, 15*(2), 179-198.

Vivino, B.L., Thompson, B.J., Hill, C.E. & Ladany, N. (2009). Compassion in psychotherapy: The perspective of therapists nominated as compassionate [Electronic version]. *Psychotherapy Research*, *19*(2), 157-171.

Westen, D., Novotny, C. M. & Thompson-Brenner, H. (2004). The Empirical Status of Empirically Supported Psychotherapies: Assumptions, Findings, and Reporting in Controlled Clinical Trials. *Psychological Bulletin*, *130*(4), 631-663.

Williams, E. & Hill, C.E. (2001). Evolving Connections: Research that Is Relevant to Clinical Practice [Electronic version]. *American Journal of Psychotherapy*, *55*(3), 336-343.

Williams, K. & Steer, H. (2011). Illness Perceptions: Are Beliefs About Mental Health Problems Associated with Self-Perceptions of Engagement in People with Psychosis? *Behavioural & Cognitive Psychotherapy*, *39*(2), 151-163.

Willig, C. (2008). From recipes to adventures. In C. Willig (Ed.) *Introducing qualitative research in psychology: Adventures in theory and method* (2nd edn., pp.1-14). Buckingham: Open University Press.

Willig, C. (1999). Beyond appearances: a critical realist approach to social constructionist work. In D.J Nightingale & J. Cromby (Eds.) *Social constructionist psychology: A critical analysis of theory and practice* (pp.37-51). Buckingham: Open University Press.

Appendixes

List of appendixes

Appendix A

Invitation email

Dear participant

I am a doctoral student at the University of East London's School of Psychology. I am asking for your assistance with my doctoral research my allowing me to interview you for approximately an hour about your experiences of using CBT when working with people with early psychosis.

I will be asking you questions about your work with this client group. I am interesting in what has been helpful and hindering in your work and may ask you to use clinical examples if appropriate. This study hopes to provide insight into what it is like to work with this client group in the hope that it may contribute to clinical practice.

I have gained ethical clearance for the University of East London's ethics committee. The results will be written up in the form of a doctoral thesis and the results may be published. In both of these cases, all information will be anonymised. Your participation would be voluntary; I offer no reward or compensation. You would be free to withdraw from the study at any time (before, during or after the interview) and there would be no obligation to provide me with a reason. My research is being supervised by Professor Rachel Tribe.

I look forward to hearing your response by either return email or on my mobile, 07919 556 936. I appreciate you taking the time to read this and hope you can take the time to participate in my study.

Kind regards

Kim Reid

Kim.reid01@googlemail.com

Tel: 07919 556 936

Appendix B

Introductory letter and information sheet

Dear participant,

Thank you for you interest in my study. Before you decide whether or not to take part in this study, it is essential that you understand what the study is about, why it is being done and what will be involved if you decide to take part. Please take some time to look through this information sheet and feel free to discuss it with your friends, family or health professionals. Please feel free to ask me any questions you may have.

Kind regards

Kim Reid

Encl. Information sheet

Information sheet

Who is carrying out the research?

My name is Kim Reid. I am a trainee counselling psychologist and I am conducting this research for my doctoral degree. My work is being supervised by Professor Rachel Tribe who is a counselling psychologist and lecturer with experience of carrying out this type of research. She can be contacted via email: R.Tribe@uel.ac.uk. The study has been approved by the University of East London's ethical committee.

Why am I doing this research?

The research aims to explore the experiences of therapists who use CBT to work with people with early psychosis. The research will focus on what therapists' have found helpful and unhelpful in their practice. This may be in terms of the therapy, the clients or themselves. There are not many studies that explore the experiences of therapist who work in this area. By carrying out this type of research I hope to learn more about therapists' points of view and experiences which can then be shared with other professionals working in the field.

What does taking part in this study involve?

Taking part in this study involves meeting me to have a one-to-one conversation about your experiences and your thoughts about your use of CBT with this client group. This will take approximately an hour and I will record the conversation. We will meet at a time that is suitable to you. We will meet either at your offices or at an interview room at the University of East London. When we meet, I will ask you to sign a consent form which means that you agree to take part in the study. It is up to you to decide whether to take part in the study and you can change your mind at anytime, even if you have signed the form. If you decide to change your mind you don't have to tell me why.

What will I do with the recorded conversations?

I will listen to the interviews and transcribe them verbatim. I will analyse the data using a grounded theory methodology. I will then write up the results as part of my thesis for my Professional Doctorate in Counselling Psychology. The results may be published.

Will other people know who you are from reading the results?

No, your identity will be kept confidential at all times. I will use pseudonyms in my write up and only I will be aware of your identity.

Would you like to take part?

If you have decided that you are interested in taking part, please telephone or email me and we can arrange a suitable time to meet.

If you have any questions, please feel free to contact me on the number below. If you leave a message I will return your call.

Thank you for taking the time to read this information.

Kim Reid

Telephone number: 07919 556 936

Email: kim.reid01@googlemail.com

Appendix C

Information sheet

Who is carrying out the research?

My name is Kim Reid. I am a trainee counselling psychologist and I am conducting this research for my doctoral degree. My work is being supervised by Professor Rachel Tribe who is a counselling psychologist and lecturer with experience of carrying out this type of research. She can be contacted via email: R.Tribe@uel.ac.uk. The study has been approved by the University of East London's ethical committee.

Why am I doing this research?

The research aims to explore the experiences of therapists who use CBT to work with people with early psychosis. The research will focus on what therapists' have found helpful and unhelpful in their practice. This may be in terms of the therapy, the clients or themselves. There are not many studies that explore the experiences of therapist who work in this area. By carrying out this type of research I hope to learn more about therapists' points of view and experiences which can then be shared with other professionals working in the field.

What does taking part in this study involve?

Taking part in this study involves meeting me to have a one-to-one conversation about your experiences and your thoughts about your use of CBT with this client group. This will take approximately an hour and I will record the conversation. We will meet at a time that is suitable to you. We will meet either at your offices or at an interview room at the University of East London. When we meet, I will ask you to sign a consent form which means that you agree to take part in the study. It is up to you to decide whether to take part in the study and you can change your mind at anytime, even if you have signed the form. If you decide to change your mind you don't have to tell me why.

What will I do with the recorded conversations?

I will listen to the interviews and transcribe them verbatim. I will analyse the data using a grounded theory methodology. I will then write up the results as part of my thesis for my Professional Doctorate in Counselling Psychology. The results may be published.

Will other people know who you are from reading the results?

No, your identity will be kept confidential at all times. I will use pseudonyms in my write up and only I will be aware of your identity.

Please feel free to ask me any questions.

Thank you for taking the time to read this information.

Kim Reid

Telephone number: 07919 556 936

Email: kim.reid01@googlemail.com

Appendix D

Consent Form

I confirm and understand that:

1. This study is voluntary and I have the right to withdraw at any time
2. I have read and understood what the study is about and understand what the interview will involve
3. I have been given the opportunity to ask questions and discuss concerns with the researcher.
4. I understand that this meeting will be recorded and that the information will be used in a research paper but that my personal details or identifying factors will not be revealed.
5. I understand that everything I say is confidential. What I say will not be shared with anybody else unless the researcher feels I am at risk of hurting myself or others.
6. I understand that in the research my story will be anonymous.
7. I do not have to answer questions if I do not want to.

Name: _____

Signature: _____

Date: _____

Researcher's Name: _____

Signature: _____

Date: _____

Appendix E

Interview Schedule 1

1) Can you recall a client with EP who you engaged well with?

What was it like engaging with them?

Was there anything that helped or hindered you?

About yourself?

About the therapy? Prompt: any tactics you used

About the client?

2) Can you recall a client with EP who was challenging to engage but you did?

What was it like engaging with them?

Was there anything that helped or hindered you?

About yourself?

About the therapy? Prompt: any tactics you used

About the client?

3) Can you recall any clients who you were unable to engage?

What was that like? What hindered you?

About yourself?

About the therapy? Prompt: any tactics you used

About the client?

Appendix F

Interview schedule 2:

Can you recall a client(s) that you worked really well with:

- Can you tell me what it was like working with them?
- Can you tell me a bit about engaging this client/building a relationship?
    - How did you go about it?
    - How did the client respond?
    - How did you know the client was engaged?
    - Did anything feel different for you?
    - Did anything influence your actions?
    - What was going on in therapy when you felt engaged?
    - Did anything change when you felt engaged?
- Was there anything that helped you to engage this client?
    - About the client?
    - About the therapy? (techniques)
    - About yourself? (beliefs)
- Was there anything that challenged you?
    - About the client?
    - About the therapy? (techniques)
    - About yourself? (beliefs)
- How did you overcome these challenges?
- Do you have any further comments on engagement/relationship building?

Appendix G

Interview schedule 3:

Can you recall a client(s) that you worked really well with:

- Can you tell me what it was like working with them?
- Can you tell me a bit about engaging this client/building a relationship?

- Was there anything that helped you to engage this client?
    - About the client?
    - About the therapy? (techniques)
    - About yourself? (beliefs)

- Was there anything that challenged you?
    - About the client?
    - About the therapy? (techniques)
    - About yourself? (beliefs)

- In your experience does the model of CBT impact on the process of engagement?
- Do any issues of difference and diversity impact on the process of engagement?
- Does a client receiving a diagnosis of psychosis impact on engagement?
- How does the service you work in impact on engagement?
- How does drug use impact on engagement?
- How did you overcome these challenges?

Appendix H

Interview Schedule 4

Can you recall a client(s) that you worked really well with:

- Can you tell me what it was like working with them?
- Can you tell me a bit about engaging this client/building a relationship?

- Was there anything that helped you to engage this client?
    - About the client?
    - About the therapy? (techniques)
    - About yourself? (beliefs)

- Was there anything that challenged you?
    - About the client?
    - About the therapy? (techniques)
    - About yourself? (beliefs)

- How did you overcome these challenges?
- In your experience, how does drug use impact on engagement?
- How might you approach cultural differences with clients? Are there any specific challenges germane to the area you work in?
- Are there any other differences you might work with which can be challenging to engagement? How might you overcome these?
    - Age?
    - Gender?
- In your experience, what (if any) is the impact of diagnosis on engagement?
- Is there anything about your team/service that is helpful (or not) in terms of engagement?
- Is there anything about CBT that is more or less helpful when engaging clients
    - Homework
    - Collaboration
    - Structure of CBT

- How do you see yourself in relation to others in the team?
- What do you think about the term engagement?
- Do you have any further comments on engagement/relationship building?

Appendix I

Ethical Approval

Rachel Tribe
Psychology School, Stratford

ETH/12/92

10th June 2010

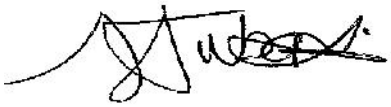
Dear Rachel,

Application to the Research Ethics Committee: Therapists experiences of working with early psychosis. (K Reid).

I advise that Members of the Research Ethics Committee have now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely



Simiso Jubane
Admission and Ethics Officer
s.jubane@uel.ac.uk
02082232976

Appendix J

Debriefing: The experiences of using CBT for early psychosis

Thank you for taking part in my study.

This study aims to look at therapists' experiences of cognitive behavioural therapy when working with people with early psychosis. I hope that this information can help us to understand what is useful and what isn't useful to therapists. By taking part in this research you have helped to do this. I am grateful for the time and effort you have taken to participate in this study, I really appreciate it.

Should you have any questions, please feel free to contact me on the following details:

Telephone: 07919 556 936
Email: kim.reid01@googlemail.com

Thank you again for taking part in this study