BELIEFS ABOUT PSYCHOLOGICAL THERAPY FOR PSYCHOSIS

A thesis submitted to The University of Manchester for the degree of Doctor of Clinical Psychology in the Faculty of Medical and Human Sciences

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Thesis Abstract
Beliefs about psychological therapy for psychosis

A thesis submitted for the Degree of Doctor of Clinical Psychology
Joanne Cater Holding, University of Manchester, 2014

The thesis provides a detailed exploration of the beliefs people with experiences of psychosis have about psychological therapy. It is presented in three papers: (1) a literature review, (2) an empirical study and (3) a critical evaluation and reflection on the research process.

The literature review used a narrative synthesis approach to systematically review, explore and consolidate the existing qualitative and quantitative literature available on beliefs about therapies for psychosis. Thirty-five studies were identified for inclusion. Distinct themes and subthemes were developed for two distinct types of beliefs: Expectations and Experience. Within expectations, three themes were described: outcomes, process and barriers. Within experience, four themes were described: satisfaction, outcomes, process and therapist characteristics. Subtheme descriptions were used to highlight the multi-faceted and complex beliefs services users hold about therapy. Levels of satisfaction were high and many positive outcomes were reported. However, the available data is primarily limited to those who have completed therapy, resulting in an unbalanced account available in the literature. Data about expectations has also not been adequately addressed. Key areas for clinical intervention and future research opportunities are highlighted.

The empirical study attempted to build on findings from the literature review and employed Q-methodology to explore beliefs about therapy for psychosis with young people in Early Intervention Services (EIS). Four distinct belief factors were identified: (1) Therapy is helpful and gives hope for the future; (2) Therapy is just talking, people need medication; (3) Therapy is useful but stigmatising; (4) Therapy is better than medication. Positive accounts of therapy were most strongly expressed within factor 1, but all factors contained some regard for the therapeutic process. Other important views were present in these accounts as well, including both the importance and dislike of medication, as well as concerns about potential stigmatisation. Q methodology proved to be a useful tool for engaging with young people and developing a rich understanding of a complex topic. The Q study has addressed some of the limitations described in the literature review and highlighted important areas for clinical consideration. Further research is still required to address outstanding issues, such as beliefs of people who are difficult to engage and people from Black and Minority Ethnic (BME) communities.

The third paper is a critical evaluation of the research process in totality. This includes reflections on decision-making processes, as well as lessons learned for the future. It provides a final overview of the clinical and research implications highlighted by the previous two papers, concluding that beliefs about therapy are important and warrant further detailed exploration by clinicians and researchers, to improve practice and service user experience.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
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This thesis would not have been possible without the help of many people during the process.

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I would like to thank my husband Neil for his patience, humour and unending support during the research process and my clinical training. His love and good cooking have kept me going in the best and worst of times.

Finally, I would like to thank my son Jack, who without even knowing it, has kept me both focused and grounded, always helping me maintain my perspective.
Individual’s experiences and opinions of psychological therapies for psychosis:

a narrative synthesis

Prepared according to submission guidelines for

Clinical Psychology Review (see Appendix 1)

Word count*: 10,896

*Excluding: references, figures and tables
Abstract
Psychological therapy is recommended as an important element for the treatment of psychosis, however, many clients refuse, do not attend or withdrawal from psychological therapy. Beliefs, attitudes and expectations about therapy are likely to influence engagement, adherence and outcomes in psychological therapy but despite increased research interest in this area, the evidence has not been systematically reviewed or synthesized. This review is the first to explore service user beliefs by synthesising existing quantitative and qualitative research in order to develop a comprehensive understanding of beliefs about psychological therapy in people with psychosis and to identify gaps in the literature. Thirty-five papers were included in this review and synthesised. Themes and subthemes of both service user Expectations (including outcomes, process and barriers) and Experiences (including satisfaction, outcomes, process and therapist characteristics) are described. High levels of satisfaction and positive regard towards therapy for psychosis were found. However, data is primarily limited to people who have completed therapy. Expectations about therapy have not been adequately addressed and warrant further exploration. Exploration of beliefs, particularly in those who refuse or terminate therapy, is essential to further our understanding of factors affecting services users’ decision-making processes, as well as the efficacy of therapy.

Keywords
Psychological Therapy, Psychosis, Beliefs, Expectations, Narrative Synthesis
Introduction

Psychological and psychosocial interventions are recognised as essential elements of treatment for people at risk of or experiencing symptoms of psychosis, either as adjuncts or alternatives to pharmacological treatments (NICE, 2011; 2014). These recommendations are based on a growing evidence base for the efficacy of psychological therapy in psychosis, particularly for Cognitive Behavioural Therapies (e.g. Jauhar et al, 2014; McGurk, Twamley, Sitzer, McHugo, & Mueser, 2007; Morrison et al, 2014; Pilling et al, 2002). However, there remains a critical debate over the evidence available (e.g. Lynch, Laws, & McKenna 2010). Not everyone improves using these approaches and there is currently little evidence for improvement in clinical outcomes for people with coexisting substance misuse (e.g. Barrowclough et al, 2014; Cleary, Hunt, Matheson, Siegfried & Walter, 2008).

Research has therefore begun to explore predictors of outcomes in therapy (e.g. severity and type of symptoms; substance use; insight, illness history; duration of untreated psychosis (DUP) and demographic characteristics) (e.g. Fanning et al, 2012; Lambert et al, 2005; Lincoln et al, 2014; Morrison et al, 2012b; Naeem, Kingdon & Turkington, 2008; Perivoliotis et al 2010; Tarrier et al, 1998a) but consensus has not been achieved.

Service users’ beliefs about therapy do not appear to have been considered when exploring factors related to engagement or clinical outcome, which may limit our understanding of the efficacy of therapy (Fowler, Garety & Kuipers, 1995). Moreover, the appropriateness and acceptability of psychological interventions is often determined by number of sessions attended, rather than the participant’s own evaluation. Historically, some researchers doubted the ability of this client group to
provide accurate and useful information. There is good evidence that people with psychosis can provide insightful and reflective accounts of their subjective experience (e.g. Allen, Burbach & Reibstein, 2012; Coursey, Keller & Farrell, 1995; Newton, Larkin, Melhuish & Wykes, 2007), which can offer researchers and clinicians valuable insight into service users’ understanding of therapy as well as into therapy practices (Kilbride et al, 2013).

Two reviews have acknowledged the importance of these beliefs and explored the qualitative literature available for experiences of therapy. Berry & Hayward (2011) used a qualitative synthesis approach to investigate service user perspectives about Cognitive Behavioural Therapy for psychosis (CBTp). A strength of this study was that it focused on direct accounts from service users, not author interpretations. However, only eight studies were found for inclusion and other therapy modalities were ignored. Hodgetts & Wright’s (2007) review explored qualitative accounts of service users’ general experiences in mental health settings, which also included process and therapy issues. It was not limited to services users with psychosis however and included summaries of other authors’ interpretations.

CBT is not the only therapy available to people with psychosis, and broadening the scope to include other forms of therapy such as Family Interventions (FI) and Cognitive Remediation Therapy (CRT) is warranted to further enhance our understanding of service user experiences. Preconceptions or expectations may impact on whether and how service users engage with therapy, but accounts of these are missing from the literature (Hui et al, 2006; Lecomte et al 2008; Mutsatsa et al, 2003).
Many factors are likely to influence if and how people engage in therapy, which may in turn impact on outcomes (Westra, Aviram, Barnes & Angus, 2010). A more comprehensive understanding of beliefs about therapy for psychosis could be useful to both research and clinical practice, to support better communication between professionals and service users, and potentially promote engagement and improve outcomes. Previous reviews included only qualitative data. While these provide the ‘richest’ accounts of the service user perspective, few have been conducted. The inclusion of quantitative data along with subjective accounts, may allow for the inclusion of more evidence, which may help further our current understanding of service user beliefs.

**Objectives**

The aims of this review were to answer two primary questions:

1. How many studies have described beliefs and experiences about therapy of psychological therapies for psychosis?
   a. What is the nature of those studies and the characteristics of the populations described?
   b. How have beliefs and experiences been measured?

2. What does the evidence say about individual’s beliefs and attitudes about therapy for psychosis?
   a. What are people’s expectations about therapy?
   b. What do people think about their experience of therapy?
   c. What do people think about those who delivered therapy?
Method

Eligibility criteria

This review aimed to identify papers that presented any account from potential or actual service users about therapy for psychosis, therefore did not restrict the search to one type of methodology or articles published during a particular period of time. Inclusion criteria for studies were: (a) available in English; (b) described data which examined peoples’ expectations or experience of any psychological therapy for psychosis (c) included data from potential, current or past service users, including families of service users if involved in family interventions and (d) included participants aged 16 to 65. Exclusion criteria were: (a) studies focusing solely on medication treatments; (b) studies presenting only theoretical or opinion data from researcher or clinician viewpoints; and (c) studies examining solely other mental health diagnostic categories. Studies with Serious Mental Illness (SMI) samples, which predominantly included people with psychosis diagnoses, were included.

Search procedures

Twenty-four electronic databases were initially searched via Ovid SP (Appendix A). All databases were searched using multiple combinations of the three categories: Psychosis terms (n=9) (Psychosis, Psychotic, Schizophren*, Voice*, Delusion*, Paranoi*, Hallucination, Voice Hearing, Negative symptom*) (identified from the abstract); Belief/Experience Terms (n=18) (Attitude*, Belief*, Opinion*, Barrier*, Preference*, Choice, Choose, Expect*, Experience*, Perspective*, Outcome, Drop out, Engage*, Disengage*, Adhere*, Fail to continue, Attend*, Perception*) (identified from the title), and Therapy terms (n=30) (Psychological
therap*, Psychological treatment, Psychological intervention, Psychotherap*,
Psychosocial therap*, Psychosocial treatment, Psychosocial intervention, Cognitive
therap*, Behav* therap*, Cognitive Behav* Therap*, CBT, Metacognitve therap*,
MCT, Mindfulness, MBCT, Schema therap*, Compassion focused therap*,
Acceptance and Commitment Therap*, ACT, Interpersonal Therap*, Psychoanaly*,
Psychodynam*, Family Therap*, Family Treatment, Family Intervention, Social
Skills Training, Cognitive Remediation, Neuropsychological Therap*.
Neuropsychological Treatment, Neuropsychological Intervention) (identified from
the title). Search terms were agreed by all authors following a detailed review of
terms describing psychosis and of therapies available for this population.

Towards the end of the initial screening process, an additional search term of
‘satisfaction’ was identified and the decision was made to conduct an additional
search using this term, in combination with psychosis and belief terms. It was
decided that ‘satisfaction’ would be most appropriately identified from the abstract,
as this is usually included as an outcome measure, not a primary aim of research. The
flow diagram for the 35 included papers, including two separate searches, can be
seen in Figure 1. In summary, a total of 812 articles were identified in the Ovid
search, 758 of which were excluded at initial screens. A further 49 articles were
identified as potentially eligible through reference searching. One hundred and three
full text articles were screened for inclusion: 68 were excluded, which resulted in a
total of 35 articles to be included in this review.

[Figure 1. HERE]
**Data extraction and quality assessment**

The first author (JH) assessed the eligibility, extracted the data, and rated the papers using quality assessment checklists for all the papers included in the review. The first author consulted with the other authors to make final decisions about article inclusion where necessary. One article was excluded as it contained opinions and reflections about a single therapist and interviews were conducted years after therapy had concluded (Levander & Cullberg, 1994). Six articles including satisfaction data were excluded because they did not provide details of the measures used, data collection procedures, or context of results (Jenner et al, 1998; Jolley et al, 2003; Moritz & Woodward, 2007; Röhrich & Priebe, 2006; Sensky et al, 2000; Waller et al, 2013). One article with participant ages exceeding upper limits was included, [range 20 – 74, mean (SD) = 38.1 (11.3)] as the majority of participants were within age limits and seemed appropriate to consider as an ‘adult’ sample.

Quality of included studies was assessed using the National Institute for Health and Clinical Excellence (NICE) Methods for the development of NICE public health guidance checklists (NICE, 2012) which are suitable for both qualitative and quantitative reports (Appendices 2 to 4). Qualitative studies were given one total rating and quantitative studies two ratings, one for internal validity (IV) and one for external validity (EV), both on a three point system (+++, +, or –). Studies achieve a ‘++’ when all or most of the checklist criteria have been fulfilled (good); a ‘+’ when some criteria have been fulfilled (fair), and where not fulfilled or not adequately described, the conclusions are unlikely to alter; and a ‘–’ when few or no checklist criteria have been fulfilled and the conclusions are likely to alter (poor).
Quality appraisal was not used as a decision making tool about inclusion for this review (Popay et al, 2006). If a paper received a low score (i.e. −) it was not excluded from the review on these grounds since the aim of this review was to include as many service user viewpoints as possible. Limitations of papers are considered throughout the review. A second rater (PI) independently assessed 20% of papers (n=8). Inter rater reliability was 87.5%. When differences arose, discussion took place and consensus was achieved and third party consultation was not deemed necessary. Data were extracted and tabulated for all papers included in the review.

Data analysis

Data analysis and reporting was guided by narrative synthesis techniques, supported by recommendations from Popay et al (2006), as well as the PRISMA statement (Moher, Liberati, Tetzlaff, Altman, The PRISMA Group, 2009). Narrative synthesis uses words and text to summarise and explore data that can be from both quantitative and qualitative approaches. Recommendations were followed about using specified search methods and organising the output as a synthesis, to ‘tell a story.’ First, a preliminary synthesis was developed. The same relevant data was extracted from all papers (Appendix 5) and tabulated (Appendix B). Data extracted varied according to study methodology. From qualitative papers, the main focus was on extracting actual quotes from participants, not themes already coded by other authors, in order to create a synthesis. Frequency counts from content analysis, and in some cases narrative summaries of data from authors, were also considered. From quantitative papers, relevant questionnaire or survey data, usually presented as frequencies was extracted.
Thematic analysis techniques were used to extract, code, organise and report patterns or themes (Braun & Clark, 2006; Vaismoradi, Turunen & Bondas, 2013). Data was initially organised as either expectations or experience of therapy, and other codes were developed to describe specific aspects of these categories. Themes and subthemes were developed and refined until a coherent pattern was formed. As can be seen in Table 1, within expectations, three themes were identified: outcomes, process, and barriers. Within experience, four themes were identified: satisfaction, outcomes, process, and therapist characteristics. Subthemes were developed to help clarify nuances of each theme. The second and third authors independently verified the structure.

[TABLE 1 Here]

**Results**

**Question 1.**

How many studies have described beliefs and experiences about therapy of psychological therapies for psychosis? (a) What is the nature of those studies and the characteristics of the populations described? (b) How have beliefs and experiences been measured?

A description of included studies in presented in detail in Appendix B. The 35 included studies were conducted in six countries, with 74% (n=26) of the research conducted in the UK. Other countries included the USA (n = 5), Australia (n= 1), Canada (n= 1), the Netherlands (n= 1), and Sweden (n= 1). The number of participants in each study ranged from three to 422. Seventeen studies were qualitative; 11 quantitative and seven employed mixed methods. In several
quantitative or mixed methods studies, the number of participants completing the relevant measures was less than the total sample size on which demographic characteristics were reported.

As per inclusion criteria, the majority of studies only included participants with psychosis-spectrum diagnoses. Seven studies did not use diagnostic categories for inclusion but rather presence of symptoms, such as hallucinations or delusions, or engagement in psychosis services (Hayward & Fuller, 2010; Kilbride et al, 2013; Kuipers et al, 1997; McGowan et al, 2005; McLeod et al, 2007; Messari & Hallam, 2003; Newton et al, 2007) likely reflecting the tendency for many services’ (particularly Early Intervention Services) to avoid use of diagnostic labels (Newton et al, 2007). One study recruited only participants at-risk of developing psychosis (Byrne & Morrison, 2010). Three studies also included participants with other forms of ‘severe mental illness’ (SMI) (Coursey et al, 1998; Svennson & Hansson, 1998; Revheim et al, 2001). Participants were recruited from a variety of settings, including community settings, such as Community Mental Health Teams (CMHT), Early Intervention Services (EIS), Assertive Outreach Teams (AOT), and Inpatient Wards.

Five studies did not report age, and eight only reported means. Three studies did not report gender. Over half (n=19) of studies did not report ethnicity data and three studies only recruited participants from Black and Minority Ethnic (BME) communities.

Five studies did not report therapy type. Three of these asked about therapy experience in general, one study was a Cognitive Remediation Therapy (CRT) demonstration used to develop cultural adaptations for BME clients (Press et al, 2011), and one explored hypothetical preferences for therapy (Sumner et al, 2013). In the
remaining 30 studies, cognitive-behavioural approaches were predominant but other types were described as well, such as Relating Therapy, CRT, and integrative approaches. Sixteen studies concerned individual therapy, including one adapted for BME service users (Rathod et al, 2013) and one explored web-based Cognitive Behavioural Therapy for Psychosis (CBTp) (Gottlieb et al, 2013). Group therapy approaches were explored in nine studies, usually focusing on mindfulness or hearing voices. Two studies included Family Intervention (FI) approaches and three studies focussed on CRT. Reporting of further details, such as therapy duration, therapist background, or number of sessions offered or attended was variable. As can be seen in Table 1, 15 studies included data about service user expectations and 32 about experience, nine of which included participant views about therapist characteristics.

Quality appraisal ratings for the qualitative studies were predominantly high, with 13 achieving good quality ratings (++). One was of fair quality (+) and three had poor ratings (−). Quantitative studies were more mixed, with none achieving good ratings for both internal and external validity. Appraisal of the mixed methods studies also produced variable results, with no studies meeting all checklist criteria to a good standard. With the exception of Sumner et al (2013), none of these studies report rigorous qualitative research, neglecting to describe methods or analysis in detail. As such, none would have reached full qualitative checklist criteria. Qualitative data was considered along with the reliability of subjective measures and procedures, in order to produce a final internal validity score.

Two studies were not rated using the NICE (2012) checklists, as the focus of these papers was not compatible with quality appraisal (Lecomte et al, 2003;
Revheim et al, 2001). These papers described the rationale, design, and implementation of a therapy into a service. They met inclusion criteria as basic satisfaction data and comments from service users were included, although very little detail was provided as to how this information was obtained.

**Question 2.**

What does the evidence say about individual’s beliefs and attitudes about therapy for psychosis?

**2a. What are people’s expectations about therapy?**

*Expectations about outcome*

*Positive expectations about outcome*

As can be seen in Table 1, five studies presented information about individuals’ positive expectations for therapy to be useful or bring about change in their life, although very little data was available overall. The three qualitative studies included achieved good (++ quality ratings, however the two qualitative and mixed methods studies achieved fair ratings (+/+). This was mainly due to omission of potentially confounding variables and limitations on participant inclusion, including small sample size in one study (Miles et al, 2007).

Participants in Miles et al.’s study (2007) had high expectations about how much progress they would make, rated at the end of therapy, not the beginning. Some people expressed positive beliefs about therapy’s usefulness, as well as being a different kind of support than they already had, possibly offering a deeper understanding or more consistent support (Rathod et al, 2010; Sumner et al, 2013).

“I probably would like to see if I could get to the bottom of why I have developed this illness.” (Rathod et al, 2010, p.522)
Others talked about feeling hopeful that therapy could help, and anything that could help would be worth trying (Goodliffe et al, 2010; Sumner et al, 2013).

“Well, anything might help, anything. Any type of therapy or psychology or talk might help. And that’s why I wanted to come.” (Goodliffe et al, 2010, 451)

Others spoke about having fixed, almost all or nothing expectations, about what they could achieve in therapy (Goodliffe et al 2008). For example, people may believe therapy can help them get rid of voices, and that this would be the only way a positive outcome could be achieved.

“I wasn’t expecting to be able to cope with the voice still there. I wasn’t expecting to, just be in control. I was expecting to either have the voice or not have the voice.” (Goodliffe et al, 2010, p.454)

Finally, expectations about positive outcomes weren’t limited to improvements in mental state, but were also practical, such as to achieve other aims, like complying when on an inpatient ward with the hope of being discharged sooner (Messari & Hallam, 2003).

*Negative Expectations about Outcome*

Five studies presented data on people’s negative expectations (either current or past) on therapy’s ability to bring about change, two of which present lay people or family members viewpoints (Rathod et al 2010; Standbridge et al, 2003). One study was not rated. Three of the four qualitative studies received good ratings (++). One received a fair rating (+) due to lack of information available about the role of
the researchers in conducting interviews and data analysis, which could introduce potential bias in the results.

Individuals and families expressed general doubts about the utility of therapy (Dunn et al, 2002; Lecomte et al, 2003; Messari & Hallam, 2003; Stanbridge et al, 2003).

“I was concerned that it wouldn’t do us any good and that we wouldn’t achieve the objectives we were there for.” (Father) (Stanbridge et al, 2003, p.188)

Some felt therapy could worsen their situation (Stanbridge et al, 2003), while others felt hopeless because they felt their problems were unique or nothing else had worked before (Lecomte et al, 2003).

“An intellectual fear that things would unravel and not be able to be put back together again. We were relieved someone was picking it up but not sure where it would all end.” (Client and wife) (Stanbridge et al, 2003, p.188)

Finally, in a study only including BME participants, a lay perspective suggested that negative evaluation of therapy effectiveness was more to do with attributions about the origin of mental health problems, such as due to previous wrong-doing (personal or family) or supernatural beliefs (such as evil spirits, spells, or the evil eye) (Rathod et al, 2010). In these situations, therapy was not considered appropriate or helpful, and families favoured alternative approaches such as speaking with religious leaders, faith healers, or community elders (Press et al, 2011; Rathod et al, 2010).

**Ambivalent expectations about outcome**

Seven studies presented data suggesting therapy was in some way not appropriate, either because participants felt they were not in need of it, or believed
something else would be more beneficial (not explicitly negative about therapy).

Some people didn’t think they needed therapy at the time they were offered because it had been offered after the time it may have been helpful or because they were satisfied with other support (Sumner et al, 2013; Tarrier et al, 1998). Some simply did not want help, e.g. in McLeod et al.’s (2007) study four potential participants had positive relationships with benevolent voices so opted not to take part in group therapy.

Some thought medication would be more useful than therapy. In a large survey, Coursey and colleagues (1995) found that 15.4% of their sample believed they would find medication alone most useful, compared to talking therapy or a combination of medication and therapy. Preferences were not related to beliefs about aetiology of mental health problems (e.g. brain disease or psychological problem).

Two studies found cultural differences between participants’ medication preferences over therapy. Coursey et al’s (1995) African-American participants endorsed medication alone compared to White respondents (26% vs. 9%). In a study with only BME participants, Rathod and colleagues (2010) found South Asian Muslim participants were more positive about being medicated than African Caribbean participants.

“They believe in physical ‘would take pill rather than talk to’ . . . Drips are seen as effective and reinforced by medical professions and private hospitals . . . The concept of the “drip hanging” and the person lying supine is embraced in belief that “strength is being transferred to a person” (Pakistani lay member) (Rathod et al, 2010, p.522)

One participant in one study reporting dropping out of group therapy because he believed physical exercise to be more effective than medication or therapy (Lecomte et al, 2003) but no further information was provided about this participant,
and this study had not been designed as qualitative study or quantitative study. It had limited data overall and was unable to be quality appraised. Other studies in this section received variable ratings, with two receiving good (++) qualitative ratings and two receiving fair (+/-) ratings due to restrictions on sample and potential bias of confounding variables on the results. Two had poor (−/−) quality ratings as they have very small self-selected sample sizes with non-validated outcome measures designed for each study’s purposes. In addition, it is not clear if McLeod et al’s (2007) data were obtained by someone administering the questionnaire as an interview or from participants’ hand written responses.

Expectations about process

Positive expectations about therapy process

Accounts of positive expectations about the therapy process were reported in three studies (Kilbride et al, 2013; Press et al, 2011; Sumner et al 2013). The two qualitative studies were robust and achieved good (++) quality ratings. The mixed methods study (+/-) (already included in previous sections) had limitations on sample selection. Some people felt generally positive about the process.

‘‘It’s good to have more information from people who have had the experiences so I know what to do in the future’’ (Sumner et al, 2013, p.4)

Views on group experiences were mixed. Some were anxious but others welcomed the group format, even when they did not particularly feel positively towards CBT in general, suggesting the perceived importance or desirability of the social or community aspect of group approaches.

‘‘I’m not over the moon about cognitive therapy but I like the idea of meeting people with the same experiences’’ (Sumner et al, 2013, p.4)
It also seems evident that people can hold unrealistic positive expectations about what therapy may be like.

“When I first like you know got told I was gonna have CBT you just expect you get better…” (Kilbride et al, 2013, p.96)

Negative expectations about therapy process

Five studies reported participants’ negative expectations about the process of therapy. Two qualitative studies were of good (+/+) quality, although one was poor (−). The findings of this study were rich, but the authors did not report how data was collected or analysed so data quality could not be judged (Allen et al, 2012). One study was fair (+/+ and one was poor (− /−), for reasons described previously, suggesting their findings should be interpreted with caution.

Common themes were anxiety, worry and uncertainty about the therapy process and the affect it could have on them. Stanbridge et al (2003) reported that 10 families experienced anxiety or worry when referred to family therapy, and this view seems to have been shared by others thinking about individual or group formats.

“I was a bit nervous because I didn’t want anyone to know what state I was in at the time, because it made me feel really vulnerable” (Allen et al, 2012, p. 217)

Some people expressed concerns about others involved in the therapy; for some, this was about the expected dynamic with the therapist and whether it would be a trusting relationship or not. Coursey and colleagues (1995) presented data about how long people expect it to take to feel comfortable and trust a new therapist. Forty-two per cent said it would take a month, 23.2% said 3 months, 12.7% said 6 months, and 22% said a year or more.

“If you don’t trust them you aren’t gonna tell them what you’ve been through and you aren’t going to go into depth with people.” (Kilbride et al, 2013, p.91)
For others, there was a bigger trust issue regarding mental health services as a whole, with some fearing hospitalisation or incarceration if they engaged with services. There were also worries about confidentiality and members of the local community becoming aware of individuals’ difficulties (Rathod et al, 2010). Other participants had negative expectations about what a group process would be like. Three participants in McLeod et al’s (2007) study felt too threatened by the idea of a group and chose not to take part.

“I don’t like talking about problems in a group” (Sumner et al, 2013, p.4)

*Expectations about barriers to therapy*

Five studies present accounts of other potential barriers to people starting therapy, that do not necessarily have to do with negative expectations about the process or outcome of therapy. Overall the studies included here were methodologically sound and achieved good ratings (++), with only one study receiving a poor rating for reasons already described (McLeod, et al, 2007).

For some, while they may recognise that they do need help, it can be difficult to come to terms with having difficulties or knowing what to say to others, or feel limited by cultural expectations (Byrne & Morrison, 2010; Rathod et al 2010). Women in some Black communities are expected to be emotionally strong for the family and admitting they needed help would be a sign of vulnerability or weakness (Rathod et al, 2010).

“I’d always really wanted help but I had trouble admitting I had problems… it was even harder to admit it to somebody else to get help for it” (Byrne & Morrison, 2010, p.165)
One participant mentioned that her voices could have stopped her from attending therapy, and while they did allow her to attend, they laughed at her for doing so, which could be a further potential barrier to attendance (Goodliffe et al, 2010).

“They allowed me to come to these groups and the reason for that was that they could laugh at me and what I was doing here (Goodliffe et al, 2010, p.451).

There appeared to be other practical barriers as well, such as preferring home visits to avoid costs of childcare or travel, however others said they would not prefer visits at home because of potential distractions (McLeod et al, 2007; Press et al, 2011).

There were concerns in BME communities about cultural differences, including language or cultural barriers and preferences about gender or ethnicity of professionals that could prevent people from engaging in therapeutic approaches (Press et al, 2011; Rathod et al, 2010). For example, first generation immigrant males tended to prefer male staff as they perceived them to have more authority. Some Pakistani participants had concerns about gender and race of visiting staff, e.g. a white male seen working with a Pakistani female because of fears about future marriage arrangements. Community members also had worries about being misunderstood or difficulties with interpreters and anticipated a better therapeutic relationship with someone of the same colour or background (Rathod et al, 2010).

The largest barrier concerned the potential stigma of receiving treatment for a mental health problem. This was evident in both white and BME populations. Participants in Goodliffe et al’s (2010) group felt judged by others who did not share in their voice hearing experiences. BME participants were concerned about the effect on their future prospects (e.g. marital, employment) as well as bringing shame on
themselves, families and the wider BME community. Keeping difficulties within the family was sometimes preferred (Press et al, 2011; Rathod et al, 2010).

“When I first became ill, I was reluctant to talk to people, because I thought, what are they going to think of me?…, the doctor said, do you want to be referred to counselling and I said no, I don’t want to be classed as someone who is ill…I was like, really conscious of what everybody would think about me and like if everybody found out I was in hospital, what they would be thinking about me.” (Press et al, 2011, p.124)

**Summary: Expectations about therapy**

In total, 15 studies reported findings about people’s expectations about therapy. In many cases this was limited to one or two comments per paper. None of the studies focused on expectations about therapy and there is a subsequent lack of evidence. Available data was collected in a number of different ways, including by questionnaire, structured or semi-structured interview, in individual or focus group formats, which each have strengths and limitations.

Researchers investigating hypothetical preferences or cultural adaptations for therapy (Press et al, 2011; Rathod et al, 2010; Sumner et al, 2013) provided the most relevant findings. In the twelve remaining studies, the majority of participants had largely completed therapy. Only four studies asked about participant expectations (Goodliffe et al, 2010; McGowan et al, 2005; Miles et al, 2007; Stanbridge et al, 2013) but McGowan et al (2005) did not report any expectancy results. Questions were only asked after therapy had been completed in the other three studies, which will have introduced bias of therapy experience on responses.

Recruitment difficulties and early drop out from therapy was common. Miles et al (2007) reported that less than half of their referrals completed therapy and 28% of those who commenced therapy, dropped out before the fifth session. Those that
dropped out or refused therapy are not reflected in any of the views about expectations presented here.

**2b. What do people think about their experience of therapy?**

*Satisfaction with Therapy*

As can be seen in Table 1, studies used a variety of different measures to obtain client satisfaction ratings about therapy. Three studies use the Client Satisfaction Questionnaire-8 (CSQ-8; Attkisson & Zwick, 1982), one used the Patient Experience Questionnaire (PEQ; IAPT, 2008) and one used the Satisfaction with Therapy questionnaire (STQ; Beck et al. 1993). Four studies used novel questionnaires designed for their individual studies and four used interview methods.

Rates of satisfaction with therapy were high across these 14 studies, and when asked, participants almost unanimously said they would recommend the therapy to others.

The qualitative studies were rated good (++) and poor (−), the latter due to poor planning and lack of detail about research design, data collection, or analysis. The other quantitative or mixed method studies received lower ratings most often due to limitations on sample selection or size, as well as limitations of measures making it difficult to draw firm conclusions.

**Outcomes**

*Positive outcomes from therapy*

Twenty-three studies include accounts of positive outcomes from people’s experiences of therapy, including improvement and making changes in their lives, skill acquisition (often linked to change), acceptance, and providing hope for the
future. Three of the studies included self-report data (Coursey et al, 1995; Rose et al, 2008; Stanbridge et al, 2003) but most of the data are qualitative accounts of people’s views. This section has the most papers included and the most data available. Over half of the studies contributing to this section used qualitative methodology and were overall of good (++) quality, although one study was of fair (+) quality and three studies were poor. For two studies this was due to lack of detail reported in the paper (Allen et al, 2012; Dunn et al, 2002), however two were planned after initial interventions took place, one of which used pre-existing data (Brown et al, 2010; Cupitt et al, 2004). Three did not describe who conducted the data collection or analysis and in Brown et al’s (2010) study, this was the lead investigator, who was also the lead instructor for the mindfulness group, introducing significant bias and bringing into question the accuracy of the findings. For the quantitative and mixed methods studies, quality was variable. Many were pilot or feasibility studies, so did not meet rigorous standards of full-powered RCTs, and had limitations due to sample sizes and composition, measures and subsequent analyses.

Positive outcomes were most often described as change or improvement in symptoms, including distressing beliefs, voices, mood, anxiety, and self-concept.

“that gives me more confidence, more self-esteem, because I think I don’t have to be . . . under the control of the Devil [voice] anymore. I can just try and be myself” (Hayward & Fuller, 2010, p.369)

Quantitative studies describe high improvement rates, including general positive changes, such as feeling better about themselves, improvement in symptoms, changes in beliefs about voices and managing problems better (Chadwick et al, 2000; Coursey et al, 1995; Rose et al, 2008; Stanbridge et al, 2003).
Many people viewed the acquisition of new skills as a positive outcome (included in 16 studies). The majority of included studies were cognitive therapy based and participants valued developing awareness of their thoughts, symptoms, and reactions. People felt like they could cope better with their experiences and valued gaining new understanding or knowledge about their experiences.

“I do feel more stable and relaxed and it’s helped me with my paranoia . . . I find myself asking, ‘Is this really happening or am I perceiving it happening?’ since I’ve been practicing the meditation and breathing.’” (Brown et al, 2010, p.235)

Positive outcome was not always linked to change, but developing an acceptance of ones’ symptoms or situation was also viewed as a benefit of therapy.

“I was bitterly bitterly resentful toward myself, that this illness had come into my life… I’m quite a lot happier in myself now that I’ve accepted it.” (Goodliffe et al, 2010, p.454)

Finally, the development of a more positive outlook, particularly having hope for the future, was a dramatic outcome for many therapy clients.

“The first time I came into contact with the mental health services I couldn’t see anywhere forward, didn’t want to be here, couldn’t see the point of being here, now I’ve got things to aim for, it’s like, okay, I’ve got things to aim for.” (Kilbride et al, 2013, p.98)

**Negative outcomes of therapy**

Eight studies presented client accounts of perceived negative outcomes of therapy, which were of relatively low incidence when compared to positive accounts. Two poor (−) qualitative studies contribute to this section and although the remaining data is good (++) or fair (+/+) data must be interpreted with caution.

Therapy can be very emotive for many clients, and some perceived negative emotions or painful memories as a negative outcome of the therapeutic experience.
“I think the worst thing is getting upset and being left with it once they’ve gone” (Kilbride et al, 2013, p.97)

Lack of change, no perceived benefit, or negative changes were also reported (Coursey et al, 1995; Cupitt et al, 2004; Rose et al, 2008). Svensson & Hansson (1998) were only able to obtain unspecified negative statements, such as saying that nothing had been helpful/curative. Some participants also expressed disappointment when expectations for change went unrealised.

“‘My goal was that meditation might help to block or control symptoms and that hasn’t happened.’” (Brown et al, 2010, p.236)

Process

Positive experience of setting/process

Twenty studies present positive accounts of the therapeutic process. This is the second largest category of data in the review. There is considerable overlap between studies contributing to this section and to ‘positive outcome of therapy’ and hence the considerations about representativeness and validity of findings are similar. The majority of studies contributing to this section used qualitative methodology and were overall of good (+++) quality, although one study was of fair (+) quality and two studies were poor.

The therapeutic setting was consistently described as a safe, containing space, due to its regular and consistent nature, which fostered trust. People therefore felt more able to be open about their experiences and possibly learn something new. Sometimes this was also contrasted with receiving help from friends or family, as people (therapists or other service users) came from a different place of understanding.
“…have an outlet once a week, dignity, you know? You don’t have to ponder on it or […] let it eat me up” (Messari & Hallam, 2003, p.176)

Therapy clients seem to value the interpersonal aspects of therapy. For some it was about general social contact and building relationships with others (therapist or other service users).

“It was good because you didn’t feel isolated. ….I had no idea of other people’s suffering, and it made it better for me because I would, sort of, relate to them (Goodliffe et al, 2010, p.453)

People often hadn’t the experience of feeling that their opinions were valued, feeling some control over or initiative to work towards recovery. It was important to feel that they had a voice during the process, sharing ideas in individual and in group formats (e.g. helping each other).

“It was very much a partnership between myself and the psychologist, it was really put to me as team work (Kilbride et al, 2013, p.93)

The therapeutic process also appears to be extremely valued for its normalising effects. People felt they weren’t being judged, reducing stigma or shame, which was often encountered in other areas of the clients’ lives.

“Acceptance that perhaps that I’m no different . . . . . . and listening to someone else’s experience, who I regard as so-called normal…and that their experience was the same, that helped me accept a big chunk about myself. I’ve thought that basically that I’m not wrong, that I’m quite acceptable.” (Abba et al, 2008, p.84-85)

Negative experience of process/setting

Twelve studies provide accounts of people’s negative experience of the process of therapy. The qualitative data included in this section is largely sound (++); although, one fair (+) and one poor (−) study are included. The representativeness or
validity of the quantitative or mixed methods data is more questionable, with three studies achieving fair (+/+) scores and two receiving poor (−/−) ratings.

These accounts included people experiencing negative emotions, such as anxiety, stress, or embarrassment, (including as part of delusional processes), and in one instance a physical reaction (a technique triggering a migraine; Hayward & Fuller, 2010), possibly not feeling able to cope with them, and not acknowledging that this was an understandable part of the process. Three participants in McLeod et al’s (2007) study did not feel they could actively fully participate with certain tasks, such as engaging with malevolent voices, because it might be too distressing. Changes during the process e.g. therapist going away or leaving were perceived as disruptive to the therapeutic process (Coursey et al, 1995).

Others felt the process lacked a collaborative feel. For example, they did not understand the process or tasks asked of them e.g. homework (HW) and case formulation (CF), that there were not mutually agreed goals, that they could not speak openly, or that there was a power imbalance with the therapist.

“…The other psychologist I had in the hospital, if I told him I could do something, he’d say, “I'm not really sure you can do that” to the point to where it was discouraging sometimes, because a lot of things that I told him that I wanted to do were things that I thought were very small steps ... and it seems that he put a limit on what kind of progress I could do” (Coursey et al, 1995, p.294)

The majority of Rathod et al’s (2010) BME clients reported that they had been treated in an impersonal manner, and expected a level of self-disclosure. They also felt that they and therapists avoided cultural topics or themes that might be misunderstood by others as ‘racist,’ which felt unsatisfying and led to disengagement.

People also described feeling stuck, with no expectation that things could get any better.
“we’ve probably achieved as much as we’re going to […]. I’ve got doubts or slight doubts about the ideas that I have, but I don’t think that er, no matter how much we talk about it, that those doubts would get any bigger” (Messari & Hallam, 2003, p.179)

Some people had more practical negative comments about the sessions themselves, such as being too long, too frequent or repetitive (Coursey et al, 1995; Cupitt et al, 2004; Rose et al, 2008; Tarrier et al, 1998b).

**Experience of challenges in process**

Thirteen studies present accounts of realistic challenges people faced during the therapy process. Half of the studies contributing to this section are of poor quality, calling into doubt the validity of the conclusions. Only six qualitative studies make a contribution, three of which failed to achieve good (++) ratings. Three studies were either internally or externally poor (or both), and one could not be rated.

For the majority of data available, these were challenges that people overcame and they continued with therapy. Participants spoke about people taking responsibility for their recovery, including being involved in the sessions and keeping therapy in mind outside of the therapy session (e.g. homework). However, they also acknowledged that this could be difficult, as change takes motivation, time, and effort and could sometimes be unpleasant.

“To be honest there would have been times where there was no way I would have engaged with it or benefited from it. . .think you’ve got to be ready and motivated for it cos there is quite a lot of thinking and you need to be fairly open minded” (Kilbride et al, 2013)

However they recognised that while unpleasant negative feelings didn’t last forever.

“It was hard, it wasn’t easy. . .to go through things that had happened in the past. Erm. . .I got upset a lot, so it wasn’t easy but. . .I knew it had to be done.” (Kilbride et al, 2013, p.96)
The influence of others’ views was apparent in Tarrier et al.’s (1998) study, as someone dropped out of therapy because their Case Manager said it was causing them worry and advised they stop attending. As well as difficult emotions, tasks of therapy can also be challenging, potentially leading people to feel unskilled, frustrated, or judged.

“I couldn’t think of the thoughts, I struggled identifying the thoughts, cos I had loads running through my head” (Kilbride et al, 2013, p.96)

In Rose et al’s (2008) CRT study, 60% said the therapy made them aware of their limitations and disabilities, and half of these found this frustrating. Others had the challenge of facing initial disappointment when expectations about the therapy process or goals, as described earlier, went unmet. Goodliffe et al (2008) reported that several people in their group were disappointed to learn that the group’s aim was to cope better with rather than reduce voices. Others had unrealistic expectations of therapy being a quick fix or that all the work would take place within the sessions.

“I like things to happen instantly, but it doesn’t happen like that” (Dunn et al, 2002, p.365)

Consistent with expectations, other people had other responsibilities or practical obstacles that made attending therapy difficult such as scheduling conflicts with work, limited session times offered, travel and dislike of location (Chadwick et al, 2000; Davis et al, 2008; Rose et al, 2008; Tarrier et al, 1998b).

Trust and breaches of confidentiality also posed challenges for clients. It takes time to build a trusting relationship and it can falter if a therapist has to break confidentiality. Coursey et al (1995) report several instances of therapists failing to
keep a confidence private, resulting in significant upset, with 10% subsequently dropping out of therapy.

“The only thing [the therapist] does that I don't like is, when I have sessions with her, she makes the psychiatrist aware of the session and what went on during the session, and I don't like that.” (Coursey et al, 1995, p.298)

Endings can pose another challenge for clients, particularly when they have had a positive experience of therapy, with some participants desiring further contact with the therapist, either because they missed them or they wanted to maintain and consolidate therapeutic gains (Miles et al, 2007; Rose et al, 2008).

Finally, specifically related to group processes, very little negative data was available in one study, and not in the form of direct quotes. Chadwick et al (2000) reported that four participants raised concerns about other group members’ behaviour during sessions and 1 person also described difficulties when attendance varied from week to week.

**Summary: Experiences of therapy**

Experiences of therapy were present in 32 studies, representing the largest area of exploration in this review. Experiences varied, from general data about satisfaction, to more detailed accounts about outcomes and the process, including challenges faced in therapy. Satisfaction with therapy seems to have received little attention (Rose et al, 2008) and qualitative data was lacking. Many studies used structured interviews, which can impose researchers preconceptions on participants’ accounts (Newton et al 2007) or were limited to authors’ summarising accounts, not participant quotes. Satisfaction data was primarily quantitative and often only represented by a numerical score, with little discussion. The conclusions that can be
drawn about satisfaction are limited since different scales were used, and some were not well designed.

Furthermore, almost all of the satisfaction findings are from people who completed therapy, not taking into account those who terminated therapy prematurely, who are unlikely to express the same levels of satisfaction. Cupitt et al (2004) was the exception and included three participants who had not completed a full course of CRT (along with 2 others that did). No details were available about the number of sessions completed before discontinuing therapy, and the research took place 18 months later introducing recall bias. Few other authors reported attempts to interview poor or non-engaging clients but they declined to participate (Fisher & Savin-Baden, 2001; Chadwick et al, 2000).

In contrast to the satisfaction evidence, the majority of the studies presenting experiences findings were qualitative in nature. Some studies were very focussed e.g. on mindfulness, homework, and case formulation, and each had different aims and thus different methods for collecting, analysing, and presenting data. It is likely that more relevant data to this review was collected, but as it may not fit with researchers’ goals, was not published. For example, Hayward and Fuller (2010) only presented three of out five themes developed as they focused on themes most relevant to their pilot therapy. ‘Therapists’ approach’ and ‘challenges to change’ were excluded, and would have likely provided useful insights to this review.

Many different qualitative methodologies were employed. Some qualitative researchers have criticised the use of content analysis, as it quantifies participants’ views into frequency counts, which can result in loss of richness or detail in the accounts (Newton et al, 2007). Focus groups have benefits but may also result in
some important views remaining unheard (Goodliffe et al, 2010). The data appear to lack richness at times, with many authors providing their own summative account of participants’ views, instead of presenting direct quotes. When other participants were interviewed as well, such as therapists (McGowan et al, 2005 – therapist findings not used in this review) or family members (Stanbridge, et al 2013), there seems to be an overreliance on their views, losing the service user perspective.

Since from the majority of data included in this review came from participants who completed therapy, often in a research setting, findings are predominantly positive. This may also reflect publication bias, with authors less likely to publish results showing dissatisfaction. While some negative beliefs were found, they usually contained less detail. Only three studies presented findings from people that terminated therapy early, with only one study focusing on drop out as its primary aim. Tarrier et al’s (1998b) data was limited by small sample size and the use of a novel questionnaire with reasons for drop out derived by clinicians’ judgement. Respondents did however endorse multiple items and used the free response item. It remains the only study of its kind to obtain this type of data.

2c. What do people think about those who delivered therapy?

Positive experiences of therapists

Eight studies provide participant accounts of their positive experience with therapists. Quality appraisal ratings were overall of fair or good quality. Two fair (+/+ ) mixed methods studies contribute to this section, along with four good (+) and two poor (−) qualitative studies, one of which only achieved this rating likely due to missing descriptive information in the paper (Allen et al, 2012).
Coursey et al (1995) participants reported to have had encountered twice as many positive therapists (mean = 2.6, SD = 2.1, median = 2.0) as negative therapists (mean = 1.3, SD = 2.0, median = 0.5). Overall, comments seem to be around three main themes: personal qualities of therapist, the way the therapist makes individual’s and families feel, and therapist skills.

People had many positive things to say about the personal qualities of therapists they had worked with, including, friendly, caring, helpful, and non-judgemental (Hayward & Fuller, 2010; Rose et al, 2008; Stanbridge et al, 2003).

"It was like these people are here to help you... and are also here to show you that they care and try to get you to start caring again—about yourself." (Coursey et al, 1995, p.289)

Therapists made them feel listened to, valued, understood, and cared for (Allen et al, 2012; Stanbridge et al, 2003).

“no one was told ‘that is wrong or that is right;…I think everyone was made to feel that their input was as important as the next person’” (Allen et al, 2012, p217)

Others valued certain skills of the therapist, such as being a guide, an outside opinion, teaching new skills, or providing a containing environment (Allen et al, 2012; Rose et al, 2008)

“it was good to have an outside professional opinion (…) it’s like an outward perspective looking at it (…)”(Allen et al, 2012, p.218)

**Negative experiences of therapists**

Four studies present negative accounts of therapist interactions, which are of mixed quality. The two qualitative studies included in this section were rated good
(++) and poor (−), due to insufficient reporting. The mixed method study was fair
(+/+) and the quantitative study was poor (−/−).

In Tarrier et al’s (1998) questionnaire study, some participants cited their
relationship with the therapist as reason to drop out, including issues around
likability (two felt the therapist didn’t like them and two did not get on with their
therapist), not trusting the therapist and preferring a different therapist, however no
further specific information was elicited. Some therapists were viewed as
impersonal, with a lack of compassion or care about their clients:

"I'd get the feeling that I was just another number on the wall. I just got the
impression that he really didn't care—it was just another job." (Coursey et al,
1995, p.289)

Others felt that the therapist may not value their views, evidenced by a non-
collaborative style or feeling that they weren’t listened to, including when others’
views, such as a family member, were taken more seriously. For example, in a family
session, a participant felt that the therapist lost a neutral stance and seemed to take
sides with another family member (Allen et al, 2012).

"He did a lot of talking. I think he did more talking than me and I'm a
talker…” (Coursey et al, 1995, p.289)

Summary: Experience of therapists

Nine studies presented data about people’s beliefs about therapists. Two
studies in particular contribute most strongly to this section (Coursey et al, 1995;
Stanbridge et al, 2013). As described above, findings from Stanbridge and colleagues
(2013) heavily relies on family member perspectives. Overall, there is relatively little
data compared to people’s experience of process or outcomes. Limitations of studies,
including methodology, participants, and data have been explored in previous sections.

**Discussion**

As far as the authors are aware, this is the first systematic review and narrative synthesis of people’s beliefs about psychological therapy for psychosis. Thirty-five studies were identified for inclusion. Two overarching areas of beliefs, expectations and experiences, were explored in this synthesis. Three themes emerged for expectations about therapy: outcomes, process, and barriers. Four themes were identified for experiences of therapy: satisfaction, outcomes, process, and therapist characteristics. Key components of each of these themes were identified and described. The greatest number of relevant papers were found for positive experiences of outcomes and the process of therapy. The narrative synthesis has provided additional support for the use of psychological therapies with people with psychosis as well as highlighting knowledge gaps in the literature.

The available data suggests that talking therapies for psychosis are largely acceptable and beneficial to service users and their families. High levels of satisfaction are present, and many people view it as a positive and helpful experience. Therapy for psychosis has been able to facilitate change, such as improving symptoms, development of new skills, fostering acceptance, and providing hope for the future. There was less data available about therapist characteristics, however there is likely an overlap with experiences of the therapy process, with therapists creating settings that are safe, containing, collaborative, and normalising. People are able to acknowledge and move beyond the challenges faced
in therapy, which may be particularly comforting for others who are uncertain or anxious about the process and unsure whether they will engage in therapy or not.

It is difficult to draw conclusions about the impact of expectations on experience. Limited data about expectations exists, and even less about whether expectations were realised. Anticipatory worry is prevalent, however feedback was predominantly positive, with participants expressing relief. There seems to be some discrepancy between what people say they want from therapy in terms of their expectations and what they end up valuing in terms of positive outcomes. Positive expectations tended to be pragmatic, such as obtaining information or preventing relapse. While these were cited as important outcomes, people seemed to value other aspects of the process, such as normalisation and interpersonal relationships, even more.

The synthesis has highlighted a number of areas that have not been adequately addressed in the literature. While the picture of therapy for psychosis is presented as generally positive and useful, this account is biased. Views are overwhelmingly from therapy ‘completers’ and all were willing to speak to researchers who may be different to those who were not. Evidence suggests that people may be reluctant to criticise therapy or therapists (Rennie, 1994; Rhodes, Hill, Thompson & Elliott, 1994), particularly if the assessor is perceived to be invested in the research (Rose et al, 2008). In some studies the therapist was the assessor and many did not report who administered interviews. Even when independent assessors are used participants may not perceive them to be independent.

Negative accounts of the process, outcomes, and therapist are present in the literature but less frequent. People have experienced negative emotions, lack of
change, lack of collaboration, and hopelessness. This data is limited and much less specific than positive accounts. Evidence is available that there are high refusal and drop-out rates from therapy, so it is likely that these and other negative beliefs exist, but are missing from the literature. There is virtually no data about people who refuse therapy outright or drop-out of therapy, possibly skewing the picture of therapy presented here.

Expectation data is also relatively absent from the literature, and when asked, there is notably a lack of positive expectations from BME groups. Some negative expectation data are only available from BME populations, such as fears of incarceration or detainment, however this review does not suggest that these concerns are constrained to minority groups. This is likely to be a much wider concern trans-culturally, as well as beliefs about being given medication forcibly or having children taken into care, and represent potential reasons why some people might not engage in therapy, or in mental health services (NICE, 2011). With few exceptions in the hypothetical or preferences literature, expectations about therapy have only been elicited after therapy had been completed. As it is generally accepted that expectations about therapy can influence engagement and outcomes (Westra et al, 2010) it seems surprising that so little is known about these beliefs for people with psychosis.

The composition of the study samples present potential bias for this review. Participants were mostly white, with few exceptions (e.g. Davis et al, 2008). BME populations are underrepresented, except when they were specifically targeted for inclusion (Press et al, 2011; Rathod et al, 2010). Participants were also largely based in the community, with only two studies exclusively exploring views of people
currently admitted to mental health wards (Messari & Hallam, 2003; Svensson & Hansson, 1998). One study included views of people at-risk of developing psychosis (Byrne & Morrison, 2010). Levels of substance use were not reported for these samples, or was used as an exclusion criterion for RCTs. Participant characteristics and therapy experiences are very diverse across the studies, so the synthesis has not been able to elucidate whether any trends in the data exist, e.g. do different populations, e.g. first episode psychosis, have different beliefs than older counterparts?

The limitations of the studies available limit the synthesis process itself. The synthesis can only use results available and bias in the available literature means there is inherent bias in the synthesis. Care has been taken to understand the context of available qualitative data, but this requires a reliance on the primary author’s interpretations of the original data’s meaning and context. It is possible that quotes could be misunderstood or misinterpreted in the primary source or in this synthesis. Finally, the findings represent only one way of structuring the available evidence.

Clinical and research implications

A number of areas for exploration with service users, either potential, new or on-going therapy clients, have been highlighted. Beliefs about therapy appear to be numerous and diverse. They may be positive, negative or uncertain and expectations in particular may impact on engagement (Westra et al, 2010). Service users and professionals often have different priorities (Byrne & Morrison, 2010) and thorough discussions are required if a true collaborative approach is to be undertaken. Some people will claim that therapy it is not suitable for them. These views should be
respected but the synthesis also suggests that some people may find it difficult to accept help, or have fears about the process or consequences of therapy and these ambivalent or negative beliefs should be explored in a normalising and sensitive manner, addressing any concerns or misconceptions that individuals may have. It is possible that some people may need additional support to articulate a response, particularly when faced with complex issues such as therapy involvement and beliefs. Appropriate prompts and follow-up questions should be used in order to develop a true understanding of people’s viewpoints, which should also in turn provide richer qualitative material for clinical work and publication.

Therapy can be difficult and people can feel anxious, unsatisfied, frustrated or like a failure. The synthesis supports general therapy literature about the importance of managing challenges, barriers, or ruptures in therapy, to help clients remain engaged in the process. It may also be useful for clients to be aware of these challenges before they are encountered, to help manage expectations and problem solve to minimise their impact on the therapeutic process (Kilbride et al, 2013). Pitt et al (2007) argue that sharing recovery stories with other service users can provide hope and inspiration. Sharing experiences including any negative or unrealistic expectations, as well as challenges and how they may have been overcome, may also be a useful tool to achieve these ends. This exploration of therapy beliefs identified co-existing beliefs about cultural values and other means of support, such as medication, other professionals, or communities, which will be useful to understand from the client’s perspective.

The synthesis provides continuing support that people with psychosis, including those with cognitive impairments, can articulate their viewpoints, needs,
and experiences. A number of studies have used qualitative methods successfully with this population, although it appears that researchers vary in the level of effort applied into obtaining and presenting these views. Many studies present only limited quotes, possibly due to publication restrictions or lack of appropriate material, but participants deserve to have their viewpoints heard.

The narrative synthesis has identified areas for exploration in future research. The literature is missing a comprehensive understanding of people’s expectations about therapy for psychosis. To date, studies have not been able to reliably predict who does and does not want therapy or who will or will not engage (e.g. Sumner et al, 2013; Tarrier et al, 1998). So, what is important? It appears that pre-existing beliefs about therapy can influence decision-making processes. Research to explore these beliefs is warranted and must take into account limitations of previous research. Timely data collection is essential. To address biases, such as memory and experience of therapy, it seems most appropriate to enquire about expectations before people commence therapy. This could be during assessment in a research trial or on entry to mental health services. It would also be useful to obtain follow-up data to see if beliefs change over time and whether they predict outcomes, such as engagement, improvement, or satisfaction. Data collection following therapy must also be timely, as some studies planned evaluations posteriori, interviewing participants up to 18 months following termination of therapy, potentially introducing recall bias as memories can become distorted (Allen et al, 2012; Cupitt et al, 2004).

Our current understanding of individuals’ beliefs about therapy for psychosis is unbalanced and more research with people who do not engage with therapy or who
terminate it early is needed to inform future practice. Research studies and services should ask, record, and explore why people say no to therapy or why they drop out. This is understandably a difficult task based on the nature of the problem but worth pursuing. What can be done to encourage service users/participants to engage in feedback when they no longer want to engage with therapy? It may be useful to discuss these issues early, before early termination occurs and emphasise the importance of this feedback. This may be normalising for the client and make them feel more inclined to discuss potentially difficult emotions or experiences. And as described above, these pre-emptive conversations may lead to better outcomes by default. A number of researchers have suggested that involving service user researchers in the research and assessment process may also be normalising and offer other advantages (Byrne & Morrison, 2010; Coursey et al, 1995; Kilbride et al, 2013; Rose et al, 2008). User-led interviews may identify with or focus more on the experience of the participants, reducing potential for unintentional bias when conducted by clinicians, and may elicit a more balanced account of concerns or dissatisfaction (Kilbride et al, 2013; Rose et al, 2008). Incorporating qualitative research into quantitative studies, such as clinical trials, may be a way to better understand the factors that are impacting on engagement and outcomes (Kilbride et al, 2013).

Studies in this synthesis have tried multiple methods to obtain service user perspectives, however they do all have limitations. Another approach, Q-methodology (Stephenson, 1953), merits consideration for future research in this topic. Q-method is a quanti-qualitative approach that involves participants sorting and ranking statements covering a broad range of beliefs and exploring their
subsequent intercorrelations using factor analysis, but ultimately understood with rich meaning in a detailed qualitative account (Watts & Stenner, 2012). Q-method has been used and found acceptable for use with people with experiences of psychosis (e.g. Dudley et al 2009; Gregg, et al 2009; Jones et al, 2003; Wood et al, 2013) and has the potential to include more service user viewpoints as it can be conducted with larger samples than most qualitative research methods.
References


Cognitive insight predicts favorable outcome in cognitive behavioral therapy for psychosis. *Psychosis: Psychological, Social and Integrative Approaches, 2*(1), 23-33. doi: [http://dx.doi.org/10.1080/17522430903147520](http://dx.doi.org/10.1080/17522430903147520)


Figure 1. Flowchart on process of article identification.
Table 1. Thematic structure and frequency of beliefs identified in 35 studies.

<table>
<thead>
<tr>
<th>Beliefs about therapy…</th>
<th>Number (%) of studies identifying belief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectations</td>
<td>15 (43%)</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td><strong>11 (31%)</strong></td>
</tr>
<tr>
<td>Positive</td>
<td>5 (14%)</td>
</tr>
<tr>
<td>Negative</td>
<td>5 (14%)</td>
</tr>
<tr>
<td>Neutral; N/A</td>
<td>7 (20%)</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td><strong>8 (23%)</strong></td>
</tr>
<tr>
<td>Positive</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Negative</td>
<td>5 (14%)</td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
<td><strong>5 (14%)</strong></td>
</tr>
<tr>
<td><strong>Experiences</strong></td>
<td><strong>32 (91%)</strong></td>
</tr>
<tr>
<td><strong>Satisfaction</strong></td>
<td><strong>14 (40%)</strong></td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td><strong>23 (66%)</strong></td>
</tr>
<tr>
<td>Positive</td>
<td>23 (66%)</td>
</tr>
<tr>
<td>Negative</td>
<td>8 (23%)</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td><strong>22 (63%)</strong></td>
</tr>
<tr>
<td>Positive</td>
<td>20 (57%)</td>
</tr>
<tr>
<td>Negative</td>
<td>12 (34%)</td>
</tr>
<tr>
<td><strong>Challenges</strong></td>
<td><strong>13 (37%)</strong></td>
</tr>
<tr>
<td><strong>Therapist characteristics</strong></td>
<td><strong>9 (26%)</strong></td>
</tr>
<tr>
<td>Positive</td>
<td>8 (23%)</td>
</tr>
<tr>
<td>Negative</td>
<td>4 (11%)</td>
</tr>
</tbody>
</table>
Appendix A: Electronic databases and search terms

Databases

24 electronic databases via Ovid SP used for systematic search of the literature:

Appendix B. Table. Characteristics of studies (n=35) including beliefs about therapy for psychosis.
(missing data not reported by original study)

<table>
<thead>
<tr>
<th>Authors</th>
<th>Country</th>
<th>Sample Characteristics (e.g. sample size, diagnosis, age, gender, ethnicity, marital, employment)</th>
<th>Recruitment Settings</th>
<th>Method</th>
<th>Measures</th>
<th>Therapy Characteristics (type, who delivered, duration, setting)</th>
<th>Types of beliefs about therapy</th>
<th>Quality appraisal rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abba, Chadwick &amp; Stevenson (2008)</td>
<td>UK</td>
<td>N=16; 13 paranoid schizophrenia, 2 psychotic depression, 1 psychotic episode; Age: range 22-58 years; 12 male/4 female Years in service: 3-10 years; 15 unemployed, 1 undergraduate student</td>
<td>Clinical psychology service</td>
<td>Qualitative: Grounded theory</td>
<td>Individual and group interviews</td>
<td>Mindfulness Group; clinical psychology service; group completion (?weeks) and attended at least 4 sessions; community</td>
<td>-Positive experience of outcome -Positive experience of process</td>
<td>++</td>
</tr>
<tr>
<td>Allen et al (2012)</td>
<td>UK</td>
<td>N = 7; Psychosis; Age: 19-64; 4 male/3 female</td>
<td>Family Intervention Service</td>
<td>Qualitative: IPA</td>
<td>Interview schedule</td>
<td>Integrative Family Intervention</td>
<td>-Negative expectations about</td>
<td>–</td>
</tr>
</tbody>
</table>
Brown et al (2010)  USA  N=15; 5 schizophrenia, 10 schizoaffective; Age: mean (SD)= 51 (4.78), range 45-58; All Male; 60% white, 40% Black (African American); 7 never married, 7 divorced, and 1 widowed;  
Veterans Affairs (VA) medical centre or CMHT  
Programme evaluation interview, midway and end of programme  
Qualitative: Content Analysis  
Mindfulness meditation Group training for reduction of anxiety related distress; (3 groups, with 5 participants each); Clinical Psychologists, Mental Health Therapist; 8 weeks (some

<table>
<thead>
<tr>
<th>approach; (psychoeducation, CBT techniques, systemic and solution-focused techniques); at least 6 months in FI service; range 12 – 59 sessions</th>
<th>process</th>
<th>Positive experience of outcome</th>
<th>Positive experience of process</th>
<th>Experience of challenges in process</th>
<th>Positive experience of therapists</th>
<th>Negative experience of therapists</th>
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</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Sample Size</td>
<td>Condition</td>
<td>Setting</td>
<td>Methodology</td>
<td>Therapeutic Details</td>
</tr>
<tr>
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<tr>
<td>Byrne &amp; Morrison (2010)</td>
<td>UK</td>
<td>N = 8; At risk mental state; Age: mean (range) = 22.4, (16-28); 7 male; 1 female; All White British</td>
<td>Early Detection and Intervention Team service</td>
<td>Qualitative: Grounded theory</td>
<td>Semi-structured interviews</td>
<td>Therapy details not reported</td>
</tr>
<tr>
<td>Chadwick et al (2000)</td>
<td>UK</td>
<td>N=22; Schizophrenia or Schizoaffective disorder; at time of assessment, 8/22 in hospital; 20/22 had been hospitalised within last year because of problems coping with voices</td>
<td>Clinical psychology services</td>
<td>Mixed methods: Quantitative and Content analysis</td>
<td>Structured interview; ‘standard satisfaction questionnaire ’</td>
<td>Group CBT for drug resistant auditory hallucinations/voices (5 different groups); 2 therapists (unreported discipline); 8 sessions offered, no details on average number of sessions attended</td>
</tr>
<tr>
<td>Coursey, USA</td>
<td>N=191; ‘Serious Psychosocial’</td>
<td>Mixed</td>
<td>Questionnaire</td>
<td>Varied, not</td>
<td>-Ambivalent</td>
<td>IV: +</td>
</tr>
<tr>
<td>Keller &amp; Farrell (1995)</td>
<td>Mental Illness,’ (mixed diagnostic category used, 37.6% self-reported schiz. Diagnosis); Age mean (SD) = 38.1 (11.3), range 20-74; 93 (48.7%) male, 98 (51.3%) female; Mean (SD) duration of mental health problems 13.8 (10.2) years; 59.7% White; 37.2% African-American; 3.1% Other; 71.1% Single; 5.3% married/living together; 21.6% separated/divorced; 2.1% widowed; 75.9% unemployed; 13.4% employed part-time; 3.2% employed full-time; 7.5% volunteer work</td>
<td>rehabilitation centres</td>
<td>methods: Survey/Questionnaire (delivered by ‘consumers’); brief interview with (n= ? 1 or 2 at each site? 12 sites)</td>
<td>e, 147 items, designed for this study</td>
<td>reported; Psychiatrist (not just for medication, 51.1%), social worker (19.1%), psychologist (16.3%), psychiatric nurse (9.0%), or minister (4.5%); Duration: 1 month – 24 years, mean 34.3 years; median = 12 months</td>
<td>expectations about outcome -Positive experience of outcome -Negative experience of outcome -Negative experience of process -Experience of challenges in process -Positive experience of therapists -Negative experience of therapists</td>
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<tr>
<td>Cupitt et al (2004)</td>
<td>N=5; psychosis; Mental Health</td>
<td>Qualitative; not reported</td>
<td>Semi-structured</td>
<td>CRT; direct care staff (clinical</td>
<td>-Satisfaction -Positive</td>
<td>–</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Sample Details</td>
<td>Methods Description</td>
<td>Findings</td>
<td>IV:</td>
<td>EV:</td>
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<tr>
<td>------------------------</td>
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<tr>
<td>Davis et al (2008)</td>
<td>USA</td>
<td>Total sample: N=44; 21 Schizophrenia; 23 Schizoaffective disorder; All male; 64% African American, 34% White, 1% Hispanic; All unemployed</td>
<td>Mixed methods: mean scores, content analysis? (tallying number of times response was given in a thematic response category)</td>
<td>- Positive experience of outcome</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Dunn et al (2002)</td>
<td>UK</td>
<td>N = 10; Psychosis (EIS); Age: mean (range) = Qualitative: Grounded theory</td>
<td>Semi-structured interview; if CBTp; Clinical Psychologists and CBT nurse</td>
<td>- Negative Expectations about</td>
<td>+</td>
<td>−</td>
</tr>
</tbody>
</table>
Durham et al (2003)  UK

Total sample: n=66; Medication resistant psychotic symptoms and ICD-10 diagnosis of schizophrenia (18, 86%) schizoaffective disorder (2, 9%) or delusional disorder (1 (5%); Age mean (SD) =36 (10.4); 45 (68%) male; 21 female (32%); Duration of illness, CMHTs, Inpatient service, and community care facilities

Mixed methods: Brief semi-structured interview; group comparison (chi square)

Responses to 2 questions – “perceived helpfulness and quality of relationship with therapist or key worker” CBT: n=20; SPT: n=18

CBT for medication resistant psychotic symptoms (22) v Supportive psychotherapy (SPT) (23) v TAU; CBT: Clinical Nurse specialists with CBT training SPT: mental health professionals (nursing, 

-Satisfaction IV: ++ EV: +

Outcome

-Positive experience of outcome
-Positive experience of process
-Negative experience of process
-Experience of challenges in process

necessary, questionnaire: “possible reasons for not doing self-help assignments” checklist

therapists; Recently completed or almost completed therapy, number of sessions mean (range) =16.6 (11-30)

37.5 (31-52); 6 male; 4 female; duration of symptoms: mean = 10.1 years (6-15 years)
years, mean (range) = 13 (2-31); 85% in community; 15% inpatients; Single: 44 (67%); Married/cohabitating: 14 (21%); Divorced/separated: 8 (12%); Unemployed: 58 (88%); sheltered work: 4 (6%); Employed: 3 (4%)

<p>| Farhall et al (2009) | Australia | Therapy sample, n=45; 24 DSM-IV Schizophrenia, 1 Schizoaffective, 4 Schizophreniform, 2 delusional disorder, 10 mood disorder with hallucinations/delusions, 4 other, with positive symptoms; Age mean (SD) = 32.09 (9.61); Male = 26, Female = 19; FT or PT employment = 9, unemployed/pension | CMH clinics | Quantitative: Mean score from questionnaire | CSQ-8 (n=34) | CBTp v TAU; Clinical psychologists; Received 12+ sessions = 35; Received &lt; 12 sessions = 10 -Satisfaction IV: + EV: + | psychiatry, occupational therapy; 9 month treatment phase, maximum 20 sessions; CMHT |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Sample</th>
<th>Recruitment</th>
<th>Methodology</th>
<th>Intervention</th>
<th>Positive Experience</th>
<th>Outcome Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fisher &amp; Savin-Baden (2001)</td>
<td>UK</td>
<td>N=5; early psychosis; first episode within previous 2 years</td>
<td>Occupational therapy department</td>
<td>Qualitative: Interpretative Interactionism</td>
<td>Semi-structured interviews</td>
<td>‘TIME’: integration of early intervention, family intervention, cognitive therapy, and cognitive-behavioural therapy, and occupational therapy; Occupational Therapists</td>
<td>-Positive experience of outcome -Positive experience of process</td>
</tr>
<tr>
<td>Goodliffe et al (2010)</td>
<td>UK</td>
<td>N = 18; Medication resistant- and distressing voice hearers (2 years); ICD schizophrenia or schizoaffective disorder; Age: 30-59 years; 6 male; 12 female</td>
<td>NHS trusts (method of referral to group not explained)</td>
<td>Qualitative: Grounded theory</td>
<td>6 post-therapy Focus groups, semi-structured interview schedule (data from 5 only used as Person-based cognitive therapy Group for distressing voices; 8 sessions (offered) All participants attended 6-8 sessions</td>
<td>-Positive expectations about outcome -Expectations about barriers to therapy</td>
<td>++</td>
</tr>
</tbody>
</table>

er = 32, other – 4; Never married = 26, Married/defacto = 9, divorced/separated = 9
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Sample Size</th>
<th>Description</th>
<th>Methodology</th>
<th>Data Collection</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gottlieb et al (2013)</td>
<td>USA</td>
<td>N=21; 62% male; age mean (SD, range) = 40.10 (13.63, 23-64); DSM-IV 76% schizophrenia, 24% schizoaffective; 57% White, 38% African American, 5% Asian; 62% unemployed; 86% unmarried;</td>
<td>CMH clinics</td>
<td>Quantitative: Descriptive statistics/frequencies</td>
<td>Survey designed for the pilot including qualitative/open ended questions (n=16)</td>
<td>Web-based CBTp for coping with voices; Community Mental Health clinics; 10 lessons</td>
</tr>
<tr>
<td>Hayward &amp; Fuller (2010)</td>
<td>UK</td>
<td>N=3; Voice hearers, (also, therapists, n = 3; referrers, n = 2; relatives, n = 2); age ranges/brackets presented for each client (e.g. 20-29), so max range in 20-</td>
<td>CMHT</td>
<td>Qualitative: IPA</td>
<td>Semi-structured interview</td>
<td>Relating therapy; therapists; 12 sessions offered, with up to a further 12 available through negotiation; range of 11 – 16</td>
</tr>
</tbody>
</table>
Kilbride et al (2013)  | UK  | N= 9; 8 from EIS, 1 from CMHT; Age mean (range) = 26 (21-65); 4 male; 5 female; 8 white British, 1 black British | EIS or CMHT | Qualitative: IPA | Semi-structured interview | CBTp within last 12 months | ++
---|---|---|---|---|---|---|
| 49; 1 male; 2 female; All white british | sessions, which included a follow-up period | -Negative experience of process  -Positive experience of process  -Positive experience of outcome  -Negative experience of outcome  -Positive experience of process  -Experience of challenges in process  -Positive experience of therapists |
| **Kuipers et al (1997)** | **UK** | Therapy sample, n = 28; age mean (range) = 38.5 (19-65); 15 Male, 13 female; duration of illness (years mean (range)= 12.1 (1-26); at least one current positive psychotic symptom | Community teams and inpatient units | Quantitative: Descriptive statistics/ frequencies | Satisfaction with therapy questionnaire (n=20) | CBTp v. TAU; Clinical psychologists; Median number of sessions 15, mean 18.6 (range 0-50); outpatient clinics, home visits, or ward visits | -Satisfaction IV: + EV: + |
| **Lecomte et al (2003)** | **Canada** | N=5; first episode psychosis (3 schizophrenia, 2 schizoaffective); Age 19-32; 3 male; 3 female; All white; All single | A hospital and its outpatient clinics | Not designed as a qualitative study – just quotes from a questionnaire presented | ‘Satisfaction with treatment’ questionnaire (n=5) | Manualised, Group CBT for early psychosis; 2 co-therapists (?), no prior experience of CBT; 3 months, twice a week (24 sessions); attendance varied 50-100% | -Negative Expectations about Outcome | -Ambivalent expectations about outcome | -Positive experience of outcome | -Positive experience of process | -Experience of challenges in process | Not rated |


<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Sample Size</th>
<th>Diagnosis Criteria</th>
<th>Methodology</th>
<th>Setting</th>
<th>Intervention</th>
<th>Therapist Experience</th>
<th>Experience</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>McGowan, Lavender &amp; Garety (2005)</td>
<td>UK</td>
<td>n = 8; at least one positive symptom of schizophrenia according to DSM-IV; (also Therapists, n = 4); Age range 26 – 44; 4 male; 4 female; symptom duration reported for 6/8 clients range 3 – 20 years</td>
<td>Community rehabilitation services or acute psychiatric ward settings</td>
<td>Qualitative: Grounded Theory</td>
<td>Semi-structured interview</td>
<td>CBTp, 4 Clinical psychologists; range (6 sessions – weekly for 18 months); 3 ongoing therapy; 2 Inpatient and 6 Outpatient</td>
<td>-Positive experience of outcome -Positive experience of process -Negative experience of process</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>McLeod et al (2007)</td>
<td>UK</td>
<td>N=10; Voice hearers; 3 male; 7 female; voice hearing range 2 – 20+ years</td>
<td>Local mental health trust (referral not described)</td>
<td>Quantitative: “a feedback questionnaire” (n=10)</td>
<td>Group CBT for voice hearing; individuals trained in psychosocial interventions with over 10 years experience of working with voice hearers; 8 sessions</td>
<td>-Ambivalent expectations about outcome -Negative expectations about process -Expectations about barriers to therapy -Positive experience</td>
<td>IV: – EV: –</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Messari &amp; Hallam (2003)</td>
<td>UK</td>
<td>N = 5, Psychosis symptoms hallucinations and/or delusions; Age range 28-49; 4 male; 1 female; history of psychosis: 10-28 years; 2 White British; 1 White Irish; 1 Black African; 1 Afro-Caribbean</td>
<td>Inpatient units specialising in treatment of long-term symptoms of psychosis or an outpatient psychology department</td>
<td>Qualitative: Discourse analysis</td>
<td>Semi-structured interview</td>
<td>CBTp; 4 Clinical psychologists, 1 specialist registrar; 4 ongoing therapy; 1 terminated; (range 11 sessions – 18 months of weekly sessions); 4 Inpatient; 1 community</td>
<td>-Positive expectations about outcome -Negative Expectations about Outcome -Ambivalent expectations about outcome -Positive experience of outcome -Negative experience of process of process ++</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Miles et al (2007)</strong></td>
<td><strong>UK</strong></td>
<td><strong>N=79; Psychosis;</strong></td>
<td><strong>Psychological intervention clinic for outpatients with psychosis (PICuP)</strong></td>
<td><strong>Quantitative:</strong></td>
<td><strong>The Satisfaction with Therapy Questionnaire (STQ)</strong> (39 end of therapy only; 14 3-month follow up only; 26 both time points); not mentioned how additional comments were handled (appears to be content analysis)</td>
<td><strong>CBTp; qualified CBT therapists, clinical psychologists, and trainee clinical psychologists; approx. 6 months, either weekly or fortnightly (specifics not reported for sample)</strong></td>
<td><strong>IV: –</strong></td>
<td><strong>EV: –</strong></td>
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</table>

- Negative experience of process
- Positive experience of therapists
- Negative experience of therapists
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>N</th>
<th>Diagnosis</th>
<th>Age</th>
<th>Gender</th>
<th>Duration of Distressing</th>
<th>Setting</th>
<th>Therapists</th>
<th>Intensity</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morberg-Pain, Chadwick &amp; Abba (2008)</td>
<td>UK</td>
<td>13</td>
<td>Psychosis</td>
<td>M: 36.75 (24-64); F: 32.2 (21-52)</td>
<td>M: 8; F: 5</td>
<td>10.4 years (2-25)</td>
<td>Community and inpatient</td>
<td>CBTp: Clinical psychologists, two specialist trainee clinical psychologists, and CBT nurse specialist; ongoing, in assessment/formulation, weekly or fortnightly; community and inpatient</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Newton et al (2007)</td>
<td>UK</td>
<td>8</td>
<td>Auditory Hallucinations</td>
<td>17-18</td>
<td>M: 3; F: 5</td>
<td>4-5 years</td>
<td>Community and inpatient</td>
<td>Group-CBT for young people with auditory hallucinations; 7 weeks</td>
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</tbody>
</table>

Cognitive therapy for psychosis service run through CMHT and linked acute wards

Qualitative: Content Analysis

Semi-structured interview

Semi-structured interview

Semi-structured interview
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Sample Size</th>
<th>Diagnosis</th>
<th>Services</th>
<th>Qualitative Method</th>
<th>Semi-structured Interview</th>
<th>CRT</th>
<th>Expectations</th>
</tr>
</thead>
</table>
| Press et al (2011)  | UK      | N=10; First episode psychosis; Age mean (range) 23.3 (16-30); 6 male; 4 female; first episode within last 18 months; 2 British Asian, 3 British Pakistani; 1 Asian; 2 Indian; 2 Pakistani; 5 with family; 3 living with partner/child; 1 supported accommodation; 1 Islamic residential home; 7 unemployed; 3 student | EIS or Voluntary services | Qualitative: Framework Analysis | n/a – CRT demonstration only | -Positive expectations about process - Expectations about barriers to therapy
| Rathod et al (2010) | UK      | N=15; Schizophrenia, schizoaffective disorder or delusional disorder (also lay people) | CMHTs or Inpatient Services or local BME communities | Qualitative: Thematic, content analysis (ethnographic approach) | Semi-structured interview; focus groups | n/a (clinical sample, some had experience of CBT, some didn’t) | -Positive expectations about outcome -Negative Expectations ++
Rathod et al (2013) UK

Therapy sample:
N=16; met ICD-10 criteria for schizophrenia, schizoaffective disorder, or delusional disorder;
Male 10 (63%), Female 6 (37%); mean age (SD) = 31.37 (12.43); 5 (31%) African

CMHTs, EIS, AOT, Rehabilitation Services, and Inpatient Services

Quantitative: Mean scores, correlations

Patient Experiences Questionnaire (PEQ) (n=13)

CBTp adapted for minority ethnic groups (CaCBTp) v. TAU; Trained CaCBTp therapists; Mean (SD) number of sessions 13.6 (4.9); 3 (19%) inpatient forensic services, 1 (6%)

-Satisfaction IV: ++
EV: +
Caribbean, 1 (6%) Black African, 4 (25%) mixed race, 3 (19%) Pakistani, 2 (13%) Bangladesh, 1 (6%) Iranian; Duration of illness (years) mean (SD) 8.56 (8.24); 14 (87%) single, 2 (13%) married; 13 (81%) unemployed, 2 (13%) student, 1 (6%) employed

Revheim et al (2001) USA N=87; psychotic spectrum disorders, 27% affective disorders, 21% anxiety or personality disorders 61% male, 39% female; mean age =36; 52%

Outpatient program: Intensive Psychiatric Rehabilitation Treatment (IPRT) Quantitative: descriptive statistics Satisfaction questions for this study (quality of service, recommend?, helping, enjoyable) (n=10)

CRT; Average number of sessions =19 Intensive Psychiatric Rehabilitation Treatment (IPRT) Outpatient program; mixed disciplines including social workers and rehabilitation technicians -Satisfaction -not rated-
<table>
<thead>
<tr>
<th><strong>Rose et al (2008)</strong></th>
<th><strong>UK</strong></th>
<th>N=21; schizophrenia; Age mean = 35; 15 male; 6 female</th>
<th>From a RCT or as part of a clinical service (referral details not described)</th>
<th>Mixed methods: questionnaire – frequency counts and percentages, and content analysis.</th>
<th>The Consumer Satisfaction Questionnaire (designed for this study) (n=21)</th>
<th>CRT; ? RCT or Clinical service; 40 sessions, at least three days per week</th>
<th>-Satisfaction -Positive experience of outcome -Negative experience of outcome -Positive experience of process -Negative experience of process -Experience of challenges in process -Positive experience of therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stanbridge et al (2003)</strong></td>
<td><strong>UK</strong></td>
<td>N=4 service users, 13 families; psychosis; All male;</td>
<td>Family Interventions Service</td>
<td>Mixed methods: Summary statistics, thematic content analysis</td>
<td>Semi-structured interviews</td>
<td>Family Intervention in psychosis; multi-disciplinary team trained in FI; discharged, n = 10 families, mean = 6.5</td>
<td>-Negative Expectations about Outcome -Negative expectations about process</td>
</tr>
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<tr>
<td>Study</td>
<td>Country</td>
<td>Sample Size</td>
<td>Condition</td>
<td>Age Mean (SD, Range)</td>
<td>Gender Distribution</td>
<td>Employment Status</td>
<td>Methodology</td>
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<tr>
<td>Sumner et al (2013)</td>
<td>UK</td>
<td>N=90; 59 schizophrenia; 31 other, incl. schizoafective disorder, delusional disorder; Age mean = 37.22 (SD 11.34; range 19-63); 68 male; 22 female; 77 white, 13 other; number of years since first episode median = 8 (1-34); 63 unemployed, 27 other</td>
<td>CMHTs</td>
<td>Mixed methods: Quantitative and Content analysis</td>
<td>Information sheet describing hypothetical treatment options, semi-structured interview</td>
<td>N/A – hypothetical</td>
<td>-Satisfaction -Positive experience of outcome -Positive experience of process -Positive experience of therapists</td>
</tr>
<tr>
<td>Svensson &amp;</td>
<td>Sweden</td>
<td>N = 28, schizophrenia = 19, Inpatient units</td>
<td>Mixed methods: Helpful aspects of Cognitive Therapy;</td>
<td>-Positive expectations about outcome -Ambivalent expectations about outcome -Positive expectations about process -Negative expectations about process</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

IV: +
EV: +
| **Hansson (1998)** | Schizotypal personality disorder = 2, bipolar disorder = 1, other ‘long term mentally ill’ = 6; Age mean (range) 24.8 (17-38); 15 men; 13 women; DUS 4.6 (1-15); Age at onset 20.2 (15-26); Previous inpatient episodes 5 (1-30); Not married 27, divorced 1; Lived alone 11, with parents 14, with partner 1, in institution 2; All inpatients | Quantitative and Content analysis | Therapy Questionnaire; Curative Factors Questionnaire (n=28) | Psychiatric nurses trained in CBT; twice a week, duration of inpatient admission (not reported); of outcome - Negative experience of outcome - Positive experience of process |

| **Tarrier et al (1998)** | N=9; Chronic Schizophrenia; Age mean (SD) 35.4 (13.8); 7 male; 1 female; DUS mean = 8 years (IQR 10.3); All single; | RCT | Quantitative: Questionnaire including open ended response items | Questionnaire designed for this study – reasons for failing to attend treatment (n=9) | CBT (5) or Supportive Counselling (3) in a RCT; drop out within first 3 sessions = 4; within next 3 sessions = 3; - Ambivalent expectations about outcome - Negative experience of outcome - Experience of process |
### Turkington et al (2002)

**UK**

- Total sample, n=422; Met ICD-10 criteria for schizophrenia; Male 325 (77.01%), Female 97 (22.99%); Mean age (95% CI) = 40.47 (39.78-41.88); single 300 (71.09%), Married 58 (13.74%), Divorce/widowed 64 (15.17%); White 358 (88.90%), Black 42 (7.40%), Asian other 22 (3.10%); 
- Unemployed 371 (88.00%), Full/part time (13 (3.00%), Sheltered Workshop 12(2.84%), Other 26 (6.16%)

**Psychiatric secondary care services:** outpatient services, inpatient services, and depot medication clinics

**Quantitative:** Frequencies/ descriptives

**Satisfaction questionnaire designed for this study** (n=132)

**Brief CBTp (n=257) v TAU (n=; Community Psychiatric Nurses; up to 6 sessions over 2-3 months; Home or Secondary Care Services**

- **Satisfaction IV:** ++
- **EV:** +

### Van der...

**The N= 17 (although EIS**

- **Quantitative:** CSQ-8, Mindfulness-

- **Satisfaction IV:** –
Valk et al (2013) Netherlands only 16 entered therapy; Schizophrenia = 7 (41%), Schizoaffective = 4 (24%), Schizophreniform = 3 (18%), Depressive disorder with psychotic features = 2 (12%); bipolar disorder = 1 (6%); 12 male, 5 female mean age (SD) = 31.8 (5.2);

| Frequencies/ descriptives | adjusted for the therapy (n=14) | based therapy for psychosis (MBT); 8 sessions within 4 weeks; 9 participants attended 7 or 8 sessions; 2 mental health care workers in EIS |

Note.

Settings: AOT = Assertive Outreach Team; CMHT = Community Mental Health Team; EIS = Early Intervention Service; VA = Veterans Affairs; RCT = Randomised Controlled Trial

Methods: IPA = Interpretative phenomenological analysis

Measures: CSQ-8 = Client Satisfaction Questionnaire; PEQ = Patient Experiences Questionnaire

Therapy: CBTp = Cognitive Behavioural Therapy for psychosis; CRT = Cognitive Remediation Therapy; TAU = Treatment as Usual

Quality Appraisal Rating: IV = Internal Validity; EV = External Validity
Paper 2: Empirical Paper

Young people’s beliefs about psychological therapy for psychosis:

a Q-methodological study

Prepared according to submission guidelines for

_Psychology and Psychotherapy: Theory, Research and Practice_

(see Appendix 6)

Word count*: 5,000

*Excluding: abstract, references, figures and tables
Abstract

Objective: There is a growing evidence base for the use of psychological therapies in the treatment of psychosis, however engagement can be difficult and outcomes are variable. Beliefs, attitudes and expectations may have an important influence on whether individuals engage with therapy and on subsequent clinical outcomes. However, therapy beliefs of people with experiences of psychosis have not been adequately explored. Therefore the aim of this study was to examine what young people in Early Intervention Services (EIS) think about psychological therapies for psychosis.

Design: Q-methodology was used to examine young people’s beliefs about psychological therapy for psychosis.

Method: Thirty participants were recruited from EIS across five NHS trusts in the North West of England.

Results: The Q-analysis revealed four distinct factors, or sets of beliefs, about therapy: (1) Therapy is helpful and gives hope for the future; (2) Therapy is just talking, people need medication; (3) Therapy is useful but stigmatising; (4) Therapy is better than medication. Positive views towards different aspects of therapy were present in all four accounts, most predominantly in factor 1. Other important issues were raised, including concerns about stigma and opposing beliefs about medication.

Conclusions: These four factors provide useful insights into young people’s beliefs about psychological therapy. Individuals’ beliefs and expectations should be recognised and explored in order to promote greater engagement in and better outcomes from therapy.

Keywords: Therapy, Beliefs, Psychosis, Q methodology
Practitioner Points:

- This study highlights the multi-faceted beliefs held by young people about psychological therapy in Early Intervention Services.
- Clinical implications for exploring and managing different types of beliefs to improve engagement and outcomes in therapy are described.
- Practitioners should consider alternative strategies to explore beliefs about therapy with people who are reluctant to engage and those from black and minority ethnic communities.
Introduction

Early Intervention Services (EIS) have been developed in order to provide effective treatment to people in early stages of psychosis or prevent onset of psychosis in people with prodromal symptoms (Marshall & Rathbone, 2011). Psychological interventions have become recognised as vital elements of treatment (NICE guidelines, 2011; 2014). Studies have found that talking therapies for psychosis are both effective and acceptable to service users (e.g. Haddock & Lewis, 2005; Jackson et al, 2008; Messari & Hallam, 2003), including preliminary evidence for those who are not taking anti-psychotic medication (Morrison et al, 2012). Unfortunately however many clients refuse, do not attend or withdraw from psychological therapy before completion (Perivoliotis et al, 2010; Villeneuve, Potvin, Lesage & Nicole, 2010).

Medication adherence in psychosis has received considerable attention (e.g. Coldham, Addington & Addington, 2002) however, comparatively little research has explored factors associated with adherence to psychological therapy, and studies have typically focussed on individual characteristics to the exclusion of individuals’ views. Current understanding is limited to self-reported reasons why clients fail to continue with therapy (e.g. Tarrier, Yusupoff, McCarthy, Kinney & Wittkowski, 1998; Startup, Wilding & Startup, 2006). Even less is known about clients who have refused treatment. By the nature of the problem, this is a difficult area to examine.

A recent review (Holding, Gregg, & Haddock, in preparation) found that beliefs, attitudes, or expectations about therapy have not been adequately explored in people with experiences of psychosis. Research has focussed on individuals’ therapy experience, including the process (e.g. the setting, what happens in therapy, how they
are treated, and how it makes them feel), outcomes (e.g. change, skills), and therapist characteristics. Relatively less data is available on the challenges of therapy and as such, findings are predominantly positive. Likewise, little information is available on people’s expectations of therapy, and where studies have included questions about prior expectations, the questioning has largely taken place subsequent to completion of the therapy, which may introduce bias (Holding et al, in preparation; Westra, Aviram, Barnes & Angus, 2010). Moreover, the majority of the data has come from people who have engaged with therapy, with very little from those who have dropped out or refused therapy altogether, suggesting that the data available is not representative of the views or beliefs of many who are eligible for psychosis services (Holding et al, in preparation).

Individuals’ pre-existing beliefs about psychological therapy may impact on whether and how they engage with therapy (Hui et al, 2006; Lecomte et al 2008; Mutsatsa et al, 2003). Beliefs and expectations can also influence individuals’ experience of the therapeutic process and impact on outcome (Westra et al, 2010). Moreover, mental health professionals may not be aware of or underestimate the impact of these views (Hui et al, 2006).

We attempted to address the limitations in the current literature by using Q-methodology to explore beliefs about psychological therapy in a sample of young people with experience of psychosis. Q-methodology (Stephenson, 1953) combines qualitative and quantitative methods and aims to highlight and understand a diversity of viewpoints in a selected group of people, including unheard or uncommon perspectives. The process involves participants ranking a collection of statements in relation to each other, which provides an overview of their viewpoint on the topic of
interest (Stenner, Cooper, & Skevington, 2003). Q-methodology has been used and found acceptable for use in chronic and first episode psychosis populations (e.g. Dudley, Siitarinen, James & Dodgson, 2009; Gregg, Haddock & Barrowclough, 2009; Wood, Price, Morrison & Haddock, 2013). It can be helpful when exploring complex concepts like beliefs, as it offers a broad range of accessible and acceptable responses, providing material for participants to reflect on and identify with (Dudley, et al, 2009). Broadening the understanding of the variety of service users pre-existing beliefs about therapy could highlight areas for exploration with clients before or during therapy in clinical practice, which may promote engagement and potentially improve outcomes (Ogrodniczuk, Joyce & Piper, 2005; Westra et al, 2010).

The principal aim of this research was to explore what people in first episode psychosis services think about psychological therapy, by conducting qualitative interviews and a systematic review of the literature in order to develop a Q set, the set of statement to be sorted by participants, and applying Q-methodology to describe and examine a range of young people’s beliefs about therapy.

Method

Development of the Q concourse

The Q concourse for this study (the set of statements representing the full range of beliefs about therapy) was derived from two main sources, with the goal of developing a Q-set that adequately covered all potential viewpoints and beliefs about therapy:

(1) Existing research literature on beliefs, expectations, or experiences of psychological therapy
(2) Semi-structured interviews with young people who have experienced symptoms of psychosis \( (n = 11) \)

**The existing research literature**

A systematic search of the literature was conducted using Ovid electronic database, including a combination of terms relating to psychological therapies; mental health, symptom or diagnostic profiles; and beliefs, experiences, or expectations. The search was not limited to psychosis since expectations or reasons for refusing or dropping out of therapy, are lacking in existing psychosis research. Statements or topics relevant to beliefs about therapy were extracted, including direct quotes or items from outcome measures or surveys. Only service user or potential service user data was considered; theoretical or mental health staff views were excluded. This process resulted in 27 articles from which 245 belief statements about therapy were extracted.

**Interviews**

A semi-structured interview schedule (Appendix 7) was developed by JH (first author) and LG (2nd author) to explore expectations and beliefs about therapy and was administered to 11 people. All were White males in EIS with mean age of 28.82 (SD=4.60) (range 21-36). Participants had recently taken part in a randomised controlled trial (RCT), investigating the effectiveness of CBT combined with Motivational Interviewing (MiCBT) for young cannabis users with psychosis (Barrowclough et al, 2014). Four had been allocated to therapy (attending attended 1, 6, 17, and 22 sessions respectively) and seven had been allocated to treatment as usual (TAU). The schedule included questions about expectations of therapy and possible influences on these. Previous experiences of therapy and therapists, reasons
for participating, declining and dropping out of therapy, including difficulties or challenges, were explored. Naïve participants were asked what they thought therapy might have been like. The first author (JH) conducted the interviews, and subsequently listened to recordings, read transcripts and extracted the relevant statements. These interviews identified an additional 64 belief statements about therapy. Thematic analysis was used to identify and organise data extracted from the literature and participant responses from interview, and group into themes for inclusion in the Q-concourse (Braun and Clark, 2006). Reliability of themes was assessed by the 2nd and 3rd authors (LG and GH).

**Development of the Q set**

The 309-item Q-concourse was reduced and refined in stages on the grounds of duplication and clarity, and to adjust language (see Stainton-Rogers, 1995) by the authors and a group of young people from a local mental health support group, aged 16-24. For example, a number of items seemed to contain multiple concepts, such as therapy ‘can be a helpful experience for anyone,’ ‘is helpful for any type of difficulty,’ ‘can be useful and help people,’ and ‘works for some people and is worth trying,’ was simplified and split into two final items: ‘is helpful’ and ‘is useful for anyone.’ This resulted in a final Q-set of 64 belief statements. These were a mixture of general positive and negative beliefs about therapy, the setting or process, role expectations, perceived benefits (or lack of) including skills or improvement, medication, stigma, and other potential barriers.

**Other materials**

Additional information obtained from participants and/or from their casenotes, included demographic details; psychological therapy history, brief
substance use history and self-report symptomatology, using the Subjective Experiences of Psychosis Scale (SEPS) (Haddock et al., 2011) (Appendices 8 to 13). The SEPS is a self-report measure to evaluate multi-dimensional experiences of psychosis. It consists of 45 items, across 3 subscales, rated on a 5-point likert-type scale ranging from 1 (not at all) to 5 (very much). Subscales include: the positive and negative impact of psychotic experience on mental health and well-being, the positive and negative impact of support (such as treatment, support from friends or family, alcohol) on psychotic experiences, and the severity of different dimensions of psychotic experiences (frequency, pleasantness) symptoms.

**Participants**

Participants were recruited from five EIS in the North West of England, either as part of an exit interview following participation in an RCT or through their EIS case manager. People who were unable to read English or not able to give informed consent were excluded. Participants were not required to have prior experience of psychological therapy in order to take part. Participants who participated in the qualitative interviews to develop the Q-concourse were also invited to complete the Q-sort.

**Procedure**

The study was granted approval by an NHS research ethics committee and registered with all relevant host NHS site R&D departments (Appendices 14 to 16). The first author and two research assistants, all White females with psychology backgrounds, administered the Q-sort, after obtaining informed consent. Sixty-four numbered cards, each containing a belief statement, were shuffled and given to participants for sorting onto an A1-sized grid in accordance with their individual
perspective, with the condition of instruction to rank the cards from most agree to most disagree (figure 1.)

[INSERT FIGURE 1 NEAR HERE]

Recommended and routine procedures for breaking the sorting task down into three provisional ranking categories (agree, disagree, neutral) were followed (Appendix 13) (see Gregg et al, 2009; Watts & Stenner, 2012). Participants were encouraged to ask questions and make changes as required. Final card positions were recorded by the researcher and a brief post-Q interview was conducted to explore participants’ ranking choices and obtain the participant’s opinion of the task and topic. The Q-sort and post-Q interview were digitally recorded with the participants’ permission in order to provide data to aid interpretation of factors and for exemplar statements for write up.

Data analysis

Q-data were analysed using a dedicated software package (PQ Method v.2.35, Schmolck, 2002) and Principle Components Analysis (PCA) with varimax rotation was employed, maximising the amount of variance explained by extracted factors. A correlation matrix is produced which shows the relationship between individual participants, not the relationship between items, as in traditional factor analysis. Each factor is made up of participants who sort items or statements similarly. Significant loading Q-sorts are identified to define each factor, which are then merged and factor arrays are produced which represent the best estimate or average of the Q-sorts on each factor. The factor arrays are then interpreted in order
to develop a summarizing account of the viewpoint being expressed by each factor (Appendix 17) (Watts and Stenner, 2005; Stainton-Rogers, 1995).

Results

Participants’ demographic data and questionnaire scores are reported in full in Table 1. Thirty people completed the Q-sort. Twenty-one had participated in an RCT, 11 of whom had been interviewed to contribute to the development of the Q-set. Nine additional participants were recruited from EIS. The mean age was 26 years (range 18-36). The sample was predominantly White, unemployed and male. Most lived with someone else (partner, family, friends, supported housing).

[INSERT TABLE 1 NEAR HERE]

Principle components analysis resulted in a four-factor solution, on which 24 of the Sorts loaded, explaining 68% of the variance. Sixteen participants loaded on factor 1 (explaining 33% of the variance), three loaded on factor 2 (8%), one on factor 3 (12%), and four on factor 4 (15%). Six sorts were excluded from the factor arrays (Table 2) as they loaded on multiple factors, and were therefore not considered in interpretation of factors below.

[INSERT TABLE 2 NEAR HERE]

Interpretation of the Q Sorts

For brevity, only summary interpretations are presented here. Full summaries are available online or from the corresponding author (Appendix 18).
Factor 1 - “Therapy is helpful and gives hope for the future”

Factor 1 comprised 12 males and four females. Fifteen described themselves as White and one as Indian. All but two had previous experiences of involvement with psychological therapy, and four were currently waiting for therapy. Just over half experienced current symptoms of psychosis, experienced at variable frequency. Participants on this factor, on average, had the highest score for positive impact of support on their psychotic experiences.

This factor included people who appeared to have globally strong positive views about psychological therapy, including its ability to bring about change, the process, and the people that deliver therapy. People who loaded on this factor believed that therapy ‘provides support ‘ (+6), ‘is helpful’ (+5), ‘provides hope for the future’ (+4) and is certainly not ‘a waste of time’ (-6). They appeared to believe that therapy provided a unique service, as they disagreed that therapy ‘is not necessary, someone else could support a person’s needs instead’ (-3). People in this factor appeared to be generally ambivalent about medication as an adjunct to therapy (items 50: 0; 52: -1) as well as other ways of getting help (item 48,0), but strongly disagreed that medication is a replacement for therapy: Therapy ‘is just talking, people need medication instead’ (-6).

People in this factor believed most strongly that it ‘can help people make changes in their lives’ (+5), and disagreed that it ‘only provides short term solutions’ (-3). They rated a number of change or positive outcome statements higher than people on other factors (items 23, +3; 25, +3; 27, +3; 31, +3; 26, +2).

They also appeared to have very positive beliefs about the process or setting in which therapy takes place, including how they would be treated and having a
personal sense of control. For people in this group, therapy seemed to be a non-judgemental and non-stigmatising environment, which facilitates open and honest discussion, which may not be possible with family and friends (items 16, +6; 14, +5; 11, +4; 12, +4; 13, +4).

**Factor 2 - “Therapy is just talking, people need medication”**

Factor 2 comprised three White males. All had one previous experience of involvement with psychological therapy although two had ended it early. Two of the participants did not find therapy helpful and one was not sure. This group recorded the lowest average score on positive impact of experiences on mental health and wellbeing and on severity of negative dimensions of psychosis.

Factor 2 consisted of people with strong views about the importance of medication. In contrast to factor 1, they did not believe that therapy could be effective without other things in place, such as medication. Therapy was viewed as ‘not the only way for people to get help’ (+5) and they disagreed that it ‘is more helpful than taking tablets’ (-5). They believed that therapy ‘is just talking, people need medication instead’ (+5) and ‘is only helpful if the person is taking medication as well’ (+4). They were the only group to endorse that therapy ‘is only for people with something wrong with them’ (+2)

While medication seemed to be viewed as a necessity, they still held some positive general views about psychological therapy. They disagreed that therapy ‘makes people’s problems worse’ (-6) and believed it ‘is helpful’ (+6). They believed it would be a positive setting: ‘is somewhere to be listened to’ (+6), ‘is somewhere
to get self-understanding or insight’ (+4) and ‘is somewhere to talk to someone who understands’ (+3).

Unlike factor 1, they did not endorse many positive specific benefits to therapy and seemed to lack belief or hope that therapy could bring about change (items 8, -4; 20, -3; 24, -2; 26, -5; 27, -4; 28, -4, 30, -3). They were uncertain about therapy in general, viewing it as ‘an unknown which puts people off from trying it’ (+4).

**Factor 3 -“Therapy is useful but stigmatising”**

Only one person loaded onto factor 3, a White male, who had no previous experience of psychological therapy but was currently on the waiting list to receive CBT. He reported that he currently experienced psychotic experiences, however questionnaire data were missing for sections two and three of the SEPS. He had a relatively high score for positive impact of his experiences on his mental health and well being, compared to other group averages, and one of the lowest scores for negative impact of his experiences.

This participant expressed mixed views about therapy. He disagreed that therapy ‘is somewhere people can talk about problems without being ashamed’ (-3) and ‘accepts people as they are without judging them’ (-5), possibly leading him to disagree that therapy ‘is somewhere people can talk honestly’ (-6) and ‘is somewhere people can talk about things that they are not comfortable telling family or friends’ (-4). Moreover, he believed that therapy ‘is something that people are too embarrassed to attend because of what other people would think’ (+4) and expressed the strongest concern compared to other factors that therapy ‘makes people talk about things that will play on their mind later’ (+4).
He was the only one without a strong feeling about medication vs. therapy ‘is just talking, people need medication instead’ (+1). At the same time, he did have some positive beliefs about the benefits of therapy: He agreed that therapy ‘helps people understand the impact of the past on what is happening now’ (+6), ‘helps people feel more confident in social situations’ (+6), and ‘helps people get control over their problems’ (+4).

**Factor 4 - “Therapy is better than medication”**

Factor 4 comprised all males; three were White and one was Black. They all had previous experiences of involvement with psychological therapy, and none were currently on a therapy waiting list. Two participants self-reported that they had seen at least one course of therapy through to completion and two reported ending therapy early. Three participants reported that they were unsure about the helpfulness of past therapy and one reported that it had been unhelpful. They all reported to have current experiences of psychosis, occurring relatively frequently over the past week. On average, they had the lowest score for the positive impact of support on the psychotic experiences.

People on factor 4 were the most strongly opposed to medication, disagreeing that therapy ‘is only helpful if the person is taking medication as well’ (-6) and ‘is just talking, people need medication instead’ (-4). They appeared to be uncertain or ambivalent about whether therapy could facilitate change in their lives (items 6, 0; 25, -3; 29, -2; 23, +1; 24, +1; 26,0; 27, -1; 28, 0; 30, 0; 31, 0), but still believed it ‘is more helpful than taking tablets’ (+3).

They also had the strongest positive beliefs about the therapy setting and how they would be treated. They expressed strong consistent beliefs that therapy ‘is
somewhere to be listened to’ (+6), ‘is somewhere people are treated as individuals, not as an illness’ (+5), ‘accepts people as they are without judging them’ (+4), ‘is somewhere people can talk about things that they are not comfortable telling family or friends’ (+6), and ‘is a respectful relationship between equals’ (+4). This could in turn influence beliefs about how they could be in sessions, endorsing that therapy ‘is somewhere people can talk honestly’ (+5) and ‘is somewhere people can talk about problems without being ashamed (+3).

**Relationships between factors**

As can be seen in Table 3, the correlations between factor scores suggest some overlap between the factors, specifically between factors 1, 2, and 4. These factors all had some general positive views about therapy, and while their differing beliefs about the efficacy of therapy and medication distinguish them, they all seemed to have positive beliefs about the way they would be treated in therapy. Factor 3 did not correlate highly with any of the other factors.

(ADD TABLE 3 HERE)

**Consensus Statements**

As table 2 shows, there were a number of consensus statements, i.e. statements that were ranked similarly across factors. Eleven statements reached consensus statistically, mainly items participants were ambivalent about. Two other statements (38, 60) did not reach statistical consensus, but are worthy of comment. All factors had a strong belief that therapy ‘is private and confidential’ and agreed that it ‘gives choice in what people want to work on’. They seemed to disagree fairly
strongly that therapy ‘makes people’s problems worse’, ‘makes people make changes they don’t want to make’, ‘is offered by people who don’t understand different religions or cultures’. There was some uncertainty or ambivalence about therapists however (items 63, 64).

Discussion

This study aimed to explore young people’s beliefs about psychological therapy for psychosis using Q-methodology and four distinct factors were identified. The results suggest that young people in EIS have complex and multi-faceted beliefs about different aspects of psychological therapy, including the process, normalisation and stigma, outcomes, and the people who deliver it. All participants had some level of positive belief about psychological therapy, albeit potentially for different reasons. In addition, interesting views about medication and usefulness in relation to therapy also emerged.

Factor 1/Therapy is helpful and gives hope for the future consisted of people who presented a strong case for psychological therapy. It represents just over half of the entire study sample. These views are in line with the current research available on peoples’ beliefs about therapy for psychosis (Holding et al, in preparation). They expressed positive views about all elements of the therapeutic process and believed that therapy played a unique role in supporting people in a non-stigmatising environment, in order to facilitate change and hope for the future.

Factor 2/Therapy is just talking, people need medication illustrates a more traditional view about therapy and medication. They had strong views about the importance of medication, which were in sharp contrast to other groups. Factor 2 believed that medication is the only or best way to improve, as they did not agree
that therapy could accomplish change. People on this factor are possibly more likely to endorse a medical or biological model explanation of the aetiology of psychosis. They may have had these preconceptions before entering services, or may have been told that therapy is not helpful without medication for psychosis. This could be due to staff influences, who also often hold these views (Prytys et al, 2011). Treatment for psychosis without medication is a view that is only recently being challenged in the research literature (Morrison et al, 2012).

Factor 3/Therapy is useful but stigmatising was the only one to voice a strong belief or worry that therapy could be a stigmatising, shaming, or judgemental experience, both because of the therapy process and because of what others might think. Some people might avoid mental health settings or treatment because they may be viewed as stigmatising, particularly if they have concerns about acceptance from peers and avoiding rejection (Gaebel et al. 2006). This participant may have been acutely aware of these issues as he was currently enrolled in college and lived in supported accommodation. However, he was on a CBT waiting list, which seems consistent with his other positive beliefs about the benefits of therapy.

This factor was determined by one person’s Q-sort. There is debate about whether factors of one should be retained or not, however support for this practice is available from two noteworthy Q-researchers. Brown (1980) and Stephenson (1964) posit that solitary or unique viewpoints can be significant, and as they may not constitute the ‘norm’, will not load onto other factors. These beliefs are certainly significant as stigma and social exclusion are common in the experience of psychosis (NICE, 2014). In addition, five of the six confounding sorts also loaded highly on
this factor, suggesting that it is a valid and important belief to consider when working with young people in psychosis services.

Factor 4/Therapy is better than medication expressed the strongest beliefs against medication and about the way people are treated in therapy. It is interesting that these beliefs were held along with uncertainty or ambivalence about the helpfulness of therapy, possibly indicating feelings of hopelessness about anything being able to help.

**Clinical implications**

Clinicians need to understand service user concerns about being involved in therapy, as managing expectations and beliefs before therapy commences may facilitate better outcomes (Ogrodniczuk et al, 2005). Q methodology could be a useful tool for professionals across disciplines to assess expectations and beliefs for further exploration (Jones et al, 2003). The current sample confirmed that Q is less scrutinising and more enjoyable than traditional interview or questionnaire techniques. Negative beliefs are included in the Q-set, suggesting they are common and appropriate beliefs to hold, which may elicit more balanced accounts of beliefs.

Q can also facilitate useful content for discussions. These beliefs may be difficult to access, particularly with no prior experience of therapy. However, all people are likely to have beliefs about therapy, influenced by a number of sources, including media portrayals, which could lead to the development of faulty or unhelpful beliefs about therapy (Grazebrook et al, 2004). If these negative appraisals of therapy, such as fears or misconceptions about therapists, the process, and stigma, go unexplored and accurate explanation are not promoted, people may miss out on an important element of treatment.
Previous research has identified potential barriers to therapy, such as concerns about cultural differences, confidentiality and implications of confidentiality breaches, therapy making symptoms worse, and not having a choice in therapy (Holding et al, in preparation; Rathod, et al 2010; Westra et al, 2010). As can be seen from the consensus statements (Table 2), participants in this research did not appear to have these concerns, which may help differentiate those that agree to therapy from those that decline. These beliefs may be particularly important to highlight when exploring beliefs with people reluctant to engage.

An awareness of these beliefs may lead to different approaches or options being made available to service users. Recently revised NICE guidelines for psychosis (2014) make recommendations for the use of peer support, which involves a trained peer support worker who has recovered from psychosis to provide advice and information. Meeting people who have recovered from psychosis, potentially with the help of therapy, could be both normalising and inspiring for people who may be hopeless, unsure about therapy or have concerns about stigmatisation. Voluntary support groups (such as the Hearing Voices Network) or group therapy approaches may also be particularly beneficial for those who feel isolated or stigmatised (Goodliffe et al, 2010; Newton et al, 2007; Romme & Escher, 2000).

**Strengths and limitations**

This study aimed to incorporate service user input at all stages of the research, which is a key strength of this study. They helped generate items for the Q-concourse, providing input on final item inclusion, terminology and design of the Q-set, and piloted the final materials. Unfortunately, it was not possible to re-interview participants to comment on the factor interpretations. This would have provided
useful insight into the accuracy of the patterns of beliefs identified (Watts & Stenner, 2005). However, the factor summaries were reviewed and confirmed in line with a service user perspective with a Service User Development Worker, a former EIS user. This level of involvement throughout the study helped ensure that the content and materials were meaningful, representative and relevant from a service user perspective. While the development of the Q-set was performed systematically to be as inclusive as possible, it is not possible to cover every belief. However, none of the participants suggested additional items for inclusion in the Q-set and they judged it to be comprehensive and representative of their beliefs.

The recruited sample may not be representative of EIS (or psychosis) populations and this research encountered similar limitations of previous studies in terms of sample characteristics. Participants were predominantly White males, who were engaged with services, and almost all had experiences of therapy. However, not all had completed or had helpful experiences of therapy, and described terminating therapy prematurely, which is in contrast to the majority of previous research exploring therapy experiences (Holding et al, in preparation), which is a further strength of this study.

Overall, a positive story has been told, however, this may be in part due to limitations in recruitment. Strategic sampling is acceptable and recommended in Q-research (Watts & Stenner, 2012) and case managers were encouraged to identify BME services users or people who have refused, dropped out, or may have negative views about therapy. Recruitment of these individuals proved difficult. In some cases, when these individuals were referred and consented to take part, their views
remained hopeful about therapy or had changed. BME service users were also underrepresented despite efforts to include more.

More than two thirds of participants met criteria for substance use or dependence at some point in the last 18 months (inclusion criteria for participation in the RCT). Only one of the additional participants reported no historical substance use, however specific levels of use for the remaining participants were not assessed. People with coexisting substance use may have additional needs and complexities compared to other service users with psychosis, and it is possible their beliefs may not be representative of EIS users as a whole (Cleary et al, 2008; NICE, 2011). However, substance use and abuse rates are high in FEP populations (Lambert et al, 2005), and it is important to consider beliefs about substance use as well when working with this population (Gregg et al, 2009).

**Future research**

The impact of therapy beliefs in psychosis has yet to be seen. Future research could explore the impact of beliefs about therapy on engagement, outcomes, and satisfaction. Studies would also benefit from considering alternative recruitment strategies to promote engagement for underrepresented groups in both research and mental health services, such as people who do not engage and BME groups. For some BME groups in particular, therapy drop out rates are higher and outcomes are poorer (Rathod et al, 2005; Turkington et al, 2002). Exploring beliefs about therapy may be able to highlight any similarities and differences with other White service users, as well as considering the potential impact of cultural beliefs on engagement with therapy.
References


Stenner, P. H., Cooper, D., & Skevington, S. M. (2003). Putting the Q into quality of life; the identification of subjective constructions of health-related quality of life using Q methodology. *Social Science & Medicine, 57*(11), 2161-2172.


Additional references used for Q-development, not cited in text


Figure 1. Q-sort response matrix.
Table 1. Participant Characteristics.

<table>
<thead>
<tr>
<th></th>
<th>Total Sample (N=30)</th>
<th>Factor 1 (N=16)</th>
<th>Factor 2 (N=3)</th>
<th>Factor 3 (N=1)</th>
<th>Factor 4 (N=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean Age (SD; Range)</strong></td>
<td>26.07 (5.00; 18-36)</td>
<td>26.88 (5.85; 18-36)</td>
<td>26.33 (4.62; 21-29)</td>
<td>22.00 (4.93; 21-33)</td>
<td>26.50 (4.93; 21-33)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Male</em></td>
<td>25 (83.3%)</td>
<td>12 (75.0%)</td>
<td>3 (100%)</td>
<td>1 (100%)</td>
<td>4 (100%)</td>
</tr>
<tr>
<td><em>Female</em></td>
<td>5 (16.7%)</td>
<td>4 (25.0%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
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<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>White</em></td>
<td>28 (93.3%)</td>
<td>15 (93.8%)</td>
<td>3 (100%)</td>
<td>1 (100%)</td>
<td>3 (75%)</td>
</tr>
<tr>
<td><em>Black</em></td>
<td>1 (3.3%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (25%)</td>
</tr>
<tr>
<td><em>Indian</em></td>
<td>1 (3.3%)</td>
<td>1 (6.3%)</td>
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<td>0</td>
<td>0</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>2 (12.6%)</td>
<td>1 (33.3%)</td>
<td>0</td>
<td>1 (25.0%)</td>
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<tr>
<td><em>Volunteer Work</em></td>
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<td>2 (12.5%)</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td>Unemployed</td>
<td>Living alone</td>
<td>Living with a partner</td>
<td>Living with one or more family</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>------------</td>
<td>--------------</td>
<td>----------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td></td>
<td>3 (10%)</td>
<td>0</td>
<td>6 (20%)</td>
<td>1 (6.3%)</td>
<td>14 (46.7%)</td>
</tr>
<tr>
<td></td>
<td>2 (12.5%)</td>
<td>10 (62.5%)</td>
<td>1 (6.3%)</td>
<td>2 (66.7%)</td>
<td></td>
</tr>
<tr>
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<td>2 (66.7%)</td>
<td>2 (66.7%)</td>
<td>0</td>
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</tr>
<tr>
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<td>1 (100%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>3 (75.0%)</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>1 (100%)</td>
<td>0</td>
<td>1 (100%)</td>
<td></td>
</tr>
<tr>
<td>Distinct courses of therapy</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
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<td></td>
</tr>
<tr>
<td>0</td>
<td>3 (10%)</td>
<td>2 (12.5%)</td>
<td>0</td>
<td>1 (100%)</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>19 (63.3%)</td>
<td>9 (56.3%)</td>
<td>3 (100%)</td>
<td>0</td>
<td>3 (75.0%)</td>
</tr>
<tr>
<td>2</td>
<td>6 (20%)</td>
<td>3 (18.8%)</td>
<td>0</td>
<td>0</td>
<td>1 (25.0%)</td>
</tr>
<tr>
<td>3</td>
<td>2 (6.7%)</td>
<td>2 (12.5%)</td>
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<td>0</td>
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<table>
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<tr>
<th>Current therapy waiting list</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Completed a course of therapy? N=26</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>
### Ever ended therapy early? N=26

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>(no experience of therapy)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td>12 (46.2%)</td>
<td>5 (38.5%)</td>
<td>2 (66.7%)</td>
<td>2 (50%)</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td>13 (50.0%)</td>
<td>7 (53.8%)</td>
<td>1 (33.3%)</td>
<td>2 (50%)</td>
</tr>
<tr>
<td><strong>Unsure</strong></td>
<td>1 (3.8%)</td>
<td>1 (7.7%)</td>
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</table>

### Ever declined therapy? N=26

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>(no experience of therapy)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td>7 (26.9%)</td>
<td>6 (37.5%)</td>
<td>1 (50.0%)</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td>19 (73.1%)</td>
<td>10 (62.5%)</td>
<td>1 (100%)</td>
</tr>
</tbody>
</table>

### Any therapy helpful? N=25

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>(no experience of therapy)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td>11 (37.9%)</td>
<td>8 (50.0%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td>7 (24.2%)</td>
<td>2 (12.5%)</td>
<td>2 (66.7%)</td>
<td>1 (25.0%)</td>
</tr>
<tr>
<td><strong>Unsure</strong></td>
<td>11 (37.9%)</td>
<td>6 (37.5%)</td>
<td>1 (33.3%)</td>
<td>3 (75.0%)</td>
</tr>
</tbody>
</table>

### Self-report current
<table>
<thead>
<tr>
<th>Symptoms of psychosis</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td>19 (63.3%)</td>
<td>9 (56.3%)</td>
<td>2 (66.7%)</td>
<td>1 (100%)</td>
<td>4 (100%)</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td>11 (36.7%)</td>
<td>7 (43.8%)</td>
<td>1 (33.3%)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SEPS - frequency of psychotic experiences in last week</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not at all</strong></td>
<td>10 (33.3%)</td>
<td>7 (43.8%)</td>
<td>1 (33.3%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>A little</strong></td>
<td>4 (13.3%)</td>
<td>2 (12.5%)</td>
<td>1 (33.3%)</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td><strong>Moderately</strong></td>
<td>5 (16.7%)</td>
<td>0</td>
<td>0</td>
<td>3 (75.0%)</td>
<td></td>
</tr>
<tr>
<td><strong>Quite a lot</strong></td>
<td>10 (33.3%)</td>
<td>7 (43.8%)</td>
<td>1 (33.3%)</td>
<td>1 (25.0%)</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Mean SEPS Positive Impact of Experience (SD; | 50.37 | 50.37 | 42.33 | 78.00 | 56.75 |
|                                          | (22.02; 29-109) | (21.49; 29-109) | (19.73; 29-65) | (20.19; 31-78) | |</p>
<table>
<thead>
<tr>
<th>Range)</th>
<th>Mean SEPS</th>
<th>65.17</th>
<th>70.63</th>
<th>64 (</th>
<th>33.00</th>
<th>70.50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Impact of Experience (SD; Range)</td>
<td>(30.93; 29-142)</td>
<td>(34.63; 29-142)</td>
<td>31.19; 31-93)</td>
<td>(32.88; 31-109)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean SEPS Positive Impact of Support N=29</td>
<td>12.69</td>
<td>13.81</td>
<td>11.33</td>
<td>---</td>
<td>9.25</td>
<td></td>
</tr>
<tr>
<td>Impact of Support</td>
<td>(5.12; 5-23)</td>
<td>(4.85; 5-23)</td>
<td>(8.51; 5-21)</td>
<td>(2.75; 6-12)</td>
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<td></td>
</tr>
<tr>
<td>Mean SEPS</td>
<td>7.10</td>
<td>7.00</td>
<td>5.00</td>
<td>---</td>
<td>8.75</td>
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<tr>
<td>Negative Impact of Support N=29</td>
<td>(3.38; 2-15)</td>
<td>(3.95; 2-15)</td>
<td>(.00; 5-5)</td>
<td>(2.22; 7-12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean SEPS Positive Dimensions of Psychosis</td>
<td>4.03</td>
<td>4.12</td>
<td>4.00</td>
<td>---</td>
<td>4.25</td>
<td></td>
</tr>
<tr>
<td>(SD; Range)</td>
<td>(1.90; 2-9)</td>
<td>(2.28; 2-9)</td>
<td>(1.00; 3-5)</td>
<td>(.96; 3-5)</td>
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</table>
Experiences N=29
(SD; Range)

<table>
<thead>
<tr>
<th></th>
<th>Mean SEPS</th>
<th>Negative Dimensions</th>
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<tbody>
<tr>
<td></td>
<td>11.79</td>
<td>(3.95; 5-19)</td>
</tr>
<tr>
<td></td>
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<td>(4.22; 5-19)</td>
</tr>
<tr>
<td></td>
<td>8.33</td>
<td>(3.51; 5-12)</td>
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<td></td>
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<td>(2.87; 7-13)</td>
</tr>
<tr>
<td></td>
<td>11.25</td>
<td></td>
</tr>
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Self-report substance use history

<table>
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<tr>
<th></th>
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<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>29 (96.7%)</td>
<td>1 (3.3%)</td>
</tr>
<tr>
<td></td>
<td>15 (93.8%)</td>
<td>1 (6.3%)</td>
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<tr>
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<td>3 (100%)</td>
<td>0</td>
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<tr>
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<td>1 (100%)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>4 (100%)</td>
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</table>

SEPS = Subjective Experiences of Psychosis Scale
Table 2. Factor Arrays.

<table>
<thead>
<tr>
<th>Psychological therapy</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is a way of getting advice*</td>
<td>+2</td>
<td>+4</td>
<td>+2</td>
<td>+3</td>
</tr>
<tr>
<td>2. Is guided by a therapist, not by the person</td>
<td>-2</td>
<td>0</td>
<td>+3</td>
<td>+3</td>
</tr>
<tr>
<td>3. Is a respectful relationship between equals</td>
<td>+1</td>
<td>+1</td>
<td>-4</td>
<td>+4</td>
</tr>
<tr>
<td>4. Gives choice in what people want to work on**</td>
<td>+1</td>
<td>+1</td>
<td>+5</td>
<td>+3</td>
</tr>
<tr>
<td>5. Involves people putting the work in themselves</td>
<td>0</td>
<td>0</td>
<td>+2</td>
<td>-5</td>
</tr>
<tr>
<td>6. Is helpful</td>
<td>+5</td>
<td>+6</td>
<td>+2</td>
<td>0</td>
</tr>
<tr>
<td>7. Is useful for anyone</td>
<td>-1</td>
<td>+2</td>
<td>0</td>
<td>+2</td>
</tr>
<tr>
<td>8. Can help people make changes in their lives</td>
<td>+5</td>
<td>-4</td>
<td>+4</td>
<td>+1</td>
</tr>
<tr>
<td>9. Is somewhere to be listened to</td>
<td>+3</td>
<td>+6</td>
<td>+3</td>
<td>+6</td>
</tr>
<tr>
<td>10. Provides support</td>
<td>+6</td>
<td>+2</td>
<td>+3</td>
<td>+3</td>
</tr>
<tr>
<td>11. Is somewhere people can talk honestly</td>
<td>+4</td>
<td>+5</td>
<td>-6</td>
<td>+5</td>
</tr>
<tr>
<td>12. Is somewhere to talk to someone who understands</td>
<td>+4</td>
<td>+3</td>
<td>+5</td>
<td>+1</td>
</tr>
<tr>
<td>13. Is somewhere people can talk about things they are not comfortable telling family or friends</td>
<td>+4</td>
<td>+1</td>
<td>-4</td>
<td>+6</td>
</tr>
<tr>
<td>14. Is somewhere people can talk about problems without being ashamed</td>
<td>+5</td>
<td>+2</td>
<td>-3</td>
<td>+3</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Score</td>
<td></td>
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<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>15.</td>
<td>Is somewhere people learn that their experiences have been experiences by others**</td>
<td>+1</td>
<td>3</td>
<td>+6</td>
</tr>
<tr>
<td>16.</td>
<td>Accepts people as they are without judging them</td>
<td>+6</td>
<td>1</td>
<td>-5</td>
</tr>
<tr>
<td>17.</td>
<td>Is somewhere people are treated as individuals, not as an illness</td>
<td>+2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>18.</td>
<td>Is a way of getting regular contact with someone**</td>
<td>+1</td>
<td>3</td>
<td>+5</td>
</tr>
<tr>
<td>19.</td>
<td>Is something to look forward to each week**</td>
<td>0</td>
<td>-1</td>
<td>+1</td>
</tr>
<tr>
<td>20.</td>
<td>Provides hope for the future</td>
<td>+4</td>
<td>-3</td>
<td>-2</td>
</tr>
<tr>
<td>21.</td>
<td>Is somewhere to get self-understanding or insight</td>
<td>+1</td>
<td>4</td>
<td>-3</td>
</tr>
<tr>
<td>22.</td>
<td>Helps people understand the impact of the past on what is happening now</td>
<td>+2</td>
<td>0</td>
<td>+6</td>
</tr>
<tr>
<td>23.</td>
<td>Helps people overcome stressful life events</td>
<td>+3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>24.</td>
<td>Helps people get control over their problems</td>
<td>+2</td>
<td>-2</td>
<td>+4</td>
</tr>
<tr>
<td>25.</td>
<td>Helps people cope with their experiences</td>
<td>+3</td>
<td>0</td>
<td>+2</td>
</tr>
<tr>
<td>26.</td>
<td>Helps people feel less distressed/frightened</td>
<td>+2</td>
<td>-5</td>
<td>-3</td>
</tr>
<tr>
<td>27.</td>
<td>Helps people feel more confident</td>
<td>+3</td>
<td>-4</td>
<td>+2</td>
</tr>
<tr>
<td>28.</td>
<td>Helps people to start doing more in their life</td>
<td>+2</td>
<td>-4</td>
<td>+2</td>
</tr>
<tr>
<td>29.</td>
<td>Helps people improve in their personal</td>
<td>0</td>
<td>-1</td>
<td>0</td>
</tr>
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<td></td>
<td></td>
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<td>-----------------------------------------------------------------</td>
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</tr>
<tr>
<td>30.</td>
<td>Helps people feel more comfortable in social situations</td>
<td>+1</td>
<td>-3</td>
<td>+6</td>
</tr>
<tr>
<td>31.</td>
<td>Helps people identify when they are becoming unwell</td>
<td>+3</td>
<td>-2</td>
<td>+1</td>
</tr>
<tr>
<td>32.</td>
<td>Is a waste of time</td>
<td>-6</td>
<td>-2</td>
<td>-2</td>
</tr>
<tr>
<td>33.</td>
<td>Is for people who are weak</td>
<td>-5</td>
<td>-6</td>
<td>-2</td>
</tr>
<tr>
<td>34.</td>
<td>Only provides short term solutions</td>
<td>-3</td>
<td>+1</td>
<td>-3</td>
</tr>
<tr>
<td>35.</td>
<td>Cannot solve every problem</td>
<td>0</td>
<td>+1</td>
<td>-1</td>
</tr>
<tr>
<td>36.</td>
<td>Makes people's problems worse**</td>
<td>-5</td>
<td>-6</td>
<td>-2</td>
</tr>
<tr>
<td>37.</td>
<td>Makes people talk about things that will play on their mind later</td>
<td>0</td>
<td>+2</td>
<td>+4</td>
</tr>
<tr>
<td>38.</td>
<td>Makes people make changes they don't want to make</td>
<td>-5</td>
<td>-4</td>
<td>-5</td>
</tr>
<tr>
<td>39.</td>
<td>Does not fit in with people's religious beliefs</td>
<td>-2</td>
<td>0</td>
<td>-1</td>
</tr>
<tr>
<td>40.</td>
<td>Is something that people can get too dependent on*</td>
<td>-1</td>
<td>-2</td>
<td>-4</td>
</tr>
<tr>
<td>41.</td>
<td>Makes people talk about embarrassing things</td>
<td>-1</td>
<td>0</td>
<td>-6</td>
</tr>
<tr>
<td>42.</td>
<td>Makes people bring up things from the past, that aren’t relevant to their problems now</td>
<td>-3</td>
<td>-3</td>
<td>-1</td>
</tr>
<tr>
<td>43.</td>
<td>Is too much hard work</td>
<td>-2</td>
<td>-1</td>
<td>-2</td>
</tr>
<tr>
<td>44.</td>
<td>Is too complicated for people to understand</td>
<td>-3</td>
<td>-3</td>
<td>-1</td>
</tr>
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</tr>
<tr>
<td>45.</td>
<td>Is only for people who are good at talking</td>
<td>-4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>46.</td>
<td>Is an unknown, which puts people off from trying it</td>
<td>-1</td>
<td>+4</td>
<td>-1</td>
</tr>
<tr>
<td>47.</td>
<td>Is only for people with something wrong with them</td>
<td>-1</td>
<td>+2</td>
<td>-2</td>
</tr>
<tr>
<td>48.</td>
<td>Is not the only way for people to get help</td>
<td>0</td>
<td>+5</td>
<td>-6</td>
</tr>
<tr>
<td>49.</td>
<td>Takes too long*</td>
<td>-2</td>
<td>-1</td>
<td>-1</td>
</tr>
<tr>
<td>50.</td>
<td>Is more helpful that taking tablets</td>
<td>0</td>
<td>-5</td>
<td>0</td>
</tr>
<tr>
<td>51.</td>
<td>Is just talking, people need medication instead</td>
<td>-6</td>
<td>+5</td>
<td>+1</td>
</tr>
<tr>
<td>52.</td>
<td>Is only helpful if the person is taking medication as well</td>
<td>-1</td>
<td>+4</td>
<td>+1</td>
</tr>
<tr>
<td>53.</td>
<td>Is private and confidential**</td>
<td>+6</td>
<td>+6</td>
<td>+3</td>
</tr>
<tr>
<td>54.</td>
<td>Is too much for people to commit to with the other things going on in their lives</td>
<td>-1</td>
<td>+2</td>
<td>-3</td>
</tr>
<tr>
<td>55.</td>
<td>Is difficult to attend because of travel or cost to get there</td>
<td>-2</td>
<td>-2</td>
<td>-5</td>
</tr>
<tr>
<td>56.</td>
<td>Is something people are too embarrassed to attend because of what other people would think</td>
<td>-2</td>
<td>-2</td>
<td>+4</td>
</tr>
<tr>
<td>57.</td>
<td>Is something that people attend only if others pressure them to do it</td>
<td>-4</td>
<td>-6</td>
<td>-1</td>
</tr>
<tr>
<td>58.</td>
<td>Is not necessary, someone else could support</td>
<td>-3</td>
<td>-1</td>
<td>+1</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>---</td>
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</tr>
<tr>
<td><strong>59.</strong> Is offered by therapists that people cannot relate to</td>
<td>-4</td>
<td>-3</td>
<td>0</td>
<td>+1</td>
</tr>
<tr>
<td><strong>60.</strong> Is offered by people who don't understand different religions or cultures</td>
<td>-3</td>
<td>-1</td>
<td>-4</td>
<td>-4</td>
</tr>
<tr>
<td><strong>61.</strong> Is offered by therapists that don't care about the people they see</td>
<td>-4</td>
<td>-5</td>
<td>0</td>
<td>-3</td>
</tr>
<tr>
<td><strong>62.</strong> Is offered by people who just sit and listen, and don’t offer advice</td>
<td>-6</td>
<td>-1</td>
<td>+1</td>
<td>-6</td>
</tr>
<tr>
<td><strong>63.</strong> Is offered by therapists who are easy to talk to**</td>
<td>0</td>
<td>+1</td>
<td>+1</td>
<td>-1</td>
</tr>
<tr>
<td><strong>64.</strong> Is offered by people who want to help others*</td>
<td>+1</td>
<td>+3</td>
<td>+3</td>
<td>+2</td>
</tr>
</tbody>
</table>

Consensus statements, * = non-significant at p > .05; ** = non-significant at p > .01
Table 3. Correlations between factor scores.

<table>
<thead>
<tr>
<th></th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 2</td>
<td>0.39</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Factor 3</td>
<td>0.28</td>
<td>0.12</td>
<td>1.00</td>
</tr>
<tr>
<td>Factor 4</td>
<td>0.64</td>
<td>0.38</td>
<td>0.25</td>
</tr>
</tbody>
</table>
Critical Evaluation and Discussion

Word count*: 7432

*Excluding: references
Introduction

This paper will outline the author’s review and reflections of conducting a research project about beliefs about psychological therapy for psychosis. The review will describe the author's decision-making processes, strengths and limitations of choices, and the complexities of sample selection. Challenges and overall learning processes are considered. Implications of the two papers, taken together as whole, for future practice and research are discussed.

Paper 1: Literature Review

Rationale for topic selection

Over many years of working with people with experiences of psychosis, it has become clear that they have a voice that often goes unheard in society and services. People have shared their concerns about stigma, marginalisation, and medication, including side effects and limitations. They have expressed many views about psychosocial approaches, such as talking therapies, including benefits, uncertainty, anxiety, ambivalence, negativity, and hope.

Initial searches of the literature highlighted that service user voices are also missing from research. Qualitative research with people with psychosis is growing, with many researchers recognising the benefits of exploring the rich accounts of people with lived experience of psychosis. Quantitative studies seemed to try to incorporate beliefs about therapy in slightly different ways. However, it was clear that no one had provided a summarising account of beliefs about therapy, nor had it been the main focus of any study. Conducting a review to amalgamate the current understanding would be helpful for three reasons: it would (1) be the first time all of this information was brought together, promoting the ‘voice’ of people with
psychosis, (2) highlight what we know and perhaps more importantly, what we don’t know, and (3) identify key areas of improvement for working therapeutically with people with psychosis.

**Literature search**

The literature search was a challenging and time-consuming process. The author soon recognised difficulties of conducting a systematic search for a previously undefined topic area. As studies had not conducted research specifically about ‘beliefs,’ the search scope had to be broad. This provided challenges in developing search terms that would retrieve sufficient studies with any relevant data that could be considered representative of beliefs about therapy for psychosis. The author tried to focus the search to be inclusive of all literature available that may describe beliefs, opinions, or expectations about therapy; these terms grew as initial searches were undertaken. The inclusion of such general terms, e.g. adherence and attitude, generated many unsuitable publications. Limitations were not made on type of therapy, which widened the breadth of material to an even greater extent. This was ultimately felt to be a strength of the research.

As the search continued, it was difficult to know when to stop. For example, the decision to add ‘satisfaction’ to the initial search proved to be useful. It is possible that other search terms or concepts would have provided additional material, however time limitations and scope of the review had to be considered. Regular discussion with supervisors more experienced in the review process was invaluable to guide this process, including when to draw it to a close.

A vast number of studies were identified in initial searches and ‘belief’ and ‘therapy’ terms had to be limited to inclusion in the title of included studies in order
for the task to be feasible. Every effort was made for the search within these parameters to be exhaustive, with careful consideration of the search terms and with reference sections of every included and many excluded papers being scrutinised. However, it is possible that relevant studies could have been missed by these limitations.

**Rationale for narrative synthesis**

A number of methodologies were considered for approaching the systematic review of the literature. Meta-analyses tend to be about effectiveness and focus on quantitative methods, and that was not the aim of this research. Meta-synthesis and thematic synthesis are methods for reviewing, compiling and integrating findings of multiple qualitative studies. Thematic synthesis was particularly appealing as it employs thematic analysis techniques and has been applied to address questions about people’s perspectives and experiences (Thomas & Harden, 2008). Previous reviews had included only qualitative studies. While these provide the ‘richest’ accounts of the service user perspective, it seemed important to include as much data as possible on this understudied topic. Narrative synthesis seemed to be the best option as it allows for the inclusion of mixed methodologies, including both qualitative and quantitative approaches. Narrative synthesis offers a novel approach of bringing together evidence, using a textual approach, in order to tell a story about the synthesised findings (Popay et al, 2006).

**Quality Appraisal**

In quantitative reviews, such as meta-analyses, quality appraisal is often used as a method of excluding poor quality studies for contributing to findings. However, in qualitative methodology, researchers debate over whether formal appraisal is
either appropriate or feasible at all, and accordingly, whether these tools should be used as a deciding factor for inclusion/exclusion (Popay, 2006). The decision was made that the use of quality criterion checklists was still appropriate for the studies included in the synthesis in order to make comment on their quality, which is considered relevant for ascertaining the validity of findings. However, as the topic represented an understudied area, it was decided that papers with methodological limitations would not be excluded as this may have resulted in the loss of important data. This approach is supported in narrative synthesis guidance (Popay et al, 2006).

The author compensated for the inclusion of studies that were rated to be ‘poor’ by commenting on the strength of the evidence throughout, and by reflecting critically on the literature and the synthesis process (Velasco et al, 2002).

No clear guidance was found to suggest which appraisal tools would be most appropriate for the narrative synthesis task. Many tools are available and it was difficult for the author to choose appropriate tools for the purposes of a mixed-methods review. Initially various qualitative tools were explored. Checklists from the Critical Appraisal Skills Programme (CASP) are a popular choice (http://www.casp-uk.net/). They offer many tools and the qualitative checklist appeared to assess appropriate domains in a comprehensive and balanced manner. However, there did not seem to be an appropriate measure for the cross-sectional quantitative papers included in the review. The NICE (2012) checklists (Appendices 2-4) were decided upon as they offer complementary measures across methodologies. In addition, they were being used by peer researchers, which was considered beneficial for reliability rating purposes.
The NICE (2012) checklists were overall a good choice. They were user-friendly and comprehensive and the accompanying guidance provided useful clarification for some sections. Subsequent degree of inter-rater reliability was considered excellent (NICE, 2012), with only one paper requiring discussion about final ratings (deciding between a score of ++ or +), without the need to consult a third reviewer. However, reliability was only double-assessed (or considered independently) for 20% of included studies. To ensure the rating criteria were utilised appropriately, it would have been beneficial for all of the papers to have been checked or independently rated by a second reviewer (NICE, 2012).

The process had limitations and created some dilemmas for the author. These checklists are recommended for use in wide variety of public health research, so many of the checklist criteria could not be rated in the psychological studies included here. It also seemed very difficult for even well designed and implemented quantitative psychological research to meet full checklist standards. The process led the author to reflect on the strengths and limitations of research settings, including ‘gold standard’ RCTs versus ‘real-world’ or service related settings. As reflected in some of the included studies here, RCT sample selection is often very stringent, and can be criticised for not being representative of service populations. For example, co-existing substance use is often an exclusion criterion. However, substance use rates are very high in psychosis populations, with estimates of prevalence as high as 75% in some samples (Ananth et al, 1989) significantly limiting the external validity of their findings. Therapy offered in RCTs often does not reflect settings that could deliver it, as there can be limits on the training and expertise of staff (Fanning et al, 2012). Real-world or service settings address some of these limitations, however
internal validity ratings subsequently suffer as they often cannot manage control conditions as RCTs can.

At times, the rating system did not seem appropriate to the aim of the review as a whole. For example, for a quantitative RCT, the entire validity and robustness of how the trial was executed was rated, which involved completing extensive and detailed checklist criteria. Based on the stringent standards of the RCT checklist, it was very difficult for trials to achieve global good ratings. However only a very small proportion of data, such as a satisfaction measure, was extracted from these studies. Also it seems as though studies particularly interested in service user evaluation and satisfaction are pilot or feasibility studies, in some cases to prepare for an upcoming (possibly full powered) RCT (e.g. Davis, Ringer, Strasburger & Lysaker, 2008).

In other cases, satisfaction measures were not considered in primary outcome papers, but were instead written as companion studies (e.g. Miles, Peters & Kuipers, 2007). These were difficult to rate as much of the relevant details were included elsewhere. Two other papers included in the review did not seem to fit any checklist criteria (Lecomte, Leclerc, Wykes & Lecomte, 2003; Revheim, Kamnitzer, Casey, & Medalia, 2001). While they included some self-report data, no analyses had been conducted, as they had not been designed as either qualitative or quantitative studies.

Mixed methods papers were also difficult to rate. The author deliberated over the most appropriate way to rate quality of papers that included both quantitative and qualitative methodologies. Initially, papers were rated using both quantitative and qualitative checklists. It soon became apparent however that with the exception of Sumner and colleagues’ (2013) research into hypothetical preferences, these studies
did not plan methodologically rigorous qualitative studies, and as such there was little to rate using independent quality assessment. Quantitative checklists were therefore used as the primary guide for quality, taking into account how the qualitative data would impact on subject measures, and subsequent total rating. No guidance could be found to justify this process, and the author recognises there may be alternatives to decisions made here. Creation of an amalgamated checklist, including key points from various checklists could have been a more useful and appropriate tool for this study. A new or modified checklist may be useful to rate future research attempting to appraise or synthesise mixed methods studies, particularly if suggestions of this research and Kilbride and colleagues (2013) about integrating qualitative research into RCTs are realised.

The author experienced challenges when commenting on the quality ratings of the synthesised data. The author’s instinct was that some very useful data was obtained for ‘poor’ studies and some limited data was obtained for ‘fair/good’ studies. However, this was not always reflected in reporting of results. Some fair to poor quality studies presented findings about negative aspects or challenges of therapy. This type of data was limited in the evidence base and these studies warranted inclusion as they provided useful insights.

**Conducting the narrative synthesis**

Many qualitative or mixed method synthesis approaches do not have clear and established guidelines with relatively reliable and rigorous techniques to utilise, unlike meta-analysis. Popay and colleagues (2006) wanted to correct this and developed guidance that describes how to conduct a narrative synthesis, in the context of a systematic review. The guidance is comprehensive, including advice on
specifying the research question, identifying studies to include in the review, data extraction, as well as descriptions of various tools and techniques for researchers to use to conduct the synthesis. The author used the guidance to direct the synthesis process in order to help ensure the resulting synthesis was robust and credible.

The author utilised tools such as extracting textual descriptions for all studies, tabulation, and translating the data using thematic analysis techniques. While the author had experience in thematic analysis prior to commencing this research project, this had been limited to qualitative data. This guidance was particularly helpful when considering how to transform quantitative data into codes, including outcome data and variable labels in survey research.

The main element of the synthesis was based on thematic analysis techniques. Only the author coded the data. While the supervisors independently verified the inclusion of data within the thematic structure, they did not independently code the data. Intercoder reliability is common in other approaches such as content analysis. However, it is argued that the process of thematic analysis is a more subjective task than content analysis, and intercoder reliability may not be possible (Vaismoradi, Turunen & Bondas, 2013). The approach used here does seem appropriate, as reliability in thematic analysis is more about confirmation that the coders perspective can be understood by others (Loffe & Yardley, 2004).

**Limitations of the narrative synthesis**

As discussed in paper 1, there are limitations to the narrative synthesis process in as much as it can only be as reliable as the evidence available. Many of the qualitative sources were of good quality, but many sources of bias, particularly from sample selection and measurement decisions, exist throughout the synthesis,
and throughout this research. However, reflecting on these sources of bias has been a beneficial by-product of the research process as it has identified some important gaps in our current understanding of beliefs about therapy, leading to some exciting avenues for future research to explore.

Only a limited number of techniques were used in this synthesis process, largely based on the nature of the literature available. For example, subgroup and moderator analyses aim to answer the question “what works, for whom, and in what circumstances,” but were not deemed feasible for this review (Popay et al, 2006).

**Conclusions about paper 1**

The narrative synthesis approach was employed for its inclusive nature and the author is confident that it met those aims. It achieved a comprehensive overview of the existing knowledge about beliefs about therapy for psychosis. Through its limitations, it identified important gaps in our understanding of the topic, which resulted in valuable and feasible suggestions for both clinicians and researchers.

**Paper 2: Empirical Paper**

**Rationale for Topic**

The author chose to keep the topics of both papers closely linked. The empirical paper was seen as a good opportunity to address some of the limitations of previous research with this population. The progression of the author’s career path has led to the development of a passion for working with young people with psychosis. This group seemed like an appropriate place to start exploring beliefs about therapy for psychosis in a new way. Slightly different topics were considered, such as building on other qualitative research (e.g. Kilbride et al, 2013) and
exploring experiences or key components of cognitive behavioural therapy for psychosis (CBTp). The decision to expand the topic to beliefs about any therapy for psychosis felt appropriate as it opened up inclusion to almost anyone currently receiving care from Early Intervention Services (EIS).

**Rationale for Q-methodology**

The author had previous experience in quantitative methods, and was initially interested in building on limited experience of qualitative methodology. However, when learning about the rationale and benefits of Q-methodology (Stephenson, 1953), it seemed like a very good fit for working with young people in psychosis services. Q-methodology has received good feedback from other researchers and participants within psychosis samples, including those in EIS and with coexisting substance use (e.g. Gregg, Haddock & Barrowclough, 2009; Wood, Price, Morrison & Haddock, 2012).

Beliefs are a difficult construct to articulate for many of us, and young people experiencing symptoms of psychosis can experience additional challenges when expressing themselves. This may be due to many factors such as cognitive impairment, concentration, anxiety, or trust issues. The author’s experience was that there was a huge variability in people’s ability to articulate themselves in EIS, but did not want to exclude people from the research who may struggle to do so.

Through the use of the Q-set, the set of cards containing possible beliefs about therapy, the statements were available for participants to identify with (Dudley Siitarinen, James & Dodgson, 2009). It terms of memory, it is generally accepted that recognition is easier than recall. It seemed possible that for some participants, with the availability of relevant beliefs statements that they could refer to, more and
richer data would be obtained compared to asking the question, “what are your beliefs about therapy?”

In addition, a one-off visit was planned to conduct the research, which would leave little time to build rapport with clients, many of whom may have difficulties in engaging with or trusting new people (Morrison, Renton, Dunn, Williams & Bentall, 2004). This could have potential limitations for data collection, but Q had also been reported to be experienced as less threatening and more collaborative than having to answer direct questions (Jones, Guy & Ormrod, 2003). This approach may put participants at ease more quickly than other methodologies, as well as being a way to potentially gain a more balanced view of therapy than exists in the current literature. As negative statements are included in the Q-set, participants may be reassured that these are acceptable beliefs to hold. This may have two benefits; first this may be experienced as normalising and second, they may be more likely to endorse these negative statements.

The approach was also appealing for the author. Recruitment in psychosis services can be very challenging, and Q-methodology does not require very large sample sizes. There are unique strengths of the analysis technique, which allows for the description and exploration of shared viewpoints or beliefs in rich detail. In addition, the approach was new to the author, who saw it also as an opportunity to develop her research skills.

Q-set development

Much of the research in Q-methodology takes place even before any participants are recruited. The development of the Q-set is vital to the success of any Q study. It begins with the development of a comprehensive set of items (in this case
beliefs), the Q-concourse, which aims to be representative of the topic as a whole (Watts & Stenner, 2012). This phase of the research is both challenging and time consuming.

Due to time constraints, the Q-set needed to be developed before the systematic review for paper 1 could be completed. When the systematic review was conducted, it was going to form the basis for the review in paper 1 as well. Initial searches of the literature revealed that little was currently published about therapy beliefs in psychosis and therefore able to contribute to the Q-concourse. The decision was made to expand the search to all diagnostic categories, which resulted in a rich and meaningful Q-set. Later however, the decision was made to limit the focus of the review paper to psychosis samples only, but expand the inclusion criteria to quantitative studies so a narrative synthesis could be conducted. The author is satisfied with the results for both papers, however it did require the author to conduct two comprehensive systematic searches of the literature, albeit with some overlap. Ideally, the author would have been able to conduct one search to aid the purposes of both papers.

The initial Q-concourse contained 309 statements. Q-researchers vary as to how many statements they suggest should be included in the final Q-set, although 40-80 statements has been suggested as an appropriate range (Stainton-Rogers, 1995). Too few statements can lead to an under representative set of belief statements and too many can create difficulties for participants (Watts & Stenner, 2005). The aim was therefore to cover the breadth of material but also take into account the needs of potential participants too, including concentration and attention span. It was a difficult process to refine the statements. Organising statements into
themes was very helpful for this process as it enabled the author to feel confident that while not all of the material could be presented, all of the key themes would be well represented.

Pilot and Q-participants delivered feedback that the 64 item Q-set was inclusive and representative of their beliefs. The author feels that this would not have been possible without the contribution of service user involvement at early stages of the research. This included the use of interviews to provide content for the Q-concourse, as well guidance from young people in a mental health support group (Embracing People in Community; EPIC) about the refinement of the Q-concourse.

The author met with EPIC twice. The first meeting involved viewing all 309 items in the Q-concourse. They provided feedback in order to omit duplicate, repetitive, or overlapping statements, ensure wording was understandable and acceptable, and checking that each item only expressed a single idea. Where similar items were presented, they indicated preferences for which should be included, or offered new wording. The author then was able to make decisions about refining the Q-concourse, along with support from supervisors, resulting in a list of 72 items. The second visit with EPIC was then used as a final check of acceptability of the statements and instructions, as well as how long the sorting process took. Feedback prompted further item reduction, and resulted in the final Q-set of 64 items for inclusion in the Q-sort. Without the inclusion of these views, the Q-set may have included items with inappropriate terminology, such as language or phrasing young people might not relate to or understand.

This was the author’s first experience of collecting group feedback. The process was difficult to know how to manage at first. It felt appropriate to conduct
the first stage of item reduction with this group of young people, however this involved viewing over 300 statements. It was not possible to do this either with individual people or items. An interactive task was devised, which seemed to be an appropriate first stage of eliciting feedback that was not too time consuming or concentration intensive. The process also helped the author develop strategies and alternative ways of describing Q-methodology to young people, in order to keep them on task, which was beneficial for developing and implementing instructions for completing the Q-sort (Appendix 13). The second stage of eliciting feedback and piloting the instructions and completion of the Q-sort was more straightforward, however still offered invaluable insights into the final materials and methods of administering the Q-sort.

It was also enlightening for the author to see the reaction of the young people involved in the research. They had agreed as a group to help consult on the project and seemed to feel proud that they were contributing to research that may help other young people with mental health difficulties. The author already valued the utility of service user input as championed by other researchers, however this experience highlighted the mutual benefits of this important practice on a more personal and meaningful level.

**Q-sort administration**

As mentioned above, very useful feedback was obtained from service user consultation and piloting about how to best administer the Q-sort. Clear guidelines are available and it is important that every participant receive the same set of instructions (Watts & Stenner, 2012). This led to the development of an
administration script (Appendix 13). This was used for consistency by the author, as well as the research assistants who aided recruitment.

Two research assistants (RAs) working for the RCT were interested in learning about Q-methodology and further developing their skills. The author welcomed the opportunity to gain experience in training the RAs in the methodology, as well as the additional help with recruitment. It may be a limitation of this research that the author was not present at all of the Q-sort appointments, however, the Q-sort process was audio recorded, so the author was able to listen to the process as well as the post-sort interviews. The author trained each assistant in the use of the materials. This included acting out role-play scenarios, being observed by the RAs administering the q-sort to participants, and observing each of the RAs do the same. Appropriate feedback was given and applied by the RAs, who each had extensive experience working with young people with psychosis in research settings. The author was confident in their ability to conduct the Q-sort and accompanying materials appropriately and sensitively. Each RA was also supervised by one of the author’s co-supervisors, also experienced in the use of Q-methodology (LG) so further support was available as needed. The use of RAs to aid recruitment was beneficial for the research, but also for the author’s overall learning experience of supervising others, which is a core standard of conduct and competency required upon qualification (BPS, 2008; HCPC, 2012).

Participants responded well to the Q-sort process. Administration could be awkward as the grid provided for sorting the Q-set was quite large (A1 size). Some participants did not have a suitable table to lay out the materials, so at times the author and participant would sit on the floor. This could be potentially awkward,
particularly when meeting someone for the first time. However, no participant objected to this and often became an opportunity for shared humour, which aided rapport. Software packages for completion of Q sorts on a laptop are available, which would overcome issues of space. However, these have also been criticised for limiting how much participants can engage with statements. Watts & Stenner (2012) argue that unless all the statements can be viewed at once, it is less likely that a process of ‘relative evaluation’ can occur. Participants in this study reported that they liked the practical task, including moving the cards around the grid as necessary, which may be lost in a computer programme.

**Recruitment**

The RCT sample provided over two-thirds of the total sample. This part of the recruitment process was relatively seamless, as participants had already consented to be contacted about further research. The author did not have to get permission from Case Managers prior to contacting these service users, which sped up the recruitment process. Risk assessments were however conducted with appropriate professionals before home visits were completed. While this part of recruitment was convenient, it also created some limitations to the research. This is discussed below under ‘participants.’

Contrary to predictions, the second stage of recruitment was also relatively straightforward. The author recruited from one additional EIS, where she had previous links with and was commencing her elective placement. Being able to conduct recruitment at the author’s base was an efficient way to optimise the referral process. Case managers appeared to be interested in the content of the project, and all had experience in obtaining referrals for previous research projects. Strategic
sampling is acceptable and recommended in Q-research (Watts & Stenner, 2012) and case managers were encouraged to identify people who had refused, dropped out, may hold negative views about therapy, or were without prior experience of therapy. Case managers approached a range of clients, however clients that they had good working relationships with seemed to be more likely to be approached first or agree to take part. When individuals thought to have negative beliefs were referred and consented to take part, their views remained hopeful about therapy or had changed. One service user declined to participate in this research because he had not had therapy and despite reassurance, did not think he could be helpful to the research.

Some case managers asked for a number of Participant Information Sheets (PIS) (Appendix 8) and planned to ask each client they saw that week. This is a good strategy as it means that case managers are not necessarily selecting who they think is most appropriate, and are giving everyone the opportunity to participate. However, it remains limited if service users were accepting visits from their case manager, they were engaging in the service; these participants may be more likely to have positive views towards the service and support in general. In addition, due to this approach, the author did not record rates or reasons for declining to participate to case manager.

The author also tried to strategically sample service users from Black and Minority Ethnic (BME) communities. One team psychiatrist identified nine BME service users, and Case Managers were approached about the project. Only one of these service users completed the Q-sort. For most, the Case Manager did not think it was the right time to approach the service user, for various reasons such as the client was new to the case manager, issues with child care, or poor engagement. In one instance, someone who appeared to have a negative view to therapy declined to take
part, as he was concerned that just talking about why he did not want therapy would be too distressing for him. His primary concern seemed to be about being made to bring up things from the past, which he feared would exacerbate his symptoms. This belief is included in the q-set but was not endorsed by participants of this study, highlighting the need for exploration of beliefs with difficult to recruit individuals.

The author regrets that more effort or time could not be committed to strategic sampling of BME or difficult to engage service users. In the end, opportunity sampling had to be adopted, i.e. the author agreed to see any service user regardless of potential therapy beliefs or experience. However, even with opportunity sampling, the sample appeared to be less homogenous than previous research samples in terms of therapy experience. While many seemed to have current positive beliefs and were engaging relatively well with services, they did report to have previous unhelpful experiences of therapy and had refused or terminated therapy prematurely in the past. Without time constraints, the addition of service users that are under-represented in research would have been beneficial to the current knowledge base and clinical practice. However it does appear that special consideration and strategies would have to be employed in order to accomplish these goals.

Participants

The service users who agreed to take part in this research engaged very well with the research process and completed all tasks asked of them thoughtfully. Interesting insights about young people’s beliefs about therapy emerged as a result of their efforts. However the author acknowledges that the story told here is not without limitation, primarily due to the homogeneity of the participants recruited.
Eleven service users contributed to the development of the Q-concourse by taking part in a semi-structured interview. The aim of this stage was to speak to those people with a variety of therapeutic experiences, including those who had not had therapy, and those who had engaged at variable levels. Based on RCT data, seven had been allocated treatment as usual. Two out of four participants had not engaged fully with the therapy offered and had attended one and six sessions out of a possible 24. However all of these reported previous experiences of therapy outside of the trial, which may have limited the data included in the Q-concourse as it was biased by previous experience of therapy, as well as lack of female viewpoint. In fact, only one female participant in total was recruited from the RCT sample.

The sample completing the Q-sort overall was predominantly composed of White males who were engaging with services. Generalizability of results in Q-methodology is considered in a different way to conventional research methods. The results are unlikely to generalise to a wider population using Q-methodology, but can generalise in relation to concepts (Watts & Stenner, 2012). Beliefs are not expected to be consistent within individuals across time, however the views themselves may show some consistency over time (Watts & Stenner, 2005). However, due to constraints on recruitment, it is likely that other viewpoints about therapy are missing from the accounts presented here.

**Measures**

The focus of this exploratory study was to elicit beliefs about therapy for psychosis. It was considered beneficial for recruitment to constrain the research process to one session. Previous research experience guided this decision, as it seemed more likely that service users would agree to a one-off visit, particularly if it
did not include additional measures that could be considered intrusive or distressing. For these reasons, additional measurement was kept to a minimum.

The author debated about the inclusion of a more thorough measure of symptomatology, such as the positive and negative syndrome scale (PANSS) for schizophrenia (Kay, Fiszbein & Opler, 1987). The PANSS assesses positive symptoms, such as delusions and hallucinations, negative symptoms, such as social and emotional withdrawal, and general symptoms, including depression and anxiety. The author is trained in the use of the scale, however used previous experience to judge that this would necessitate at least one or possibly two additional research visits. This may have deterred some service users from participating. It would have also increased research costs for the author due to extra travel. However, it would have provided additional validated data to comment on when looking at individual factors. Other research has struggled to identify reliable factors, including symptoms, associated with outcomes. For example, Sumner and colleagues (2013) found that symptoms did not predict preferences about therapy. The author concluded that the same was likely to be true about beliefs. The author weighed the potential benefits of inclusion with the costs on time and resources, and the decision was made to use a new self-report measure, the Subjective Experiences of Psychosis Scale (SEPS) (Haddock et al, 2011) instead.

Initial reports suggest that the SEPS is a reliable and valid measure to evaluate multi-dimensional experience of psychosis. It was developed in close conjunction with service users, using the language of service users for their experiences, and moves beyond traditional measures that focus on presence or absence of symptoms. For these reasons, it seemed to fit nicely with the ethos of Q-
methodology. However, there were some limitations of using this measure. While participants do not need to go into great detail about their experiences, the author still had to elicit basic information about current or past experience of positive symptoms. This felt intrusive for some participants in this research, particularly as they had just met the author. To date, the SEPS has only been published describing use with a sample of participants with active, current positive symptoms of psychosis. It was also administered subsequent to a PANSS interview, providing content for the measure. This was not the case for many participants in this research, who did not experience current positive symptoms. The measure was still considered appropriate to use, as it considers how symptoms experienced in the past may still impact on current functioning, sense of identity, and relationships. It was difficult for both the researcher and the participant to keep this in mind when completing the questionnaire. After careful consideration, the participants for the most part did seem to be able to relate that they could still be affected by these past experiences, even when not experiencing the symptom anymore.

Finally, additional data obtained about therapy and substance use history was also limited. In particular for therapy history, this introduced potential memory bias, and it is likely that the self-report data contains errors about what has been offered and experienced. Electronic case notes were checked with participants’ consent to verify this data, however when therapy had been offered before acceptance into EIS, the data was often missing. Future studies may find it useful to include more detailed demographic or outcome variables, such as symptoms, substance use, or satisfaction to help understand the viewpoints and explore any associations between beliefs and participants characteristics or outcomes. However, studies wishing to attract service
users who might not normally agree to research, such as poor engagers, particularly one with lengthy and potentially intrusive measures, which would require more than one assessment appointment, should think about the use of additional measures carefully.

Q-analysis

As Q is a quanti-qualitative method, analysis takes part in two stages. The first is the use of factor analysis to extract factors. Although this process is guided by the use of statistical techniques, the author was still required to make a number of subjective decisions in order to decide on the best solution possible. In factor analysis, there are infinite potential solutions (Watts & Stenner, 2012). As a first time Q-researcher, the author felt initially overwhelmed about making these subjective decisions, including which type of factor extraction and rotation to use, which sorts to include (flagging), and the number or factors to extract. The author was concerned about how long the analysis would take, as well as knowing when the ‘best’ possible solution had been reached. Following guidance from Watts & Stenner (2012) and a supervisor with experience of conducting and publishing Q-methodology (LG), the process felt comprehensive yet contained.

The second stage of analysis involved development of individual factor interpretations from the factor arrays (the summarising Q-sort produced to represent each factor). The use of crib sheets for each factor (Watts & Stenner, 2012; Appendix 17) was a very useful way of organising the statistical data and statements in order to analyse the individual factors to develop a story. The author particularly enjoyed this stage of research, especially when interesting and defined viewpoints began to emerge. As with all qualitative methods, there is potential for researcher
bias in the interpretation of findings. To try to account for this, the author waited to view the demographic data associated with each factor, until after the factor interpretations were complete. This helps ensure that the author’s preconceptions or expectations do not in some way bias the interpretations given to each factor array.

Post-hoc analyses were originally planned to examine how different viewpoints are related to different variables, including demographic variables, symptom severity, therapy history, and substance use, for example: do substance users have a different belief about therapy than non-substance users? The sample size overall was judged to be acceptable (Stainton-Rogers, 1995; Watts & Stenner, 2012), however, the sample sizes in factors 2-4 were too small for this to be feasible. While Q-researchers describe and use demographic information in factor interpretation, they do not customarily use statistical analysis to look for differences among viewpoints. Therefore the absence of these analyses is not considered to limit the findings in a significant way.

**Limitations of Q-methodology**

After conducting the Q-study, the author feels that Q-methodology was the correct choice for the topic being investigated. Positive feedback was received from the participants, and the results appear to be robust and valid. However, as with all methodologies, some limitations must be considered.

A large number of items had to be reduced from the initial Q-concourse (n=309) to the subsequent Q-set (n=64). This process risks the exclusion of relevant beliefs from the Q-set, leading to their omission from final factor summaries. To minimise researcher bias, service user input was used to guide this process. First, service users directly provided content for the Q-concourse, and then helped decide
which items should be retained or excluded. However, as discussed previously, there
was a reliance on the available literature and participants currently engaged with
services, which may have meant important negative views could have been omitted.
This was accounted for through the use of a post-sort interview. The content of the
Q-set was explored and no additional statements were suggested for inclusion.

In the current study, it was not possible to provide materials in another
language. The research was reliant on participants being able to read the English
language, and maintain some level of concentration. The Q-sort must be conducted
in one session, as beliefs may not be consistent over time. It was interesting to
observe that a few participants were initially overwhelmed when seeing the grid and
stack of cards, and raised concerns about their ability to concentrate. However in
each of these cases, once underway, the participants engaged in the task well,
without the need to take breaks or terminate the sort early.

Finally, as with all self-report methods, there is potential for socially
desirable responding. The author was aware of this and addressed it by emphasising
to participants that all information was confidential and would not be identifiable or
seen by others involved in their care, which the author was independent from. The
researchers also encouraged people to express honest opinions, and made clear that
negative or mixed views about therapy were common and would be as welcome as
positive accounts. In addition, as the Q-set included negative statements, this could
be potentially normalising, making it more likely that people would endorse. While
additional sample bias remains, it seems appropriate to consider that the
methodology was used to minimise bias and is therefore robust.
Writing for publication

In paper 1, the author comments on the lack of actual data from participants, in the form of direct quotes, in many qualitative studies. When writing both paper 1 and paper 2, the author encountered difficulties of meeting publication word limits. In order to edit the papers to the appropriate length, the author has had to limit the amount of detail provided, which was frustrating. The author could empathise with previous researchers who may have been in similar circumstances.

Conclusions about paper 2

Q-methodology was a useful way to explore and highlight young people’s beliefs about psychological therapy for psychosis. It addressed some limitations of previous research and four robust and distinct beliefs patterns were identified. However, limitations in sample inclusion were encountered. The author was able to build on reflections from paper 1, and suggest specific ways future researchers and professionals could explore beliefs, including among service users that are difficult to engage with. This can promote improved communication, better rapport, and potentially better outcomes.

Papers 1 & 2: Implications for practice and further research

The narrative synthesis and Q-study have highlighted that many people have positive beliefs about the efficacy and process of therapy for psychosis. However, both papers have also highlighted that these findings are likely to be an inaccurate or unbalanced portrayal of beliefs in the wider psychosis population. This is due to limitations in the included samples, which have provided this information in services and in research. These identified gaps in our understanding have important implications for researchers and clinicians.
Even with the limitations described above, the research concludes confidently that beliefs about therapy are multi-faceted, diverse, and complex and worthy of further detailed exploration, by clinicians and researchers. The research has suggested that future exploration take into account several key factors:

1. Exploration of beliefs should not be limited to those who have completed therapy. Expectations, or pre-existing beliefs, about therapy for psychosis have been identified as a key gap in our knowledge base. There remains a lack of consensus about important factors that predict engagement, adherence, and outcomes. There is evidence outside of the psychosis literature to suggest that expectations may play an important role in these key areas (Westra et al, 2010).

2. Once beliefs are identified, any unhelpful beliefs or concerns should be addressed. This would aim to clarify role and process expectations, as well as challenges that can be expected in therapy to help reduce unrealistic, faulty or negative expectations about therapy. This may be via professionals or peer support. This may facilitate better outcomes by reducing early termination of therapy and increasing engagement (Ogrodniczuk, Joyce & Piper, 2005). Follow-up data on these beliefs, either as time progresses within service or following therapy, would also provide useful insight into the way beliefs change over time (Mutsatsa et al, 2003).

3. Black and Minority Ethnic (BME) are underrepresented in therapy, services and research (Weatherhead & Daiches, 2010). Evidence is available that specific
cultural influences may impact on views about help-seeking and the role of psychological therapy (Press, Drake, Swallow & Husain, 2011; Rathod, Kingdon, Phiri & Gobbi, 2010). Professionals should consider different cultural practices as necessary, and explore these alongside beliefs about therapy.

4. The literature is missing accounts from people who have refused or dropped-out of therapy. While an inherently difficult task, researchers and clinicians should endeavour to explore reasons behind these decisions. For those who drop out of research or therapy, assessment should be timely, and take place as soon as possible to elicit accurate views. Reasons are likely to be varied, individual and based on a number of influences (Sumner et al, 2013). Details of these reasons can help inform and develop future practice.

5. The Q-research focused on young people with psychosis, and research with other service users with longer durations of psychosis, older age, and more experiences of services, may identify different patterns of beliefs.

In summary, detailed exploration of beliefs about therapy with service users seems essential to expand our knowledge, to improve communication and practices, and to develop our understanding of factors that impact on engagement, process and outcomes of therapy for psychosis.
References


Appendices

Appendix 1. Clinical Psychology Review Author Guidelines

The following information has been extracted from:
http://www.elsevier.com/journals/clinical-psychology-review/0272-7358/guide-for-authors

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**DESCRIPTION**

Clinical Psychology Review publishes substantive reviews of topics germane to clinical psychology. Papers cover diverse issues including: psychopathology, psychotherapy, behavior therapy, cognition and cognitive therapies, behavioral medicine, community mental health, assessment, and child development. Papers should be cutting edge and advance the science and/or practice of clinical psychology.

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A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

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Appendix F Quality appraisal checklist – quantitative intervention studies

Public health interventions comprise a vast range of approaches, from the relatively simple through to complex national policy interventions. As a consequence, research questions about the effectiveness and efficacy of public health interventions will typically rely on quantitative evidence from a range of sources (see section 3.2). This will include evidence from small (experimental) randomised controlled trials through to large-scale observational studies (see appendix E for an algorithm outlining the range of experimental and observational quantitative study designs).

Rather than include an exhaustive list of critical appraisal tools for each individual study design, this checklist is designed to be used for randomised controlled trials, case–control studies, cohort studies, controlled before-and-after studies and interrupted time series. It is based on the 'Graphical appraisal tool for epidemiological studies (GATE)', developed by Jackson et al. (2006) revised and tailored to be more suitable for public health interventions. It is anticipated that the majority of study designs used to determine the effect of an intervention on a (quantitative) outcome will be amenable to critical appraisal with this revised tool.

It enables a reviewer to appraise a study’s internal and external validity after addressing the following key aspects of study design:

- characteristics of study participants
- definition of, and allocation to, intervention and control conditions
- outcomes assessed over different time periods
- methods of analyses.

GATE is intended to be used in an electronic (Excel) format that will facilitate both the sharing and storage of data, and through linkage with other documents, the compilation of research reports. Much of the guidance to support the completion of the critical appraisal form that is reproduced below also appears in ‘pop-up’ windows in the electronic version.
There are 5 sections of the revised GATE. Section 1 seeks to assess the key population criteria for determining the study's external validity – that is, the extent to which the findings of a study are generalisable beyond the confines of the study to the study's source population.

Sections 2 to 4 assess the key criteria for determining the study's **internal validity** – that is, making sure that the study has been carried out carefully, and that the outcomes are likely to be attributable to the intervention being assessed, rather than some other (often unidentified) factor. In an internally valid study, any differences observed between groups of patients allocated to receive different interventions may (apart from the possibility of random error) be attributed to the intervention under investigation. Biases are characteristics that are likely to make estimates of effect differ systematically from the truth. Each of the critical appraisal checklist questions covers an aspect of methodology that research has shown makes a significant difference to the conclusions of a study.

Checklist items are worded so that 1 of 5 responses is possible:

| ++ | Indicates that for that particular aspect of study design, the study has been designed or conducted in such a way as to minimise the risk of bias. |
| + | Indicates that either the answer to the checklist question is not clear from the way the study is reported, or that the study may not have addressed all potential sources of bias for that particular aspect of study design. |
| - | Should be reserved for those aspects of the study design in which significant sources of bias may persist. |
| Not reported (NR) | Should be reserved for those aspects in which the study under review fails to report how they have (or might have) been considered. |
| Not applicable (NA) | Should be reserved for those study design aspects that are not applicable given the study design under review (for example, allocation concealment would not be applicable for case control studies). |

In addition, the reviewer is requested to complete in detail the comments section of the quality appraisal form so that the grade awarded for each study aspect is as transparent as possible.
Each study is then awarded an overall study quality grading for internal validity (IV) and a separate one for external validity (EV):

| ++ | All or most of the checklist criteria have been fulfilled, where they have not been fulfilled the conclusions are very unlikely to alter. |
| +  | Some of the checklist criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter. |
| −  | Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter. |

**Checklist**

**Study identification:** (Include full citation details)

**Study design:**

Refer to the glossary of study designs (appendix D) and the algorithm for classifying experimental and observational study designs (appendix E) to best describe the paper's underpinning study design.

**Guidance topic:**

**Assessed by:**

**Section 1: Population**

1.1 *Is the source population or source area well described?*

Was the country (e.g. developed or non-developed, type of healthcare system), setting (primary schools, community centres etc.), location (urban, rural), population demographics etc. adequately described?

| ++ | Comments: |
| +  | NR |
| −  | NA |

1.2 *Is the eligible population or area representative of the source population or area?*

Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)?

Was the eligible population representative of the source? Were important groups under-represented?

| ++ | Comments: |
| +  | NR |
| −  | NA |
Methods for the development of NICE public health guidance
(third edition)

<table>
<thead>
<tr>
<th>Section 2: Method of allocation to intervention (or comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.3 Do the selected participants or areas represent the eligible population or area?</strong></td>
</tr>
<tr>
<td>Was the method of selection of participants from the eligible population well described?</td>
</tr>
<tr>
<td>What % of selected individuals or clusters agreed to participate? Were there any sources of bias?</td>
</tr>
<tr>
<td>Were the inclusion or exclusion criteria explicit and appropriate?</td>
</tr>
<tr>
<td>++</td>
</tr>
<tr>
<td>+</td>
</tr>
<tr>
<td>-</td>
</tr>
<tr>
<td>NR</td>
</tr>
<tr>
<td>NA</td>
</tr>
</tbody>
</table>

| **2.1 Allocation to intervention (or comparison). How was selection bias minimised?** |
| Was allocation to exposure and comparison randomised? Was it truly random ++ or pseudo-randomised + (e.g. consecutive admissions)? |
| If not randomised, was significant confounding likely (-) or not (+)? |
| If a cross-over, was order of intervention randomised? |
| ++ | Comments: |
| + | |
| - | |
| NR | |
| NA | |

| **2.2 Were interventions (and comparisons) well described and appropriate?** |
| Were interventions and comparisons described in sufficient detail (i.e. enough for study to be replicated)? |
| Was comparisons appropriate (e.g. usual practice rather than no intervention)? |
| ++ | Comments: |
| + | |
| - | |
| NR | |
| NA | |

| **2.3 Was the allocation concealed?** |
| Could the person(s) determining allocation of participants or clusters to intervention or comparison groups have influenced the allocation? |
| Adequate allocation concealment (+) would include centralised allocation or computerised allocation systems. |
| ++ | Comments: |
| + | |
| - | |
| NR | |
| NA | |

| **2.4 Were participants or investigators blind to exposure and comparison?** |
| Were participants and investigators - those delivering or assessing the intervention kept blind to intervention allocation? (Triple or double blinding score ++) |
| If lack of blinding is likely to cause important bias, score -. |
| ++ | Comments: |
| + | |
| - | |
| NR | |
| NA | |
2.5 Was the exposure to the intervention and comparison adequate?
Is reduced exposure to intervention or control related to the intervention (e.g. adverse effects leading to reduced compliance) or fidelity of implementation (e.g. reduced adherence to protocol)?
Was lack of exposure sufficient to cause important bias?

2.6 Was contamination acceptably low?
Did any in the comparison group receive the intervention or vice versa?
If so, was it sufficient to cause important bias?
If a cross-over trial, was there a sufficient wash-out period between interventions?

2.7 Were other interventions similar in both groups?
Did either group receive additional interventions or have services provided in a different manner?
Were the groups treated equally by researchers or other professionals?
Was this sufficient to cause important bias?

2.8 Were all participants accounted for at study conclusion?
Were those lost-to-follow-up (i.e. dropped or lost pre-, during or post-intervention) acceptably low (i.e. typically <20%)?
Did the proportion dropped differ by group? For example, were drop-outs related to the adverse effects of the intervention?

2.9 Did the setting reflect usual UK practice?
Did the setting in which the intervention or comparison was delivered differ significantly from usual practice in the UK? For example, did participants receive intervention (or comparison) condition in a hospital rather than a community-based setting?
<table>
<thead>
<tr>
<th>Section 3: Outcomes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.10 Did the intervention or control comparison reflect usual UK practice?</strong></td>
<td>++ Comments:</td>
</tr>
<tr>
<td>Did the intervention or comparison differ significantly from usual practice in the UK? For example, did participants receive intervention (or comparison) delivered by specialists rather than GPs? Were participants monitored more closely?</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>NR</td>
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<tr>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>3.1 Were outcome measures reliable?</strong></td>
<td>++ Comments:</td>
</tr>
<tr>
<td>Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking -)?</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>-</td>
</tr>
<tr>
<td>How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)?</td>
<td>NR</td>
</tr>
<tr>
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<td>Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?</td>
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<td><strong>3.2 Were all outcome measurements complete?</strong></td>
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<tr>
<td>Were all or most study participants who met the defined study outcome definitions likely to have been identified?</td>
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<td><strong>3.3 Were all important outcomes assessed?</strong></td>
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<td>Were all important benefits and harms assessed?</td>
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<tr>
<td>Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?</td>
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<tr>
<td><strong>3.4 Were outcomes relevant?</strong></td>
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<tr>
<td>Where surrogate outcome measures were used, did they measure what they set out to measure? (e.g. a study to assess impact on physical activity assesses gym membership – a potentially objective outcome measure – but is it a reliable predictor of physical activity?)</td>
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### 3.5 Were there similar follow-up times in exposure and comparison groups?

If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison.

Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).

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### 3.6 Was follow-up time meaningful?

Was follow-up long enough to assess long-term benefits or harms?

Was it too long, e.g. participants lost to follow-up?

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</table>

### Section 4: Analyses

#### 4.1 Were exposure and comparison groups similar at baseline? If not, were these adjusted?

Were there any differences between groups in important confounders at baseline?

If so, were these adjusted for in the analyses (e.g. multivariate analyses or stratification).

Were there likely to be any residual differences of relevance?

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#### 4.2 Was intention to treat (ITT) analysis conducted?

Were all participants (including those that dropped out or did not fully complete the intervention course) analysed in the groups (i.e. intervention or comparison) to which they were originally allocated?

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#### 4.3 Was the study sufficiently powered to detect an intervention effect (if one exists)?

A power of 0.8 (that is, it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard.

Is a power calculation presented? If not, what is the expected effect size?

Is the sample size adequate?

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### Methods for the development of NICE public health guidance (third edition)

#### 4.4 Were the estimates of effect size given or calculable?

Were effect estimates (e.g. relative risks, absolute risks) given or possible to calculate?

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#### 4.5 Were the analytical methods appropriate?

Were important differences in follow-up time and likely confounders adjusted for?

If a cluster design, were analyses of sample size (and power), and effect size performed on clusters (and not individuals)?

Were subgroup analyses pre-specified?

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</table>

#### 4.6 Was the precision of intervention effects given or calculable? Were they meaningful?

Were confidence intervals or p values for effect estimates given or possible to calculate?

Were CI’s wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?

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### Section 5: Summary

#### 5.1 Are the study results internally valid (i.e. unbiased)?

How well did the study minimise sources of bias (i.e. adjusting for potential confounders)?

Were there significant flaws in the study design?

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#### 5.2 Are the findings generalisable to the source population (i.e. externally valid)?

Are there sufficient details given about the study to determine if the findings are generalisable to the source population? Consider: participants, interventions and comparisons, outcomes, resource and policy implications.

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</table>
Appendix 3. Quality appraisal checklist – quantitative studies reporting correlations and associations

Methods for the development of NICE public health guidance (third edition)

Appendix G Quality appraisal checklist – quantitative studies reporting correlations and associations

A correlates review (see section 3.3.4) attempts to establish the factors that are associated or correlated with positive or negative health behaviours or outcomes. Evidence for correlate reviews will come both from specifically designed correlation studies and other study designs that also report on correlations.

This checklist[1] has been developed for assessing the validity of studies reporting correlations. It is based on the appraisal step of the ‘Graphical appraisal tool for epidemiological studies (GATE)’, developed by Jackson et al. (2006).

This checklist enables a reviewer to appraise a study’s internal and external validity after addressing the following key aspects of study design: characteristics of study participants; definition of independent variables; outcomes assessed and methods of analyses.

Like GATE, this checklist is intended to be used in an electronic (Excel) format that will facilitate both the sharing and storage of data, and through linkage with other documents, the compilation of research reports. Much of the guidance to support the completion of the critical appraisal form that is reproduced below also appears in ‘pop-up’ windows in the electronic version[1].

There are 6 sections of the revised GATE. Section 1 seeks to assess the key population criteria for determining the study’s external validity – that is, the extent to which the findings of a study are generalisable beyond the confines of the study to the study’s source population.

Sections 2 to 4 assess the key criteria for determining the study’s internal validity – that is, making sure that the study has been carried out carefully, and that the identified associations are valid and are not due to some other (often unidentified) factor.

Checklist items are worded so that 1 of 5 responses is possible:

| ++ | Indicates that for that particular aspect of study design, the study has been designed or conducted in such a way as to minimise the risk of bias. |
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| + | Indicates that either the answer to the checklist question is not clear from the way the study is reported, or that the study may not have addressed all potential sources of bias for that particular aspect of study design. |
| - | Should be reserved for those aspects of the study design in which significant sources of bias may persist. |
| Not reported (NR) | Should be reserved for those aspects in which the study under review fails to report how they have (or might have) been considered. |
| Not applicable (NA) | Should be reserved for those study design aspects that are not applicable given the study design under review (for example, allocation concealment would not be applicable for case-control studies). |

In addition, the reviewer is requested to complete in detail the comments section of the quality appraisal form so that the grade awarded for each study aspect is as transparent as possible.

Each study is then awarded an overall study quality grading for internal validity (IV) and a separate one for external validity (EV):

- **++** All or most of the checklist criteria have been fulfilled, where they have not been fulfilled the conclusions are very unlikely to alter.
- **+** Some of the checklist criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter.
- **-** Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.

**Checklist**

| Study identification: Include full citation details |
| Study design: |
| - Refer to the glossary of study designs (appendix D) and the algorithm for classifying experimental and observational study designs (appendix E) to best describe the paper's underpinning study design |
Methods for the development of NICE public health guidance (third edition)

<table>
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<th>Guidance topic:</th>
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<td>Assessed by:</td>
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</table>

### Section 1: Population

#### 1.1 Is the source population or source area well described?
- Was the country (e.g., developed or non-developed, type of health care system), setting (primary schools, community centres etc), location (urban, rural), population demographics etc adequately described?

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#### 1.2 Is the eligible population or area representative of the source population or area?
- Was the recruitment of individuals, clusters or areas well defined (e.g., advertisement, birth register)?
- Was the eligible population representative of the source? Were important groups underrepresented?

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#### 1.3 Do the selected participants or areas represent the eligible population or area?
- Was the method of selection of participants from the eligible population well described?
- What % of selected individuals or clusters agreed to participate? Were there any sources of bias?
- Were the inclusion or exclusion criteria explicit and appropriate?

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### Section 2: Method of selection of exposure (or comparison) group

#### 2.1 Selection of exposure (and comparison) group. How was selection bias minimised?
- How was selection bias minimised?
Methods for the development of NICE public health guidance  
(third edition)

<table>
<thead>
<tr>
<th>2.2 Was the selection of explanatory variables based on a sound theoretical basis?</th>
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<tr>
<td>• How sound was the theoretical basis for selecting the explanatory variables?</td>
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<th>2.3 Was the contamination acceptably low?</th>
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<td>• Did any in the comparison group receive the exposure?</td>
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<tr>
<td>• If so, was it sufficient to cause important bias?</td>
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<tr>
<th>2.4 How well were likely confounding factors identified and controlled?</th>
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<tbody>
<tr>
<td>• Were there likely to be other confounding factors not considered or appropriately adjusted for?</td>
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<td>• Was this sufficient to cause important bias?</td>
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<th>2.5 Is the setting applicable to the UK?</th>
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<td>• Did the setting differ significantly from the UK?</td>
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Section 3: Outcomes
## Methods for the development of NICE public health guidance (third edition)

### 3.1 Were the outcome measures and procedures reliable?
- Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking -)?
- How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)?
- Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?

### 3.2 Were the outcome measurements complete?
- Were all or most of the study participants who met the defined study outcome definitions likely to have been identified?

### 3.3 Were all the important outcomes assessed?
- Were all the important benefits and harms assessed?
- Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?

### 3.4 Was there a similar follow-up time in exposure and comparison groups?
- If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison.
- Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).
### 3.5 Was follow-up time meaningful?
- Was follow-up long enough to assess long-term benefits and harms?
- Was it too long, e.g. participants lost to follow-up?

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### Section 4: Analyses

#### 4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)?
- A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard.
- Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?

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#### 4.2 Were multiple explanatory variables considered in the analyses?
- Were there sufficient explanatory variables considered in the analysis?

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#### 4.3 Were the analytical methods appropriate?
- Were important differences in follow-up time and likely confounders adjusted for?

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#### 4.6 Was the precision of association given or calculable? Is association meaningful?
- Were confidence intervals or p values for effect estimates given or possible to calculate?
- Were CIs wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?

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</table>
### Section 5: Summary

#### 5.1 Are the study results internally valid (i.e. unbiased)?
- How well did the study minimise sources of bias (i.e. adjusting for potential confounders)?
- Were there significant flaws in the study design?

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#### 5.2 Are the findings generalisable to the source population (i.e. externally valid)?
- Are there sufficient details given about the study to determine if the findings are generalisable to the source population?
- Consider: participants, interventions and comparisons, outcomes, resource and policy implications.

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[^4]: Available from CPHE on request.
Appendix 4. Quality appraisal checklist – qualitative studies

There is considerable debate over what quality criteria should be used to assess qualitative studies. Quality in qualitative research can be assessed using the same broad concepts of validity (or trustworthiness) used for quantitative research, but these need to be put in a different contextual framework to take into account the aims of qualitative research.

This qualitative checklist is designed for people with a basic understanding of qualitative research methodology, and is based on the broadly accepted principles that characterise qualitative research and which may affect its validity. The following notes provide suggestions for completing the checklist. A list of publications on qualitative research is provided at the end of these notes for further reading on this topic.

The studies covered by this checklist are studies which collect and analyse qualitative data, usually (but not exclusively) textual (written), spoken or observational data. Qualitative data are occasionally collected by structured questionnaires (for example, as thematically organised free text comments), but such data needs to be carefully scrutinised as it may not meet acceptable quality criteria for consideration as a qualitative study.

The checklist’s questions are framed in such a way so that it can encompass the variety of ways qualitative research is conducted. Care must be taken to apply the checklist in a way that matches the research methodology.

Please note that the sub questions given as examples under each question are intended to highlight some of the key issues to be considered for that question. They are not intended to be exhaustive. Please add any additional considerations in the comments box.

Notes on the completion of the separate sections of the checklist are appended to it.

In some circumstances it may be necessary to analyse qualitative material using a different approach, where the goal will be to seek to extract underlying theories, propositions and principles from the data, rather than focusing on the quality of the study per se. This may be appropriate where the aim is to gain particular insights into social processes. Where developments of the processes of appraisal are required these will be discussed with the CPHE team.
# Checklist

<table>
<thead>
<tr>
<th>Study identification: Include author, title, reference, year of publication</th>
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<tbody>
<tr>
<td>Guidance topic:</td>
<td>Key research question/ aim:</td>
</tr>
<tr>
<td>Checklist completed by:</td>
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</table>

### Theoretical approach

1. **Is a qualitative approach appropriate?**
   - For example:
   - Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings?
   - Could a quantitative approach better have addressed the research question?

2. **Is the study clear in what it seeks to do?**
   - For example:
   - Is the purpose of the study discussed – aims/objectives/research question/s?
   - Is there adequate/appropriate reference to the literature?
   - Are underpinning values/assumptions/theory discussed?

### Study design

---

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(third edition)

<table>
<thead>
<tr>
<th>3. How defensible/rigorous is the research design/methodology?</th>
<th>Defensible</th>
<th>Indefensible</th>
<th>Not sure</th>
<th>Comments:</th>
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<td>For example:</td>
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<td>• Is the design appropriate to the research question?</td>
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<tr>
<td>• Is a rationale given for using a qualitative approach?</td>
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<td>• Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used?</td>
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<td>• Is the selection of cases/sampling strategy theoretically justified?</td>
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<tr>
<th>Data collection</th>
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<td>• Were the appropriate data collected to address the research question?</td>
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<td>• Was the data collection and record keeping systematic?</td>
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<td>• Has the relationship between the researcher and the participants been adequately considered?</td>
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<td>• Does the paper describe how the research was explained and presented to the participants?</td>
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## Methods for the development of NICE public health guidance
(third edition)

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<th>Question</th>
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<td>• Are the characteristics of the participants and settings clearly defined?</td>
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<td>7. Were the methods reliable?</td>
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<td>8. Is the data analysis sufficiently rigorous?</td>
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<td>• Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results?</td>
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<td>• How systematic is the analysis, is the procedure reliable/dependable?</td>
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<td>• Is it clear how the themes and concepts were derived from the data?</td>
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### 9. Is the data 'rich'?

For example:
- How well are the contexts of the data described?
- Has the diversity of perspective and content been explored?
- How well has the detail and depth been demonstrated?
- Are responses compared and contrasted across groups/sites?

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<th>Rich</th>
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### 10. Is the analysis reliable?

For example:
- Did more than 1 researcher theme and code transcripts/data?
- If so, how were differences resolved?
- Did participants feed back on the transcripts/data if possible and relevant?
- Were negative/discrepant results addressed or ignored?

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<th>Reliable</th>
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### 11. Are the findings convincing?

For example:
- Are the findings clearly presented?
- Are the findings internally coherent?
- Are extracts from the original data included?
- Are the data appropriately referenced?
- Is the reporting clear and coherent?

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<th>Convincing</th>
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### 12. Are the findings relevant to the aims of the study?

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<th>Relevant</th>
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### 13. Conclusions

For example:
- How clear are the links between data, interpretation and conclusions?
- Are the conclusions plausible and coherent?
- Have alternative explanations been explored and discounted?
- Does this enhance understanding of the research topic?
- Are the implications of the research clearly defined?

Is there adequate discussion of any limitations encountered?

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### Ethics

14. How clear and coherent is the reporting of ethics?

For example:
- Have ethical issues been taken into consideration?
- Are they adequately discussed e.g. do they address consent and anonymity?
- Have the consequences of the research been considered i.e. raising expectations, changing behaviour?
- Was the study approved by an ethics committee?

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### Overall assessment
Methods for the development of NICE public health guidance (third edition)

| As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes) | ++ | + | - | Comments: |

Notes on the use of the qualitative studies checklist

Section 1: theoretical approach

This section deals with the underlying theory and principles applied to the research.

1. Is a qualitative approach appropriate?

A qualitative approach can be judged to be appropriate when the research sets out to investigate phenomena which are not easy to accurately quantify or measure, or where such measurement would be arbitrary and inexact. If clear numerical measures could reasonably have been put in place then consider whether a quantitative approach may have been more appropriate. This is because most qualitative research seeks to explain the meanings which social actors use in their everyday lives rather than the meanings which the researchers bring to the situation.

Qualitative research in public health commonly measures:

- personal/lives experiences (for example, of a condition, treatment, situation)
- processes (for example, action research, practitioner/patient views on the acceptability of using new technology)
- personal meanings (for example, about death, birth, disability)
- interactions/relationships (for example, the quality of the GP/patient relationship, the openness of a psychotherapeutic relationship)
- service evaluations (for example, what was good/bad about patients experiences of a smoking cessation group).

2. Is the study clear in what it seeks to do?

Qualitative research designs tend to be theory generative rather than theory testing; therefore it is unlikely that a research question will be found in the form of a hypothesis or null hypothesis in
Appendix 5. Article Summaries Extraction Template

Reference:

Country:

Sample Characteristics/Participants:
  N=
  Age:
  Male/Female:
  Dx:
  Years in service:
  Ethnicity:
  Employment:
  Accomodation status:

Where Recruited from:

Method:

Measures:

Therapy
  Type:
  Who delivered:
  Duration:
  Setting:

Key topics/themes:

Summary, including limitations

Extracted quotes/narratives/data, and codes
Appendix 6. PAPTRAP Author Guidelines

The following information has been extracted from Author Guidelines which can be found at:
http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%292044-8341/homepage/ForAuthors.html
Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special issue papers: 5000 words

3. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

4. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/paptrap/
(http://www.editorialmanager.com/paptrap/). The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission
(IPS Journals Terms and Conditions of Submission.doc) and the declaration of competing interests
(IPS Journals Declaration of Competing Interests.doc).

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded here (Sample Manuscript Title Page.doc).
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.
- All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.
- Manuscripts describing clinical trials must be submitted in accordance with the CONSORT statement on reporting randomised controlled trials (http://www.consort-statement.org (http://www.consort-statement.org)).

6. Multiple or Linked submissions

Authors considering submitting two or more linked submissions should discuss this with the Editors in the first instance.

7. Supporting Information

PAPT is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, video clips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at http://authorservices.wiley.com/bauthor/suppmat.asp (http://authorservices.wiley.com/bauthor/suppmat.asp)

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9. Colour illustrations

Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded here (PAPT_SN_Sub2000_F_CoW_PAPT.pdf).

10. Pre-submission English-language editing

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11. OnlineOpen

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13. The Later Stages

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Further information about the process of peer review and production can be found in this document. [What happens to my paper?](http://onelibrary.wiley.com/store/10.1111/j.1467-9299.2010.00300.x?c=1&c=77139ed36e6e616244d762434bc517e5147cc)
Appendix 7. Qualitative Interview Topic Guide

Note: shaded sections designed for purposes of exploring therapy beliefs

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**Trial Experiences Topic Guide**

> **NOTES for interviewer**

***Information Sheet and Consent Form, including whether they have agreed to be recorded, should have already been discussed with participant***

*(Key points about recording: therapists and the previous researchers involved won't listen to the interview or read the transcript - just researcher, manager and the person typing it up. The tapes/transcripts are all anonymised)*

This topic guide is meant to be a guide – you do not need to rigidly adhere to the questions provided. In addition, questions may make sense in chronological order, but if participants start answering questions that might come up later, that is OK. Just make sure the main issues are covered.

If you notice that the conversation has drifted into non-relevant areas, gently and respectfully try to interrupt and refocus to the purpose of the interview. Some people may be more likely to respond with yes/no answers, but it is important to try to elicit further information as much as appropriate. Try to be comfortable with reasonable silences – participants may need time to gather thoughts, think of a reply, or reflect on their experiences (remember, they first took part in the study over 18 months ago). You can let participants know that it's OK to take their time and that some of the questions do require some thought.

**General Prompts for use throughout (to get more information or clarification)**

*Can you tell me a bit more about that?*
*What did you mean by …….?*
*So are you saying …….?*
*By that do you mean…….?*
*You said, “……...” ?*

> **INTRODUCTION**

Thank you for meeting me today. We are going to have an informal talk about your experiences and opinions of taking part in the ReCAP trial. Anything you can tell me, positive, negative or a mixture between the two, will be really helpful. We are really interested in your view so there are no right or wrong answers; and if you are not sure about something, that’s OK too. I will be happy to answer any specific questions once we have finished. Hopefully by using your feedback, we can improve our research and other peoples’ experiences in the future.

As we discussed, I will be recording our conversation so I don’t miss anything. If you want me to stop at anytime, let me know. I may also take a few notes down as we go along. If you need a break at any point let me know. Do you have any questions before we start?
Begin recording – “Trial Experience Interview, Client ID, Rater ID, Date”

For the purposes of the tape, can I just double check that you are happy that I record the interview?

Have you taken part in any research since ReCAP (e.g. ESM/wristwatch study)? – I would like to ask that you just focus on your opinions and experiences of ReCAP…If you are not sure which is which, just let me know…

Q.1. I’m going to test your memory a bit now…How did you find out about the study? (prompt as necessary: I know its hard to remember; don’t worry if you have forgotten)

• Do you remember who first told you about it? (clarify whether an RA or CC)
• Do you remember how they told you? (Information sheets, verbally?)
  - What did they tell you? (What was the study about?)

If CC first told them verbally, Do you remember receiving an information sheet?

• Did you understand the information you were given?
• Were you given enough information about the study?
• Was that a good way to tell you about the study? / Do you wish you had been told about it differently?
• Is there anything else you would like to say about how you found out about the study?

Q.2. What do you think the purpose of the trial was?

Q.3. Why did you agree to take part?

  Prompt 1: Did you think taking part would be helpful to you?
  Prompt 2: Why do you think other people generally take part in research?

• Before you decided, did you discuss taking part with anyone else?
  - What did they think?

• Why do you think you were asked to take part?

Q.4. When you agreed to take part, did you understand what taking part would involve? (e.g. length of study, follow ups with RAs, being allocated to therapy or not?)

Q.5. People who agreed to take part were randomly allocated to a group. Do you know what that means? [Explain if participant not sure]

• Do you know how you were randomised, how it was decided which group you were put into?

• Do you remember what group you were in?

• How did you feel about that? (Were you happy with the group you were given?)
  - Why / Why not?
**For people who did not receive therapy:**
What do you think therapy would have been like?
For Q-purposes ONLY: Have you ever been offered or been involved in psychological therapy before? Declined, Completed, Dropped out? (Reasons for declining or dropping out?)
Has anyone ever talked to you about their experiences of views towards therapy?
What do you think about psychological therapies in general?

**For people who did receive therapy:**
“I’m going to ask you some more questions about what you thought about therapy in a little while but I have a few more to run through before we get to that part. Is that okay?”

**Q.6.** The study was supposed to be confidential. Do you know what that means?

**Q.7.** The study was supposed to be ‘blind’. Do you know what that means?

**Q.8.** Did you know that you could drop out of the study at any time?
- Did you consider dropping out at any point?
  - If yes, why was that?
  - Why did you stay in the study?

**Q.9.** Did you talk to friends/family about taking part?
- How did they react?
- Were they supportive?
  - Did this affect your participation in any way? Make you more or less likely to take part?

- **Did you speak to your care coordinator about taking part? Or about questions/concerns about continuing with the study?**
  - How did they react?
  - Were they supportive of the trial?
    - Did this affect your participation in any way? Make you more or less likely to take part or stay in the study?

**Q.10.** Do you remember meeting a researcher to complete assessments at different stages of the study? (offer names, descriptions to help clarify if appropriate; make sure participant is clear about differences between RAs and Therapist appointments if necessary)
- Where did you meet? / Were you happy to meet there?

- Did you attend all of the appointments with the researcher?
- Why/Why not?
  - Was there anything that made it difficult for you to attend?
  - Was it easy for you to attend?
  - Did anything put you off?

- How did you feel about the number of times you were asked to meet with the researcher (at each time point, and also through the trial overall)

- How did you feel about the amount of information you were asked for by the researcher?
  - How did you feel about the number of questionnaires and interviews you were asked to complete?
  - Do you remember how the assessments made you feel? How did you feel about the questions the researcher asked you?
  - What was it like sharing information with the researchers? How did it feel?
  - Was there anything about the assessments/questions you liked or found useful? Anything that you didn’t like?
  - What were your general impressions of the researcher / the researchers you met during the study?
  - Would you have liked a follow up appointment or telephone call after taking part in assessments? (i.e., to see that you were okay afterwards?)
  - Is there anything the researchers could /should have done differently? Was there anything that you particularly disliked or found annoying?

- Is there anything else you would like to say about the assessments or the researchers?

> If NOT allocated to Therapy, skip to Q.12.

You told me earlier that you had seen the therapist/had been allocated to therapy…

FOR Q Purposes ONLY: Have you ever been offered or been involved in psychological therapy before taking part in ReCAP? Completed, Dropped out, Declined? (Reasons for declining or dropping out?)

> This interview will focus only on therapy completed as part of the ReCAP trial

(offer names, descriptions to help clarify if appropriate; make sure participant is clear about differences between RAs and Therapist appointments if necessary)
Q.11. Did you attend all of your therapy appointments?

- Where did you meet with the therapist? / Were you happy to meet there?
  - Was it easy to keep these appointments?
  - Was there anything that made it difficult for you to attend?
    - Was there anything that put you off?
- Did you think you were offered enough sessions to get some benefit out of therapy?
  - Did therapy last too long? Or not long enough?
- Did the therapist make it clear what the purpose of meeting was?
- Was therapy what you expected? What did you think it would be like?
  - If not, in what ways did you think it would be different?
  - Were you surprised by anything?
- Did you talk about therapy with anyone else before starting? (e.g. Case manager, family, partner, friends)
- Was your experience of therapy in any way different to the talks you had with your case manager/family/partner/friend? Has anyone spoken to you about their experiences of therapy? Different to how others described therapy?
  - If so, in what ways was it different?
  - What kinds of things did you hope the appointments might be able to help you with?
- Do you feel that being involved in therapy had any effect on you?
  - How do you think it affected you?
  - Why don’t you think it affected you?
- Did you find some subjects uncomfortable or difficult to discuss?
- Overall, what were the most useful things about therapy?
- What were your general impressions of the therapist?
  - Did you feel comfortable with the therapist?
- Would you have liked therapy / the therapist to be any different? Was there anything you particularly disliked or found annoying?
- How did you feel when therapy came to an end?
- Is there anything else you would like to say about the therapy or the therapist?

Q.12. Were you asked to give any samples as part of the study? (Hair, Urine, Saliva)

- Did you give any samples, if so, which ones?

Samples
- If not, why not?

• How did you feel about being asked for samples?

• How did you feel about providing samples?
  - *If negative:* what didn’t you like about that?

• Was there anything the researchers could have done better when asking for or taking samples?

• Do you know what the samples were for?

• *Is there anything else you would like to say about being asked to give samples?*

**Q.13. What did you think about the trial overall?**

  - Did you enjoy taking part? Anything you particularly enjoyed?

  - How did you feel about the trial ending? *(relieved/sorry?)*
    - Are you glad you took part?

  • Were there any benefits to taking part? Anything you particularly benefitted from?

  • Anything you particularly disliked or found annoying?

  • Was there anything that surprised you?

  • Would you take part again knowing what you know now?

  • Had you taken part in research before?

  • Would you take part in research again?

  • Are you interested in the results of the study?
  • How would you prefer to be informed about the results?

**Q.14. When we next do a study, are there any topics that you think would be good for us to look at? In terms of mental health, are there any research topics that you think we should look at?**

**Q.15. Is there anything else you would like to say about the study. Anything at all?**

  - Anything else you can think of that the researchers or the therapist should do differently next time? Anything else you can think of that you particularly liked?
  - Do you have any advice for future Researchers? Future Therapists?
Thank you very much for your time
Do you have any questions?

END RECORDING

---

Before Q sort is ready:
We spoke briefly about this in the information sheet - there is a second stage to this project that is not quite ready yet; some of your answers during this interview are helping us prepare it. If you agree to meet up again, we would be doing something a little different. You would be asked to sort statements about psychological therapy onto a grid. This will help us get a better understanding of the variety of beliefs that different people have, many of which professionals might not be aware of. We hope that we will then be able share these issues with professionals, which should improve communication and the care that people receive.

Would you be happy for us to contact you again when the next stage of the study is ready? We can give you a ring when the statements are ready - you can then decide not to take part then or we can set up another appointment?

<RECORD RESPONSE>

---

Once Q sort is ready:
<Q sort to be introduced if client agrees>
<SEPS to be administered if client agrees>
Participant Information Sheet

Beliefs about Psychological Therapy

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Why are we doing this research? We are inviting you to participate because you are receiving care from the Early Intervention Service (EIS) and we are interested in your views. We would like to learn about people’s beliefs about psychological therapies. The findings of this study could help Early Intervention Services gain insight into the beliefs of their clients, which may improve future communication between service users and mental health professionals.

Do I have to take part? It is up to you to decide. We will describe the study and go through this information sheet, which you can keep. We will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

What will I have to do? If you decide to take part we will ask you to spend about an hour with a researcher. As part of this interview you will be asked to rank or sort some statements about psychological therapy onto a grid according to how much you agree or disagree with them. With your permission, the interview will be audio-recorded and the contents of the interview will be transcribed in order to be analysed by the research team. You may decline permission for us to use the tape recorder and still take part in the study. We will also ask you to answer some brief questions about your background and fill in a brief questionnaire about your experiences and the impact that these have had on you. You may decline to answer the additional questions or fill in the questionnaire and still take part in the study.

The research appointment will normally take place in your home. However, sometimes we see people in their local community, such as a GP surgery or mental health centre. We will reimburse reasonable travel expenses in such cases, on submission of a valid receipt.

Are there any disadvantages? The assessments involve talking about your personal experiences. It may be that this causes some clients discomfort or distress. If you do become distressed, the interview can be stopped at any time and you would not need to answer any further questions. If further support is required, the researcher can liaise with the Early Intervention Team, with your consent.
What are the possible benefits? Although you will not benefit directly from taking part in this research, the results will help to guide practice in the future.

Will my taking part in the study be kept confidential? Yes. With your permission, we may access your medical records held by the Early Intervention Service in order to collect relevant background information. All information that is collected about you during the course of the research will be kept strictly confidential and will conform to the Data Protection Act of 1998 with respect to data collection, storage and destruction. This will include the information we collect on the help you receive from different sources by accessing your records held by the NHS. Any information about you which leaves the hospital or elsewhere will have your name and address removed so that you cannot be recognised from it. Information collected in the study will not be fed back or exchanged without your consent unless there is evidence that you are at risk at harming yourself or other people. If we feel you are at risk to yourself or others, it will be necessary for us to break confidentiality and share information with an appropriate member of staff.

Your Psychiatrist or Case Manager will be notified of your participation in the study and a copy of your consent form will be retained in your records. However, unless there is information that puts you or others at serious risk of harm, information collected during the research will not be fed back or exchanged without your consent.

What will happen if I don’t want to carry on with the study? If you decide to withdraw from the study it is entirely up to you. It will not affect the care you receive. Information already collected may still be used, unless you notify us otherwise.

What will happen to the results of the study? We intend to publish the results in journals where it will have the most influence. We will publish in medical journals as well as making sure that service users will have access to the information whether or not they took part in the research. Participants who would like to receive information will be sent a leaflet explaining the results in a non-scientific format.

You will not be identified in any of these reports although they may include quotes from your interview. You may decline permission for us to use quotes from your interview and still take part in the study.

What if there is a problem? If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 275 7583 or 0161 275 8093 or by email to research-governance@manchester.ac.uk.

Who should I contact for further information about the study?

Researcher: Joanne Holding
Project Supervisor: Lynsey Gregg
Phone number: 0161 275 8486
Email: joanne.holding@manchester.ac.uk
       lynsey.gregg@manchester.ac.uk

Thank you for taking time to read this information and for agreeing to take part in the study.

You will be given a copy of this information sheet and a copy of the signed consent form to keep.

The study has been reviewed and granted favourable ethical approval by the NRES Committee North West - Greater Manchester East.
Appendix 9. Consent Form

Consent Form

Beliefs about Psychological Therapy

Name of the Researcher:        Please put your initials into the box

1. I confirm that I have read and understood the information sheet (October 23rd 2012) for the above study. I have had the opportunity to consider the information and to ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from The University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

4. I understand that my psychiatric consultant or case manager will be informed of my participation in the research.

5. I consent to the interview being audiotaped and transcribed.

6. I understand and consent that quotes from the transcribed interview may appear in a scientific journal but I will not be identifiable from these.

7. I agree to take part in the study

-------------------------------------------------------------------
Name of participant              date             signature
<table>
<thead>
<tr>
<th>Name of Person taking consent</th>
<th>date</th>
<th>signature</th>
</tr>
</thead>
</table>

When completed
1 copy is for the participant
1 copy is for the research file
1 (original) is for the medical notes
Appendix 10. Demographic information

**DEMOGRAPHIC INFORMATION (self report)**

**Date of Birth (ddmmyyyy)**

**Gender**
(1 = male, 2 = female)

**Current Living Arrangements**
(1 = living alone, 2 = living with a partner, 3 = living with one or more family members, 4 = house share, 5 = hostel/temporary accommodation)

**Primary living arrangements over the last 2 years**
(1 = living alone, 2 = living with a partner, 3 = living with one or more family members, 4 = house share, 5 = hostel/temporary accommodation)

**Contact with relative(s)**

Does the client have contact with any family members?
(1 = yes, 0 = no)

7 = not applicable

**Ethnicity**
(01 = white, 02 = Black Caribbean, 03 = Black African, 04 = Black other, 05 = Indian, 06 = Pakistani, 07 = Bangladeshi, 08 = Chinese, 09 = Other Asian, 10 = Other)

**Education**
Age left formal education

**Further/Higher Education (post 16)**
(1 = yes, 0 = no)
Employment
(1 = employed, 2 = self employed, 3 = retired, 4 = unemployed, 5 = student)

Primary employment status over the last 2 years
(1 = employed, 2 = self employed, 3 = retired, 4 = unemployed, 5 = student)
8 = refused
9 = missing

First Issues around psychosis
(ddmmyyyy)
66 66 6666 = unknown
88 88 8888 = refused
99 99 9999 = missing

Reported first Contact with mental health services
(ddmmyyyy)
66 66 6666 = unknown
88 88 8888 = refused
99 99 9999 = missing

Reported first contact with services for psychosis
(ddmmyyyy)
66 66 6666 = unknown
88 88 8888 = refused
99 99 9999 = missing

Reported number of hospital admissions for mental health issues
666 = unknown
888 = refused
999 = missing

Psychological Therapy History:

Ever been offered therapy
(1 = yes, 0 = no)

If yes, Accepted therapy
(1 = yes, 0 = no)
If **NO**: Reason for declining therapy

Please specify: ________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________(end)

If **YES**: Who delivered the therapy

(1 = Clinical Psychologist, 2 = Trainee Clinical Psychologist, 3 = CBT Therapist, 4 = Counselor, 5 = CPN/Care Coordinator/Care Manager, 6 = Other)

66 = unknown

Please specify: ________________________________________________

What type of therapy

(1 = CBT 1:1, 2 = CBT Group Therapy, 3 = Counseling, 4 = Family Therapy, 5 = Support Group, 6 = Other)

66 = unknown

Please specify: ________________________________________________

Therapy location

(1 = Home, 2 = Mental Health Outpatient Clinic, 3 = Inpatient Unit, 4 = Non-Mental Health Location in Community, e.g. GP surgery, 5 = School, 6 = other)

Please specify: ________________________________________________

Reported number of therapy sessions

666 = unknown

888 = refused

999 = missing

Reported duration of therapy (weeks)

666 = unknown

888 = refused

999 = missing

Focus/Purpose of therapy

(1 = psychotic symptom reduction, 2 = psychotic symptom distress reduction, 3 = anxiety, 4 = depression, 5 = substance use reduction, 6 = bereavement, 7 = OCD, 8 = other)

66 = unknown

88 = refused

99 = missing

Please specify: ________________________________________________
**Self-reported outcome: was therapy helpful?**
(0 = no, 1 = yes, 2 = unsure)

Please specify:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Why did therapy end?**
(1 = therapy completed, 2 = early ending: mutually agreed end between client and therapist, 3 = early ending: client stopped attending appointments, 4 = early ending: therapist decision, 5 = therapist left the service… 66 = unknown 88 = refused 99 = missing)

If therapy ended early, please specify why
________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**CONSENTS**

**Consented to sessions being taped**
(1 = yes, 0 = no)

**Consented to view casenotes**
(1 = yes, 0 = no)
DEMOGRAPHIC INFORMATION (from notes)

Primary DSM-IV diagnosis
(1 = schizophrenia, 2 = schizophreniform, 3 = schizoaffective disorder, 4 = drug induced psychosis, 5 = delusional disorder, 6 = psychosis NOS, 7 = 'at risk')
9 = missing

Duration of untreated psychosis years    months

Recorded first Contact with mental health services
(ddmmyyyy) 99 99 9999 = missing

Recorded first contact with services for psychosis
(ddmmyyyy) 99 99 9999 = missing

Recorded number of hospital admissions for mental health issues 999 = missing

Recorded Personality Disorder
(1 = yes, 0 = no) 9 = missing

Assessed Personality Disorder
(1 = yes, 0 = no) 9 = missing

Secondary DSM-IV diagnosis
(1 = alcohol abuse, 2 = alcohol dependency, 3 = drug abuse, 4 = drug dependency, 5 = drug and alcohol abuse or dependence) 9 = missing

Psychological Therapy History:

Ever been offered therapy
(1 = yes, 0 = no)

If yes, Accepted therapy
(1 = yes, 0 = no)
If NO: Reason for declining therapy
Please specify: ____________________________________________
________________________________________________________
________________________________________________________(end)

If YES: Who delivered the therapy
(1 = Clinical Psychologist, 2 = Trainee Clinical Psychologist, 3 = CBT Therapist, 4 = Counselor, 5 = CPN/Care Coordinator/Care Manager, 6 = Other)
66 = unknown

Please specify: ____________________________________________

What type of therapy
(1 = CBT 1:1, 2 = CBT Group Therapy, 3 = Counseling, 4 = Family Therapy, 5 = Support Group, 6 = Other)
66 = unknown

Please specify: ____________________________________________

Therapy location
(1 = Home, 2 = Mental Health Outpatient Clinic, 3 = Inpatient Unit, 4 = Non-Mental Health Location in Community, e.g. GP surgery, 5 = School, 6 = other)

Please specify: ____________________________________________

Reported number of therapy sessions
666 = unknown
888 = refused
999 = missing

Reported duration of therapy (weeks)
666 = unknown
888 = refused
999 = missing

Why did therapy end
(1 = therapy completed, 2 = early ending: mutually agreed end between client and therapist, 3 = early ending: client stopped attending appointments, 4 = early ending: therapist decision, 5 = therapist left the service…
66 = unknown
88 = refused
99 = missing

If therapy ended early, please specify why________________________
## Appendix 11. Substance Use Checklist

<table>
<thead>
<tr>
<th>Name of Substance</th>
<th>History of use? (please circle Yes/No)</th>
<th>Used in the last 3 months? (please circle Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol</strong></td>
<td>Hx: Yes/No</td>
<td>3 m? Yes/No</td>
</tr>
<tr>
<td><strong>Cannabis</strong></td>
<td>Hx: Yes/No</td>
<td>3 m? Yes/No</td>
</tr>
<tr>
<td>marijuana *</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cocaine</strong></td>
<td>Hx: Yes/No</td>
<td>3 m? Yes/No</td>
</tr>
<tr>
<td><strong>Hallucinogens/Dance Drugs</strong></td>
<td>Hx: Yes/No</td>
<td>3 m? Yes/No</td>
</tr>
<tr>
<td>Ecstasy, ketamine, LSD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other____________</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Opioids</strong></td>
<td>Hx: Yes/No</td>
<td>3 m? Yes/No</td>
</tr>
<tr>
<td>Heroin, methadone, codeine, morphine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other____________</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stimulants</strong></td>
<td>Hx: Yes/No</td>
<td>3 m? Yes/No</td>
</tr>
<tr>
<td>Amphetamines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other____________</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sedatives/Hypnotics/Anxiolytics</strong></td>
<td>Hx: Yes/No</td>
<td>3 m? Yes/No</td>
</tr>
<tr>
<td>Benzodiazepines, barbiturates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other____________</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Steroids</strong></td>
<td>Hx: Yes/No</td>
<td>3 m? Yes/No</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>Hx: Yes/No</td>
<td>3 m? Yes/No</td>
</tr>
<tr>
<td>Glue, paint, inhalants, butyl nitrate (poppers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other____________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 12. SEPS

The Subjective Experience of Psychosis Scale
2011

Publication details:

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The Subjective Experience of Psychosis Scale

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University of Manchester and Manchester Mental Health and Social Care NHS Trust

Lisa Wood
Greater Manchester West NHS Trust

Rachel Watts
Greater Manchester West NHS Trust

Graham Dunn
University of Manchester

Anthony P. Morrison
University of Manchester and Greater Manchester West NHS Trust

Jason Price
Greater Manchester West NHS Trust

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Zochonis Building
Brunswick Street
Manchester
M13 9PL

Permission for use must be sought from the first author at the above address.
The Subjective Experience of Psychosis Scale

Service users and clinicians have developed this scale. It aims to assess people's personal experience of psychosis. Psychosis can include things like hearing voices, seeing things others don’t see, paranoia and unusual beliefs that others don't share. Sometimes these are called psychotic experiences or symptoms. The questions ask about different ways that these can change or affect people’s lives. Some of these may apply to you and some may not. Everyone’s experiences are different. The scale can be completed alone, with a friend, carer or mental health worker.

This questionnaire has three sections. There are examples to show you how to fill out each section.

Instructions for Section One and Two

1. Think about what you call your experiences (e.g. symptoms, psychosis, voices, illness, paranoia etc). You may want to write this in the space below.

My experiences are: ........................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

2. Spend time looking at each question and rate how your experiences have affected you OVER THE LAST WEEK. For each question, consider whether there has been a positive or negative effect. There is an example on the next page that shows you how to do this.
An example of how to fill out Section One:

John has been hearing voices for some time. They vary in how much they bother him. Sometimes he feels glad that the voices are there as they can be helpful and supportive. This gives him confidence to get out and meet people. At other times he finds them demeaning. This sometimes makes him feel anxious and he avoids his friends.

So, for John, the experiences he has sometimes have a positive effect on his ability to socialise as well as a negative effect. This scale is designed to let you rate both the good aspects of your experiences as well as the bad aspects. An example of how John might fill out an item is shown below:

In the past week, how have your 'Voices' affected you:

1. Ability to socialise?  
   - In a positive way
   - Not at all  
   - A little  
   - Moderately  
   - Quite a lot  
   - Very much

   - In a negative way
   - Not at all  
   - A little  
   - Moderately  
   - Quite a lot  
   - Very much

   X

As John only has voices, he has used this term to describe his experiences in the sentence above.

He has identified that his voices have had a moderately positive effect on his ability to socialise, and a little negative effect.
## Section 1 - In the past week, how have your experiences affected you.....

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Quite a lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ability to socialise?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>In a positive way</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a negative way</td>
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<tr>
<td>2. Ability to trust others?</td>
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</tr>
<tr>
<td>In a positive way</td>
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<td></td>
<td></td>
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<tr>
<td>In a negative way</td>
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<tr>
<td>3. Relationships with friends and loved ones?</td>
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<tr>
<td>In a positive way</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a negative way</td>
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<tr>
<td>4. Levels of anxiety and stress?</td>
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<tr>
<td>In a positive way</td>
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<tr>
<td>In a negative way</td>
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<tr>
<td>5. Levels of energy?</td>
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</tr>
<tr>
<td>In a positive way</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>In a negative way</td>
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<tr>
<td>6. Ability to look after yourself?</td>
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<tr>
<td>In a positive way</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>In a negative way</td>
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<tr>
<td>7. Hope for the future?</td>
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<tr>
<td>In a positive way</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a negative way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Personality/character?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a positive way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a negative way</td>
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<td></td>
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</tr>
<tr>
<td>9. Motivation to change any experiences you may have?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>In a positive way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a negative way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Participant:**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

218
## Section 1 - In the past week, how have your experiences affected you.....

<table>
<thead>
<tr>
<th>Question</th>
<th>In a positive way</th>
<th>In a negative way</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Amount and/or quality of sleep?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Ability to enjoy hobbies and/or activities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Feelings of Isolation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Concerns about becoming unwell?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Concentration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Levels of depression?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Feelings of empowerment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Ability to find work (e.g. paid/voluntary)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Worries over your financial situation?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Participant:

[ ] [ ] [ ] [ ] [ ]
Section 1 - In the past week, how have your experiences affected your.....

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Quite a lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Ability to control your own thoughts?</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>In a <strong>positive</strong> way</td>
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<tr>
<td>In a <strong>negative</strong> way</td>
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<tr>
<td>20. Ability to cope with everyday life?</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>In a <strong>positive</strong> way</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>In a <strong>negative</strong> way</td>
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</tr>
<tr>
<td>21. Memory?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>In a <strong>positive</strong> way</td>
<td></td>
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<tr>
<td>In a <strong>negative</strong> way</td>
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</tr>
<tr>
<td>22. Your feelings of control over any experiences you may have?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a <strong>positive</strong> way</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>In a <strong>negative</strong> way</td>
<td></td>
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<tr>
<td>23. Levels of embarrassment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>In a <strong>positive</strong> way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a <strong>negative</strong> way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Feelings about your freedom and personal rights?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>In a <strong>positive</strong> way</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>In a <strong>negative</strong> way</td>
<td></td>
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<tr>
<td>25. Feelings of discrimination or being judged?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a <strong>positive</strong> way</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>In a <strong>negative</strong> way</td>
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<tr>
<td>26. Ability to feel emotion?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a <strong>positive</strong> way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a <strong>negative</strong> way</td>
<td></td>
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<tr>
<td>27. Feelings of vulnerability?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>In a <strong>positive</strong> way</td>
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<td></td>
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<tr>
<td>In a <strong>negative</strong> way</td>
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</tbody>
</table>

Participant
**Section 1 - In the past week, how have your experiences affected you...**

<table>
<thead>
<tr>
<th>28. Sense of personal identity?</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Quite a lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>In a <strong>positive</strong> way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a <strong>negative</strong> way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>29. Amount of anger and frustration?</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Quite a lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>In a <strong>positive</strong> way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a <strong>negative</strong> way</td>
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</tbody>
</table>

Please turn over for Section Two
An example of how to fill out Section Two:

This section is interested in how things have affected your experiences. This may again be in a positive or a negative way. For example John felt his medication affected his voices moderately in a positive way as his bad voices happened less often. The medication also affected his voices in a negative way as his supportive voices reduced.

So John rated this item as follows:

In the last week, how have the following things affected your experiences:

<table>
<thead>
<tr>
<th>Not Applicable</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

30. Medication that you have taken.

- In a **positive** way
  - Not Applicable
  - Not at all
  - A little
  - Moderately
  - Quite a bit
  - Very much

- In a **negative** way
  - Not Applicable
  - Not at all
  - A little
  - Moderately
  - Quite a bit
  - Very much

If any of the questions don't apply to you then you can just tick the 'not applicable' option, for example if you don't take any medication or use any alcohol/drugs.
**Section 2- In the last week, how have the following things affected your experiences?**

<table>
<thead>
<tr>
<th>Question</th>
<th>Not Applicable</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Quite a lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. Medication that you have taken?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In a positive way</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>In a negative way</td>
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<tr>
<td>31. Support from other service users?</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>In a positive way</td>
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<tr>
<td></td>
<td>In a negative way</td>
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<tr>
<td>32. Support from friends and loved ones?</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>In a positive way</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In a negative way</td>
<td></td>
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<tr>
<td>33. Support that you have got from mental health services?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>In a positive way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In a negative way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Alcohol and/or drug use?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In a positive way</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>In a negative way</td>
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<tr>
<td>35. Spirituality/religious beliefs?</td>
<td></td>
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<tr>
<td></td>
<td>In a positive way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In a negative way</td>
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</tr>
</tbody>
</table>
An example of how to fill out Section Three:

The last section looks at different aspects of your experiences and how they have been in the last week. For this section there is no positive or negative rating. So, for example, John has thought about his voices quite a lot in the past week so he would answer the question as follows:

<table>
<thead>
<tr>
<th>In this section, you have to think about different aspects of your experiences and how they have been in the last week.</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Quite a lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>36. How much have you thought about your experiences?</td>
<td>☒</td>
<td></td>
<td></td>
<td>✗</td>
<td></td>
</tr>
</tbody>
</table>
Finally, we would also be interested in whether this has caused you any upset/distress when filling this out.

Not at all  A little  Moderately  Quite a lot  Very much

Please use this space to comment on any issues that have been highlighted whilst completing this questionnaire:
Appendix 13. Q administration procedure and recording sheet

1. **Audio Record Q-sort with Participants consent; take notes of relevant comments during and after sort if not able to record.** (e.g. Did they make comments about specific statements or related experiences? Did they ask questions about certain items?)

   **If consent to record:** “As we discussed, I will be recording our conversation so I don’t miss anything. If you want me to stop at any time, let me know”

   **With or without consent to record:** “I may take a few notes as we go along, which can help us get a better understanding of your beliefs later”

2. **Read the following instructions:**
   a. “I would like to know what your views of Psychological Therapy are. Each of these cards contains a statement that other people have made about therapy and I would like you to sort these cards onto this grid according to how much you agree or disagree with the statements. There is a statement for every space on the grid but where they go is up to you. We are interested in your personal beliefs about what Psychological Therapy IS, not what you think it should be. There are no right or wrong answers”.

   b. “First, I’d like you to sort the cards into 3 piles. Take time to read each card carefully, and decide whether you agree or disagree with what it says. Place all the cards that you ‘agree’ with here and all the ones you disagree with here. If there are any that you are not sure about, or have no strong feelings about either way place them here. It doesn’t matter how many cards you place in each pile. You might find that you agree with all of them and that’s fine.

      **NOTE:** If the sorter is not sure what a statement means and asks for help, Researcher can explain, but make a note of the statement/explanation

      Once the participant has read each card and has created 3 piles; ask participant to move the disagree and neutral piles to one side, making sure they are not mixed up…

   c. “Starting with the pile of statements you definitely agree with, spread them out so you can see them all at once. Now, you need to place these cards on the right hand side of the grid. The more you agree with a statement, the further to the right it should be. SO the ones you agree most strongly with should be placed here at this side of the grid and then you can work your way backwards towards the middle. When you’ve done that we’ll do the same with the statements you disagree with.”
NOTE: If there is limited space to spread out the cards, ask sorter to search through them again

“As you go, feel free to move the cards around. It can be difficult to decide immediately which item should go where (use this prompt as necessary during the sort)

“So, to start off, which statement do you agree most strongly with? Place that card here on column 7.

“Of the ones that are left, which 2 do you agree with most? The order in which the cards appear in a particular column does not matter. For example, you have 2 cards to place in +6, it doesn’t matter which is at the top or bottom”

(Remember positive feedback “Okay great...now can you find...”)

….and can you pick the 3 that you most agree with out of these (and so on)

Have participants work their way to middle of grid until all ‘agree’ cards have been assigned a space on the grid

Other prompts
“Don’t get hung up on where you place a specific item; for example, if you find 3 cards instead of 2 you would like to place in column 6, just move 1 to column 5. We just need a general sense of your beliefs.”

NOTE: IF participant puts the wrong number of cards into a column (e.g. places cards above the grid), remind them that there is one space on the grid for each card and ask them to choose one card to move to adjacent column

“Don’t worry if you agree items cross over into negative columns (or vice versa), we don’t assume that means you disagree with the item. It just means you agree with other items more strongly.”

d. Then repeat for Disagree items, starting with -7 and working towards the middle – follow instructions as above

e. Then repeat for Neutral/Unsure items

“Now all that is left is the pile of cards that you weren’t sure about or didn’t have strong feelings about. Some people find it hard to place these cards because they don’t have a strong feeling about them in either direction. If there are some you agree with more than others, then place them towards the right hand side of the remaining spaces, or towards the left if you disagree with them more than others.”

f. Then have participant have a final look at completed grid to make any final adjustments
3. **Log whole sort** on blank A4 grid using numbers on each card
4. **Complete Post-sort questions**
4. Post-sort Questions

a. Were there any statements you didn’t understand? (NOTE to Researcher: Record if/how any items were explained)
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____________________________________________________________________
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b. Was there anything you thought was missing from the sort? If so, where would you have placed it?
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____________________________________________________________________
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c. Why did you choose the statement you agreed with most?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________


d. Why did you choose the statement you disagreed with most?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________


(OVER)
e. Can you sum up your sort in a couple of sentences?

f. Other Notes (e.g. how long did sort take? Were some cards placed randomly?)
Appendix 14. Ethics Amendment to RCT Approval Letter

Health Research Authority
NRES Committee North West - Lancaster
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ.
Tel: 0161 825 7816
Fax: 0161 825 7299

31 January 2012

Professor Christine Barrowclough
Professor of Clinical Psychology
The University of Manchester
Zochonis building, 2nd Floor
Brunswick Street
The University of Manchester
M13 9PL

Dear Professor Barrowclough

Study title: A phase-specific psychological therapy for people with problematic cannabis use following a first episode of psychosis.

REC reference: 08/H1015/82
Amendment number: 5
Amendment date: 16 January 2012

Participants who have finished the ReCAP trial will be asked to take part in a one-to-one qualitative interview with a researcher.

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trial Experiences Topic Guide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant Consent Form: Experience of Participating in ReCAP</td>
<td>1</td>
<td>16 January 2012</td>
</tr>
<tr>
<td>Participant Information Sheet: Experience of Participating in ReCAP</td>
<td>1</td>
<td>16 January 2012</td>
</tr>
<tr>
<td>Notice of Substantial Amendment (non-CTIMPs)</td>
<td>5</td>
<td>16 January 2012</td>
</tr>
<tr>
<td>Covering Letter</td>
<td></td>
<td>19 January 2012</td>
</tr>
<tr>
<td>LCFT Service User &amp; Carer Research &amp; Development Working Group Meeting Notes</td>
<td></td>
<td>16 November 2011</td>
</tr>
<tr>
<td>Example Q Sort Statements (Preliminary)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A Research Ethics Committee established by the Health Research Authority
Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

08/H1015/102: Please quote this number on all correspondence

Yours sincerely,

Dr Lisa Booth
Chair

E-mail: carol.ebenezer@northwest.nhs.uk

Enclosures: List of names and professions of members who took part in the review

Copy to: Louise Worrell, Lancashire Care NHS Foundation Trust
NRES Committee North West - Lancaster

Attendance at Sub-Committee of the REC meeting on 03 February 2012

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Lisa Booth</td>
<td>Senior Lecturer</td>
<td>Expert</td>
</tr>
<tr>
<td>Dr Nigel Calvert</td>
<td>Associate Director of Public Health</td>
<td>Expert</td>
</tr>
<tr>
<td>Professor Jois Stansfield</td>
<td>Professor of Speech Pathology</td>
<td>Expert</td>
</tr>
</tbody>
</table>
Appendix 15. New Sample Ethics Approval Letters

22 October 2012

Dr Joanne Holding, Trainee Clinical Psychologist
Division of Clinical Psychology
University of Manchester
2nd Floor, Zochonis Building
Brunswick Street
Manchester
M13 9PL

Dear Dr Holding,

Study title:  Young people’s beliefs about psychological therapy in first-episode psychosis services
REC reference:  12/NW/0752
IRAS project ref:  99350

The Research Ethics Committee reviewed the above application at the meeting held on 16 October 2012. Thank you for attending the meeting to discuss the study.

Discussion

You were commended on your excellent application.

On the question of the potential for serious distress arising in some participants, you confirmed that participants will be assured that they can stop the questionnaire at any time and do not need to answer any questions which they wish to decline. They will be directed to appropriate help where required and you will ensure that you keep your roles as researcher and therapist completely separate. Assessment of any risk of self-harm will be carried out and you will follow your organisation’s distress protocol. This was found to be satisfactory.

With regard to the payment of expenses incurred, Dr Holding acknowledged that this was reasonable and said that such expenses can be paid from the research grant which has been awarded. You were asked to include a statement about this in the information sheet.

On the question of drug use, you said that you will largely rely on self-reporting and expected people to be generally quite open about this. If necessary, you will access EIS records to check on this issue provided you have the patient’s consent to do so. You will also access these records for demographic information but will not access patients’ general medical records.
With regard to the letter to the patient's doctor, you said that the intention is to notify participants' Consultants about their taking part in the study for record purposes. A copy of the completed consent form will be sent to EIS for retention in the appropriate file. You were asked to state this in the information sheet and to include permission to do so in the consent form.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Additional Conditions

Information sheet

The following points need to be included in the information sheet:

a. Under 'Are there any disadvantages?'. it should say that besides the time and inconvenience of taking part, there is a possibility that the participant may feel distressed through taking part in the study, and explain what will happen in these circumstances.

b. It should say that the participant will be asked for permission for the researcher to access their medical records and the purpose of this.
c. It needs to give a clear statement about confidentiality limitations, to say that if information is revealed which indicates there is risk of harm to the participant or someone else, it will be necessary to breach confidentiality and refer the information to the appropriate member of staff.

d. It should say what will happen to data collected so far if the participants decides to withdraw from the study.

e. It should include a statement about the payment of travel expenses, to say that any reasonable travel expenses incurred in taking part in the study in the event that the questionnaire is not completed at the participant's home will be paid on submission of receipts.

f. It should say that the participants' Consultant will be informed about their participation in the study with their permission, and that a copy of the consent form will be retained with their records.

g. It needs to explain how the results of the study will be made available to those participants who would like to receive these.

h. It should say that the study has been reviewed by the NRES Committee North West - Greater Manchester East.

Consent form

a. This should include a point agreeing to the Consultant being informed that the participant is taking part in the study.

b. It should include the following standard research governance paragraph, adapted to your study:

"I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from [COMPANY NAME], from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records."

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You must notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
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<td>Covering Letter</td>
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<td>01 October 2012</td>
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<td>Evidence of insurance or indemnity</td>
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<td>27 September 2012</td>
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<td>GP/Consultant Information Sheets</td>
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<td>27 January 2012</td>
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<td>Interview Schedules/Topic Guides</td>
<td>G-Set - 5</td>
<td>21 September 2012</td>
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<td>Investigator CV</td>
<td>Dr J Holding</td>
<td>01 June 2012</td>
</tr>
<tr>
<td>Letter from Sponsor</td>
<td>27 September 2012</td>
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<td>Letter of invitation to participant</td>
<td>27 January 2012</td>
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<td>Other: CV - Prof G Haddock</td>
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<td>Other: CV - Dr Lynsey Gregg</td>
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<td>Questionnaire: SEPS</td>
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<td>Questionnaire: Demographics</td>
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<td>Questionnaire: Substance use checklist</td>
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<td>REC application</td>
<td>01 October 2012</td>
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<tr>
<td>Referees or other scientific critique report</td>
<td>21 November 2011</td>
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**Membership of the Committee**

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**After ethical review**

**Reporting requirements**

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

**Feedback**

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review
With the Committee’s best wishes for the success of this project

Yours sincerely

[Signature]

Mr Francis Chan
Chair

Email: nrescommittee.northwest-gmeast@nhs.net

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

“After ethical review – guidance for researchers”

Copy to: Lynne Macrae, R&D, University of Manchester

Ms Beverley Lowe, R&D, Lancashire Care NHS Foundation Trust
NRES Committee North West - Greater Manchester East

Attendance at Committee meeting on 16 October 2012

Committee Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
<th>Present</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Dr Steven Agius</td>
<td>Senior Research Fellow in Medical Education</td>
<td>No</td>
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<tr>
<td>Mr David Asher</td>
<td>Retired Community Locum Pharmacist</td>
<td>No</td>
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<tr>
<td>Mr James Burns</td>
<td>Retired</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Mr Francis Chan</td>
<td>Consultant Orthopaedic Surgeon</td>
<td>Yes</td>
<td>Chair</td>
</tr>
<tr>
<td>Dr Jacqueline Crowther</td>
<td>Research Assistant</td>
<td>No</td>
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<tr>
<td>Dr Mary Dolan</td>
<td>Nurse Lecturer</td>
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<tr>
<td>Dr Michael Hollingsworth</td>
<td>Retired Senior Lecturer in Pharmacology</td>
<td>Yes</td>
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<tr>
<td>Mr Christopher Houston</td>
<td>Lay Member</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mr Simon Jones</td>
<td>Specialist Podiatrist - Paediatrics</td>
<td>Yes</td>
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<tr>
<td>Dr Priyadarshan Joshi</td>
<td>Consultant Psychiatrist</td>
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<tr>
<td>Dr Philip Lewis</td>
<td>Consultant Cardiologist</td>
<td>No</td>
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<tr>
<td>Professor Janet Marsden</td>
<td>Professor of Ophthalmology and Emergency Care</td>
<td>Yes</td>
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<tr>
<td>Mr Howard Shilton</td>
<td>Clinical Nurse</td>
<td>No</td>
<td></td>
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<tr>
<td>Mrs Mary Speake</td>
<td>Clinical Research Practice Educator</td>
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Also in attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position (or reason for attending)</th>
</tr>
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<tbody>
<tr>
<td>Elaine Hutchings</td>
<td>Committee Co-ordinator</td>
</tr>
<tr>
<td>Anya Sekula</td>
<td>Observer</td>
</tr>
</tbody>
</table>

Written comments received from:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Steven Agius</td>
<td>Senior Research Fellow in Medical Education</td>
</tr>
</tbody>
</table>
24 October 2012

Dr Joanne Holding
Trainee Clinical Psychologist
University of Manchester
Division of Clinical Psychology
2nd Floor, Zochonis Building
Brunswick Street, Manchester
M13 9PL

Dear Dr Holding

Full title of study: Young people’s beliefs about psychological therapy in first-episode psychosis services

REC reference number: 12/NW/0752

Thank you for your letter of 23 October 2012. I confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 22 October 2012. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

<table>
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<th>Document</th>
<th>Version</th>
<th>Date</th>
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<td>Participant Consent Form</td>
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<td>23 October 2012</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>2</td>
<td>23 October 2012</td>
</tr>
</tbody>
</table>

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor’s responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

12/NW/0752 Please quote this number on all correspondence

Yours sincerely

Elaine Hutchings
Committee Co-ordinator
E-mail: nrescommittee.northwest-gmeast@nhs.net
Appendix 16. Trust R&D Permission Letter

Lancashire Care NHS Foundation Trust
Lancashire Care NHS Foundation Trust
Research and Development
The Lantern Centre
Vicarage Lane
Fulwood
Preston
PR2 8DW
Tel: 01772 773499/773626
R&D@lancashirecare.nhs.uk

1st October 2013

Dr Joanne Holding
Trainee Clinical Psychologist
University of Manchester
Division of Clinical Psychology
2nd Floor, Zochonis Building
Brunswick Street
Manchester, M13 9PL

Dear Dr Holding,

Re: NHS Trust Permission to Proceed

Project Reference: 13/14

Project Title: Young People’s beliefs about psychological therapy in first-episode psychosis services

I am pleased to inform you that the above project has received research governance permission.

Please take the time to read through this letter carefully and contact me if you would like any further information. You will need this letter as proof of your permission.

Trust R&D permission covers all locations within the Trust; however you will only be allowed to recruit from the sites/services you have indicated in section 3 of the SSI application form. If you would like to expand recruitment into other services in the Trust that are not on the original SSI then you must contact the R&D department immediately to discuss this before doing so.

You also must ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing recruitment in that service and you must contact the relevant service/ward managers prior to accessing the service to make an appointment to visit before you can commence your study in the trust.

Please make sure that you take your Trust permission letter with you when accessing Trust premises and please include the Trust reference number on any correspondence/emails so that the services are assured permission has been granted.

Supporting Health and Wellbeing
Medical Directorate
Chair: Mr Derek Brown
Chief Executive: Professor Heather Tiernan-Phillips OBE

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Honorary Research contracts (HRC)
All researchers with no contractual relationship with any NHS body, who are to interact with individuals in a way that directly affects the quality of their care, should hold Honorary Research NHS contracts. Researchers have a contractual relationship with an NHS body either when they are employees or when they are contracted to provide NHS services, for example as independent practitioners or when they are employed by an independent practitioner (Research Governance Framework for Health and Social Care, 2005). If a researcher does not require an HRC, they would require a Letter of Access (LoA). For more information on whether you or any of your research team will require an HRC or LoA please liaise with this office. It is your responsibility to inform us if any of your team do not hold Honorary Research NHS contracts/Letters of Access.

Staff involved in research in NHS organisations may frequently change during the course of a research project. Any changes to the research team or any changes in the circumstances of researchers that may have an impact on their suitability to conduct research MUST be notified to the Trust immediately by the Principal Investigator (or nominated person) so that the necessary arrangements can be put in place.

Research Governance
The Research Governance Sponsor for this study is University of Manchester. Whilst conducting this study you must fully comply with the Research Governance Framework. This can be accessed at:
For further information or guidance concerning your responsibilities, please contact your research governance sponsor or your local R&D office.

Good Clinical Practice (GCP)
GCP is an international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve the participation of human subjects. It is the responsibility of all researchers who are carrying out a research project involving NHS patients and carers to complete GCP training and to update this every 2 years. All training certificates must be forwarded to the R&D department to comply with Trust permission. Please note that student projects are exempt from this process.

Risk and Incident Reporting
Much effort goes into designing and planning high quality research which reduces risk; however untoward incidents or unexpected events (i.e. not noted in the protocol) may occur in any research project. Where these events take place on trust premises, or involve trust service users, carers or staff, you must report the incident within 48 hours via the Trust incident reporting system. If you are in any doubt whatsoever whether an incident should be reported, please contact us for support and guidance.

Regardless of who your employer is when undertaking the research within Lancashire Care NHS Foundation Trust you must adhere to trust policies and procedures at all times.
Confidentiality and Information Governance
All personnel working on this project are bound by a duty of confidentiality. All material accessed in the trust must be treated in accordance with the Data Protection Act (1998) For good practice guidance on information governance contact us.

Protocol / Substantial Amendments
You must ensure that the approved protocol is followed at all times. Should you need to amend the protocol, please follow the Research Ethics Committee procedures and inform all NHS organisations participating in your research.

Monitoring / Participant Recruitment Details
If your study duration is less than one year, you will be required to complete an end of study feedback report on completion. However if your study duration is more than one year, you will be required to complete a short electronic progress report annually and an end of study report on completion. As part of this requirement, please ensure that you are able to supply an accurate breakdown of research participant numbers for this trust (recruitment target, actual numbers recruited). To reduce bureaucracy, progress reporting is kept to a minimum; however, if you fail to supply the information requested, the trust may withdraw permission.

Recruitment
Please provide the trust details of your recruitment numbers when requested. If you have any concerns with recruitment please contact the R&D team immediately for assistance.

Final Reports
At the end of your research study, we will request a final summary report so that your findings are made available to local NHS staff. The details from this report may be published on the NHS Trust internet site to ensure findings are disseminated as widely as possible to stakeholders.

On behalf of this Trust, may I wish you every success with your research. Please do not hesitate to contact us for further information or guidance.

Yours sincerely,

Dr Anna Pearson
Research Support Fellow
On behalf of the Research Governance Sub-Committee

Cc: Research-governance@manchester.ac.uk

Supporting Health and Wellbeing
Medical Directorate
Chair: Mr Derek Brown   Chief Executive: Professor Heather Tinney-Moore OBE

MINDFUL EMPLOYER
Appendix 17. Crib sheet template for Q-factor interpretation

Factor 1:

- Distinguishing statements
- Items ranked +6* & +5
- Items ranked higher in Factor 1 Array than in other factor arrays
- Items ranked lower in Factor 1 Array than in other factor arrays
- Items ranked -6* & -5
- Items that don’t fit initial criteria
  - For consideration e.g. other highly ranked items, other potentially useful items?

Factor 2:

- Distinguishing statements
- Items ranked +6* & +5
- Items ranked higher in Factor 2 Array than in other factor arrays
- Items ranked lower in Factor 2 Array than in other factor arrays
- Items ranked -6* & -5
- Items that don’t fit initial criteria
  - For consideration e.g. other highly ranked items, other potentially useful items?

Factor 3:

- Distinguishing statements
- Items ranked +6* & +5
- Items ranked higher in Factor 3 Array than in other factor arrays
- Items ranked lower in Factor 3 Array than in other factor arrays
- Items ranked -6* & -5
• Items that don’t fit initial criteria
  o For consideration e.g. other highly ranked items, other potentially useful items?

Factor 4:

• Distinguishing statements

• Items ranked +6* & +5

• Items ranked higher in Factor 4 Array than in other factor arrays

• Items ranked lower in Factor 4 Array than in other factor arrays

• Items ranked -6* & -5

• Items that don’t fit initial criteria
  o For consideration e.g. other highly ranked items, other potentially useful items?

Consensus Statements (those that do not distinguish between any pair of factors):
Appendix 18. Q-factor summaries in full

Interpretation of the Q Sorts – complete factor summaries

Factor 1: “Therapy is helpful and gives hope for the future”

Factor 1 was comprised of 12 males and four females. Fifteen described themselves as White and one as Indian. All but two had previous experiences of involvement with psychological therapy, and four were currently waiting for therapy. Eight (61.5%) self-reported that they had seen at least one course of therapy through to completion and 5 (38.5%) reported ending a therapy early. Six people (37.5%) in this group had declined therapy at some point. There were eight responses that at least one experience of therapy had been helpful in some way, six experiences when the participant was unsure about its helpfulness, and two responses about a therapy being unhelpful. Just over half experienced current symptoms of psychosis, experienced at variable frequency. Participants on this factor, on average, had the highest score for positive impact of support on their psychotic experiences i.e. they considered that external support such as therapy/medication etc had a good impact on their psychosis.

This factor consisted of people who appeared to have globally strong positive views about psychological therapy, including its ability to bring about change, the process, and the people that deliver therapy. People who loaded on this factor believed that therapy ‘provides support’ (+6), ‘is helpful’ (+5), ‘provides hope for the future’ (+4) and is certainly not ‘a waste of time’ (-6). They appeared to believe that therapy provided a unique service, as they disagreed that therapy ‘is not necessary, someone else could support a person’s needs instead’ (-3). People in this factor appeared to be generally ambivalent about medication as an adjunct to therapy
(items 50: 0; 52: -1) as well as other ways of getting help (item 48: 0), but strongly disagreed that medication is a replacement for therapy: Therapy ‘is just talking, people need medication instead’ (-6).

People in this factor believed most strongly that it ‘can help people make changes in their lives’ (+5), and disagreed that it ‘only provides short term solutions’ (-3). They rated a number of change or positive outcome statements higher than people on other factors, for example: ‘helps people overcome stressful life events’ (+3), ‘helps people feel less distressed or frightened by their experiences’ (+2), ‘helps people cope with their experiences; (+3), ‘helps people feel more confident’ (+3), as well as ‘helps people identify when they are becoming unwell (+3).

They also appeared to have very positive beliefs about the process or setting in which therapy takes place and how they would be treated. For people in this group, therapy seemed to be a non-judgemental and non-stigmatising environment, which facilitates open and honest discussion, which may not be possible with family and friends. They believed that therapy ‘accepts people as they are without judging them’ (+6) and ‘is somewhere people can talk about problems without being ashamed’ (+5). In addition, therapy was viewed as ‘somewhere people can talk honestly’ (+4), ‘somewhere to talk to someone who understands’ (+4), and ‘somewhere people can talk about things that they are not comfortable telling family or friends’ (+4).

They had some positive beliefs about therapists as well, disagreeing that therapy ‘Is offered by therapists that people cannot relate to’ (-4), ‘is offered by therapists that don’t actually care about the people they see’ (-4), and ‘is offered by people who don’t understand different religions or cultures’ (-3).
People in this group also seemed to have a sense of control over the process. They disagreed that therapy ‘makes people make changes they don’t want to make’ (-5), ‘is something that people attend only if others pressure them to do it’ (-4), and ‘is guided by a therapist, not by the person’ (-2).

**Factor 2: “Therapy is just talking, people need medication”**

Factor 2 was comprised of 3 White males. All had one previous experience of involvement with psychological therapy although two had ended it early. Two of the participants did not find therapy helpful and one was not sure. One of these participants had also declined therapy at some point in the past. Two reported current symptoms. This group recorded the lowest average score on positive impact of experiences on mental health and wellbeing and on severity of negative dimensions of psychosis.

Factor 2 consisted of people with strong views about the importance of medication. In contrast to factor 1, they did not believe that therapy could be effective without other things in place, such as medication. Therapy was viewed as ‘not the only way for people to get help’ (+5) and they disagreed that it ‘is more helpful than taking tablets’ (-5). They believed that therapy ‘is just talking, people need medication instead’ (+5) and ‘is only helpful if the person is taking medication as well’ (+4). They were the only group to endorse that therapy ‘is only for people with something wrong with them’ (+2).

While medication seemed to be viewed as a necessity, they still held some positive general views about psychological therapy. They disagreed that therapy ‘makes people’s problems worse’ (-6) and believed it ‘is helpful’ (+6). They believed
it would be a positive setting: ‘is somewhere people can talk honestly’ (+2), ‘is private and confidential’ (+6), and ‘is somewhere to be listened to’ (+6). They agreed that therapy ‘is somewhere to talk to someone who understands’ (+3) and ‘is offered by people who want to help others’ (+3), and didn’t see that therapy ‘is offered by therapists that don’t actually care about the people they see’ (-5) or ‘is offered by therapist that people cannot relate to’ (-3).

Unlike factor 1, they did not endorse many positive specific benefits to therapy and seemed to lack belief that therapy could bring about change. They were uncertain about therapy in general, viewing it as ‘an unknown which puts people off from trying it’ (+4). While not a particularly strong belief relative to other items, people in this group were the only ones to agree that therapy ‘only provides short term solutions’ (+1). They disagreed that therapy ‘can help people make changes in their lives’ (-4), or that it ‘provides hope for the future’ (-3), ‘helps people get control over their problems’ (-2), ‘helps people less distressed/frightened’ (-5), ‘helps people feel more confident’ (-4), ‘helps people start doing more in their life’ (-4), and helps people feel more comfortable in social situations’ (-3). The only positive benefit of therapy endorsed by this group was that therapy ‘is somewhere to get self-understanding or insight’ (+4).

**Factor 3: “Therapy is useful but stigmatising”**

One person loaded onto factor 3, a White male, who had no previous experience of psychological therapy but was currently on the waiting list to receive CBT. He did not recall declining therapy previously. He reported that he currently experiences psychotic experiences, however questionnaire data was missing for sections two and
three of the SEPS. He had a relatively high score for positive impact of his experiences on his mental health and well being, compared to other group averages, and one of the lowest scores for negative impact of his experiences.

This participant expressed mixed views about therapy and was the only one without a strong feeling about medication vs. therapy ‘is just talking, people need medication instead’ (+1). He disagreed that therapy ‘is somewhere people can talk about problems without being ashamed’ (-3) and ‘accepts people as they are without judging them’ (-5), possibly leading him to disagree that therapy ‘is somewhere people can talk honestly’ (-6) and ‘is somewhere people can talk about things that they are not comfortable telling family or friends’ (-4). Moreover, he believed that therapy ‘is something that people are too embarrassed to attend because of what other people would think’ (+4).

This participant had some different views about the therapeutic relationship. He was the only one to hold the belief that therapy is not ‘a respectful relationship between equals’ (-4), as well as being ‘guided by the therapist, not the person’ (+3). He also expressed some ambivalence or uncertainty about therapists. He was the only one unsure whether therapy ‘is offered by therapists that don’t actually care about the people they see’ (0). In addition, he didn’t have a strong opinion about whether therapy was ‘offered by therapists that people cannot relate to’ (0), or ‘by people who just sit and listen, and don’t offer advice’ (1).

At the same time, he did have some positive beliefs about the benefits of therapy: He agreed that therapy ‘helps people understand the impact of the past on what is happening now’ (+6), ‘helps people feel more confident in social situations’ (+6), and ‘helps people get control over their problems’ (+4). Interestingly, while he
seemed concerned about the stigmatising nature of therapy, he also viewed it as a potentially normalising experience agreeing that therapy ‘is somewhere people learn that their experiences have been experienced by others’ (+6). However, he did express the strongest concern compared to other factors that therapy ‘makes people talk about things that will play on their mind later’ (+4).

**Factor 4: “Therapy is better than medication”**

Factor 4 was comprised of all males, three of whom described themselves as White and one as Black. They all had previous experiences of involvement with psychological therapy, and none were currently on a therapy waiting list. Two participants self-reported that they had seen at least one course of therapy through to completion and two reported ending therapy early. No one reported that they had declined therapy at some point in past. Three participants reported that they were unsure about the helpfulness of past therapy and one reported that it had been unhelpful. No one reported that therapy had been helpful to him in the past. They all reported to have current experiences of psychosis, occurring relatively frequently over the past week. On average, they had the lowest score for the positive impact of support on the psychotic experiences.

Factor 4 consisted of people who appeared to be uncertain or ambivalent about whether therapy or medication could facilitate change in their lives. However, they also had the strongest positive beliefs about the therapy setting and how they would be treated. People on this factor were the most strongly opposed to medication, disagreeing that therapy ‘is only helpful if the person is taking medication as well’ (-6) and ‘is just talking, people need medication instead’ (-4).
And even with mixed feelings about therapy, they still believe it ‘is more helpful than taking tablets’ (+3).

They expressed the most ambivalence or uncertainty about therapy’s ability to help people, taking a neutral stance about whether therapy ‘is helpful’ (0). They agreed therapy ‘cannot solve every problem’ (+6), and disagreed that it ‘helps people cope with their experiences’ (-3) and ‘helps people improve their personal relationships’ (-2). There were also seemingly ambivalent about other ways it might help people (e.g. items 23, 24, 26, 27, 28, 30, 31). This was not however a global attribution. They agreed that therapy helps people understand the impact of the past on what is happening now’ (+4); ‘is somewhere to get self-understanding and insight’ (+4). They also disagreed with the statement that psychological therapy ‘is not necessary, someone else could support a person’s needs instead’ (-3). This may be due to their positive belief in the process and how they expect to be treated in therapy. They expressed strong consistent beliefs that therapy ‘is somewhere to be listened to’ (+6), ‘is somewhere people are treated as individuals, not as an illness’ (+5), ‘accepts people as they are without judging them’ (+4), ‘is somewhere people can talk about things that they are not comfortable telling family or friends’ (+6), and ‘is a respectful relationship between equals’ (+4). This could in turn influence beliefs about how they could be in sessions, endorsing that therapy ‘is somewhere people can talk honestly’ (+5) and ‘is somewhere people can talk about problems without being ashamed (+3).

**Consensus Statements**

There were a number of consensus statements, those that participants had similar views about as they ranked them in a similar way, which did not distinguish between
any pair of factors. Statistically, 11 statements reached consensus (items 1, 40, 49, and 64, p > .05; items 4, 15, 18, 19, 36, 53, and 63, p > .01), many of which the factors seemed to be relatively ambivalent about. Two other statements (38, 60) did not reach statistical consensus, but are worthy of comment. As Table 2 shows, all factors had a strong belief that therapy ‘is private and confidential’ (+6, +6, +3, +5) and agreed that it ‘gives choice in what people want to work on (+1, +1, +5, +3) and ‘is somewhere people learn that their experiences have been experienced by others (+1, +3, +6, +2). They seemed to disagree fairly strongly that therapy ‘makes people’s problems worse’ (-5, -6, -2, -4) and ‘makes people make changes they don’t want to make’ (-5, -4, -5, -2). There was more uncertainty or ambivalence about therapists however, and whether therapy ‘is offered by therapists who are easy to talk to’ (0, +1, +1, -1) and ‘is offered by people who want to help others’ (+1, +3, +3, +2). However, they disagreed that therapy ‘is offered by people who don’t understand different religions or cultures’ (-3, -1, -4, -4).