DOCTOR OF CLINICAL PSYCHOLOGY (DCLINPSY)

Doctorate in Clinical Psychology: Main Research Portfolio

1) Systematic Review of the Safety of Mindfulness-Based Interventions for Psychosis ; 2) Looking After NHS Staff and Ourselves: An Evaluation of the Impact of Trauma-Informed Compassionate Leadership Training on Managerial Staff's Confidence and Knowledge During the Pandemic ; 3) Dehumanisation in Voice-Hearers: The End of the Continuum. (Alternative Format Thesis)

Venus, Bethany

Award date:
2022

Awarding institution:
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Research Portfolio Submitted in Part Fulfilment of the requirements for the Degree of Doctorate in Clinical Psychology Volume 1 of 2

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Doctorate in Clinical Psychology

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Statement of Impact: COVID-19 Pandemic

The Service-Related Project was impacted by the COVID-19 pandemic as this was in the planning stages at the start of the pandemic. Initially, it was planned that the project would involve an evaluation of trauma-informed care training within community mental health teams. However, this was not able to go ahead due to the constraints within the Quality Improvement team regarding the types of projects being accepted for approval at the start of the pandemic. The project was thus changed to an evaluation of trauma-informed training which the two external supervisors were conducting as a direct consequence of the pandemic, with a view to supporting managers within the local NHS to be able to support their teams with the stresses and traumas associated with the pandemic. Thus, these training sessions were facilitated remotely, and all data was collected remotely.

The Main Research Project was also impacted by the COVID-19 pandemic with respect to recruitment. Initially, it was planned that recruitment would take place through Hearing Voices Network (HVN) groups. However, many of the local HVN groups approached were not accepting or were limiting the number of research studies which they were permitting tor advertise to their groups. This entailed a change of recruitment strategy to recruitment via advertisement on Twitter by sharing the study advert with a range of charities working with people with psychosis and voice-hearers. The second change was to recruit via MQ Participate, which was the source of most participants in the study. It is thus likely that the COVID-19 pandemic has impacted the demographics of the participants recruited. However, despite the pandemic, twenty participants agreed to take part in the study across a wide range of ages and ethnicities and with an almost equal balance of binary genders.

Abstracts

Dehumanisation in Voice Hearers: The End of the Continuum

Background

Meta-dehumanization and self-dehumanization have been identified as relevant phenomena for developing a deeper understanding of distress related to psychosis. Chadwick (2019) has previously argued that people with psychosis typically feel "dehumanised and set apart by their experiences of psychosis and trauma" and frames mindfulness for psychosis as a humanising therapeutic process. Exploring the experience of dehumanisation in voice hearers was selected as a useful starting point in understanding dehumanisation in people with psychosis.

Method

Qualitative data was obtained through twenty semi-structured interviews with self-identifying voice hearers and analysed using reflexive thematic analysis. This followed the recursive six phase procedure of Braun and Clarke (2022), and this was conducted from a critical realist, contextualist position.

Results

Reflexive thematic analysis of participant's experiences produced a core theme, Dehumanisation as the End of Experiential Continua, and six subthemes: Extent of Distressing Sensory Fragmentation; Sense of Belonging with Other Humans; Integrity of Self as a Private, Coherent Entity; Sense of Worth as a Human Being; Strength of Personal Agency; and Trust in Own Credibility and Reliability. Two further themes, The Push and Pull of Dehumanising Forces and Reclaiming Life through Humanising Forces, were identified.

Conclusions

Reflexive thematic analysis of voice hearers' accounts identified self-dehumanisation as the endpoint where six experiential continua coalesce. Movement along these continua was affected by a range of interpersonal, intrapersonal, and societal forces over time, including dehumanising attitudes of others and voice malevolence and omnipotence.

Key Words

Voice-hearing; Psychosis; Thematic Analysis; Qualitative; Voices

Systematic Review of the Safety of Mindfulness-Based Interventions for Psychosis

Potential harmful outcomes of mindfulness-based interventions (MBIs) are under-researched, as is the case for many psychological interventions. Noting this gap, Ellett and Chadwick (2021) have provided recommendations for how harm might be operationalised as indices to evaluate the safety of mindfulness-based interventions for psychosis. This study aimed to systematically review harm indices in Randomised Controlled Trials (RCTs) of MBIs for psychotic disorders and to assess the quality of reporting of these indices. It also aimed conduct a meta-analysis of risk differences where data was sufficient. The percentage of studies reporting on each index of harm varied greatly as did the prevalence of harm across each index. Reporting of harm was inconsistent across studies and the quality of data collection and reporting varied. It was found that there was a higher risk of hospitalization in control arms compared to intervention arms and that there were comparable levels of intervention dropout rates across both trial arms. MBIs for psychosis appear to be safe and may reduce the risk of hospitalisation. However, the absence of thorough reporting on harm precludes a weighted analysis of benefits versus harms. Future research into the effectiveness of MBIs should consistently operationalise and collect data on harm.

Key Words

Mindfulness; Psychosis; Safety; Harm; Systematic Review; Meta-Analysis

Looking After NHS Staff and Ourselves: An Evaluation of the Impact of Trauma-Informed Compassionate Leadership Training on Managerial Staff's Confidence and Knowledge During the Pandemic

Aims

This study aimed to evaluate the effect of training on the confidence and knowledge of NHS Leaders and Managers in implementing guidelines on the "Do's and Don'ts" of a trauma-informed response to staff during the pandemic. It further aimed to identify improvements to the training which could enhance its utility prior to wider dissemination.

Method

This evaluative study used a mixed methods approach and followed the Plan-Do-Study-Act (PDSA) cyclical model of service improvement adopted by the NHS. Pre-, post-, and follow-up questionnaires were developed which assessed the level of confidence and knowledge participants had in implementing the "Do's and Don'ts". These questionnaires included qualitative feedback questions related to what participants hoped for from the training, whether they achieved what they hoped, how the training impacted their support for staff wellbeing, and what improvements could be made to the training. Content analysis was used to analyse qualitative data. Paired samples t-tests and repeated measures ANOVAs were used to analyse quantitative data.

Results

There were significant improvements in participants' confidence and knowledge between the pre- and post-training time points. These were not maintained at follow-up, however, there was a high level of attrition between the post-training and follow-up time points. Most participants reported achieving what they hoped for from the training, including professional development, skills for responsive management, and improved self-care and self-compassion within demanding leadership roles. Participants provided suggestions for enhancing the helpfulness of the training which contributed to a range of recommendations.

Conclusions

This evaluation demonstrated that training focusing on the "Do's and Don't's" of a trauma-informed response to staff during the pandemic can be effective in enhancing the knowledge and skills of NHS Leaders and Managers. A range of potential

improvements could further augment the utility of the training for a wider range of NHS staff.

Systematic Review of the Safety of Mindfulness-Based Interventions for Psychosis

Literature Review Project

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Proposed Journal for Submission

Clinical Psychology Review (author guidelines in Appendix J)

This journal was chosen as it publishes substantive reviews of topics relevant to clinical psychology. There is not a specific word limit, however, the journal has a 50-page limit, which this paper is below.

Abstract

Potential harmful outcomes of mindfulness-based interventions (MBIs) are under-researched, as is the case for many psychological interventions. Noting this gap, Ellett and Chadwick (2021) have provided recommendations for how harm might be operationalised as indices to evaluate the safety of mindfulness-based interventions for psychosis. This study aimed to systematically review harm indices in Randomised Controlled Trials (RCTs) of MBIs for psychotic disorders and to assess the quality of reporting of these indices. It also aimed to conduct a meta-analysis of risk differences where data was sufficient. The percentage of studies reporting on each index of harm varied greatly as did the prevalence of harm across each index. Reporting of harm was inconsistent across studies and the quality of data collection and reporting varied. It was found that there was a higher risk of hospitalization in control arms compared to intervention arms and that there were comparable levels of intervention dropout rates across both trial arms. MBIs for psychosis appear to be safe and may reduce the risk of hospitalisation. However, the absence of thorough reporting on harm precludes a weighted analysis of benefits versus harms. Future research into the effectiveness of MBIs should consistently operationalise and collect data on harm.

Key Words

Mindfulness; Psychosis; Safety; Harm; Systematic Review; Meta-Analysis

Introduction

Background

The development of mindfulness-based interventions (MBIs) for psychosis has lagged behind mindfulness interventions for other mental health problems. This delay originated in concerns arising from uncontrolled studies reporting an association between the onset of psychosis, or deterioration of the mental health of those with psychosis, and meditation practice (Chadwick, 2014). Despite these early concerns, the research literature assessing the effectiveness of mindfulness-based interventions for psychosis has grown. A recent systematic review and meta-analysis examining acceptance and mindfulness-based interventions for psychosis found moderate to large effect sizes for psychotic symptomatology in the short and long term (SMD: 0.8 and SMD 1.10 respectively), hospitalisation (MD: 4.38) and acceptance (SMD: 0.78), as well as low to moderate effects for social functioning, depressive symptoms, negative symptoms and mindfulness (Jansen et al., 2020), and the authors concluded that the evidence to date suggests that these interventions are effective and safe for individuals with psychosis.

Jansen et al. (2020) noted that no study in their review reported any serious adverse events, however, only 44% of the studies reported on adverse events of any kind. It is known that in psychotherapy research, broadly speaking, harm is insufficiently monitored and reported on (Jonsson et al., 2014). For instance, a recent systematic review of study protocols for psychotherapy trials across a range of clinical presentations found that only 67% of the protocols examined included any reference to harm and it was unknown whether the studies subsequently went on to adequately report on harm (Klatte et al., 2022). This is despite the importance of understanding and preventing harm in healthcare professions as a key ethical duty as highlighted by Baer et al. (2019).

They also observed that there was marked variation in the terms used to define harm, with a precise definition of adverse events (AEs) lacking. This is an ongoing issue noted by Vaughan et al. (2014), who found that adverse events lacked a standardised definition as well as finding that psychopharmacological trials were significantly more likely to report on harm than psychotherapy trials. Serious adverse events (SAEs) tended to be more consistently reported on using a definition loaned from medicine (Klatte et al., 2022). However, the appropriateness of the loaned

definition of SAEs has been called into question as this includes, for instance, birth defects which appear to be unlikely implications of psychotherapy interventions. Baer et al. (2019), in their review of the conceptual issues in assessing harm in MBIs, suggested that there are three types of factors which require consideration for making sense of potential harm in MBIs: program-related factors, participant-related factors, and clinician-related factors. Their recommendations for assessing and monitoring harm in MBIs marries with the recommendations of the CONSORT checklist (Moher et al., 2005), and they note that despite the longstanding availability of this checklist, reporting on harm and a balanced discussion of benefits and harms remains rare. It is important to note that this issue is not limited to the literature examining MBIs, as demonstrated by a recent systematic review assessing reporting on adverse events in cognitive behavioural therapy for insomnia, which found that only 32.3% of studies addressed adverse events in any way, with an even smaller 7.1% of studies meeting criteria for adequate reporting of adverse events (Condon et al., 2021).

This points to two primary problems with respect to assessment of the safety of psychological interventions in trials. Firstly, the lack of a clear definition or operationalisation of harm that is relevant and comprehensively covers the range of potential adverse outcomes within the emotional, cognitive, social, functioning, and physiological domains. This operationalisation also needs to be capable of distinguishing between discomfort and potential harm in MBIs and clarify when discomfort has transitioned to harm (Baer et al., 2019). Secondly, the lack of consistent monitoring and reporting on harm in research trials with a view to ultimately being able to conclusively decide how safe an intervention is.

A recent and related systematic review and meta-analysis examined the safety of mindfulness-based interventions, specifically Mindfulness-Based Stress Reduction and Mindfulness-Based Cognitive Therapy for people with mental health problems, for healthy populations, and for those with physical health problems, however, they did not include trials of MBIs for psychosis in their review (Wong et al., 2018). The systematic review and meta-analysis presented here proposes to fill this gap in the literature by assessing the safety of MBIs for psychosis based upon reporting in the literature to date, alongside assessing the current quality of reporting on harm and providing recommendations for future research.

Ellett and Chadwick (2021) provide recommendations for how harm might be operationalised, monitored, and reported on to adequately capture the degree of safety

of MBIs for psychosis and justify conclusions related to safety. The first recommendation is for data from randomised controlled trials to be prioritised regarding obtaining any generalisable conclusion regarding harm. The remaining items are recommended indices of harm which, if systematically monitored and reported on in trials, would provide sufficient information for clear conclusions related to harm to be drawn.

This operationalisation of harm and the standards for reporting recommended by Ellett and Chadwick (2021) are utilised in this systematic review for assessing the prevalence of harm and the quality of reporting of harm. This review took a hybrid approach to reviewing adverse events, with some harm indices pre-specified (confirmatory approach) and some adverse events opportunistically captured (exploratory approach), due to the inconsistent nature of monitoring and reporting (Peryer et al., 2022).

Aims of Current Review

The aims of this review were to:

- Systematically identify randomized controlled trials or randomized pilot/feasibility studies of mindfulness-based interventions for psychotic disorders which report data regarding harm indices as operationalized by Ellett and Chadwick (2021).
- Assess the quality of reporting of harm indices within the identified studies according to standards set by the CONSORT statement (Moher et al., 2005) and the framework provided by Ellett and Chadwick (2021).
- Systematically review the prevalence of harm experienced by participants in mindfulness-based interventions for psychosis and conduct a meta-analysis of risk differences provided that sufficient numbers of studies report on relevant indices.
- Provide recommendations to improve the systematic monitoring and reporting of harm indices in future RCTs examining the effectiveness of mindfulness-based interventions for psychosis.

Research Question

This systematic review sought to answer the following main research question:

- What is the prevalence of harm experienced by participants in mindfulness-based interventions for psychosis?

The question fulfils the Condition, Context, Population (CoCoPop) criteria for a review question pertaining to prevalence, as specified in Munn et al. (2018). The condition is harm, as operationalized by Ellett and Chadwick (2021), the context is mindfulness-based interventions, and the population is adults experiencing psychosis with schizophrenia spectrum diagnoses according to the DSM-5 or ICD-11 or earlier versions of either diagnostic system.

Method

Pre-Registration

The protocol for this review was pre-registered on PROSPERO on 31st August 2021 (ID: CRD42021274649). Subsequently, an amendment to the protocol was submitted to PROSPERO on 28th February 2022. This amendment reflected the identification, following the data extraction process, that enough studies had reported on some indices of harm such that meta-analyses of risk differences were possible. The number of studies reporting on each index of harm was not known prior to data-extraction which made pre-specification of meta-analyses at the time of pre-registration impossible. Therefore, to aid transparency and reproducibility of the protocol, an amendment to the protocol was made. The protocol summarised here reflects the original pre-registration with section entitled Data Analysis below describing the meta-analysis method in the amendment.

Search Strategy

The following databases were chosen for searching this review: PUBMED, PSYCINFO, EMBASE, and Web of Science. These were chosen as they were the databases used in previous systematic reviews and meta-analyses of mindfulness-based interventions for psychotic disorders (Cramer et al., 2016; Jansen et al., 2020; Khoury et al., 2013; Louise et al., 2018), which indicated a high likelihood of records of relevant studies being held in these databases. The first ten pages of Google Scholar were searched to identify any relevant grey literature as was previously done in a related study examining the safety of mindfulness interventions in other populations

(Wong et al., 2018). The reference lists of included studies were manually checked for any other relevant studies.

The electronic databases were searched using free-text terms on October 29th, 2021. The key search terms used were: (“psychosis” OR “psychotic” OR “schizophr*” OR “voice-hearer” OR “voice-hearing” OR “voices” OR “voice”) AND (“mindfulness” OR “mindful” OR “meditation” OR “acceptance“ OR “compassion” OR “loving-kindness”) AND (“randomised control trial” OR “randomised controlled trial” OR “RCT” OR “feasibility” OR “pilot” OR “randomized control trial” OR “randomized controlled trial”). Searches were conducted for titles and abstracts. It was decided, given that adverse events and harm may not be mentioned in the title or abstract of studies, the search would not include any terms related to this. Positive psychology terms were incorporated to ensure studies involving loving-kindness approaches, which incorporate mindfulness, were captured, as in Jansen et al. (2020). Studies reporting on yoga as an intervention were included only if they specifically incorporated a mindfulness component.

Searches were saved and the records were exported from the databases and imported into Covidence, a systematic review management platform, for title and abstract screening. Both title and abstract screening and full text review were conducted by both BV and SB, the second screener, independently on Covidence and consensus for conflicts was reached through discussion and reference to the inclusion and exclusion criteria.

Inclusion and Exclusion Criteria

A screening and selection tool was produced which contained the inclusion and exclusion criteria clearly summarized in a table, as in Table 1. This was used by both BV and SB for screening studies at full text review to ensure consistency of exclusion reason.

Table 1

Screening and Selection Tool Tabulation of Inclusion and Exclusion Criteria

Criteria	Include	Exclude
Patient Population	Adult patients aged 18 years or over with a diagnosed psychotic disorder from any classification system. Adults as above regardless of comorbidity. Studies with mixed age ranges such as 15-25, provided there are participants over the age of 18.	Patients under the age of 18 if the study exclusively focuses on these. Adults over the age of 18 years who have not received a diagnosis of a psychotic disorder.
Context	Any mindfulness-based intervention regardless of outcome. This includes group and individual interventions. Mindfulness-based interventions was inclusive of Acceptance and Commitment Therapy (ACT), Compassion-Focused Therapy (CFT), Person-Based Cognitive Therapy (PBCT), any intervention adapted from Mindfulness-Based Stress Reduction or Mindfulness-Based Cognitive Therapy, plus any intervention incorporating a specific component of mindfulness.	Any intervention which is not primarily mindfulness-based.
Condition	Any data on serious adverse events, adverse events, dropout rates, hospitalisation, utilisation of crisis or home treatment teams, and the number of individuals demonstrating symptom deterioration in each arm of a study. Include even if this data is missing provided correct population, context, and	

Criteria	Include	Exclude
	study design.	
Study Design	Randomised controlled trials. Feasibility and pilot studies which are randomised.	Any study design other than those specified.

Quality Assessment

The Cochrane Risk of Bias tool, while an appropriate quality assessment tool for randomized controlled trials, was not deemed suitable for this systematic review as it is designed to evaluate how inflated or underestimated treatment effect sizes are based on sources of bias (Sterne et al., 2019). Due to the focus on harm in this review, the CONSORT statement, which is a checklist which delineates items an RCT must include to ensure quality reporting, was deemed a more appropriate quality assessment tool (Moher et al., 2005). All domains of the tool were used for assessing the quality of studies in line with guidance on the usage of the statement. As there are 22 items, a total score out of 22 was calculated for each study.

Harm Operationalisation

The indices of harm recommended by Ellett and Chadwick (2021) in their operationalization of harm for research into mindfulness for psychosis are summarized in Table 2.

Table 2

Summary of the indices of harm recommended by Ellett and Chadwick (2021)

Harm Index	Definition
Serious Adverse Events	SAEs are defined as suicides, non-suicidal deaths, or hospitalization, regardless of whether there is an imputed causal connection between study participation or not.

Harm Index	Definition
Adverse Events	AEs are clinically relevant occurrences of detrimental impacts which cover the emotional, cognitive, social, functioning, and physiological domains and which are deemed clinically relevant to the potential effects of a psychological intervention. The following are non-exhaustive examples with respect to mindfulness studies: frequency and severity of self-harm, emotional distress due to increased awareness of stigma.
Side Effects	Side effects are harmful or unpleasant effects which occur in addition to the intended effects of an intervention and are distinct from adverse events. For instance, physical discomfort such as neck and back pain due to prolonged sitting in mindfulness interventions would be a side effect.
Symptom Deterioration	A clinically important deterioration on outcome measures used within a study, for instance, deterioration of the negative and positive symptoms of schizophrenia, or depression. It is essential to know the minimal clinically important difference in order to determine the clinical significance of symptom deterioration.
Therapy Drop Out	Participants who have dropped out during the intervention phase of a clinical trial.
Study Drop Out	Participants who have dropped out during the follow-up period of a clinical trial.
Non-Completion of Treatment	Those participants who did not complete an *a priori* specified number of sessions for which they would have been deemed to have completed treatment.

They recommend:

- That these indices are consistently reported on such that even the absence of any occurrences of these indices is explicitly stated and absolute numbers of those experiencing each index are recorded, for example, the absolute number of participants experiencing symptom deterioration. The amount of deterioration

and which outcome measures deterioration occurred on are vital additional information.

- That the reasons for therapy dropout are clearly reported as these may not necessarily be related to an experience of harm.
- That the method used for monitoring harm is explicitly described, whether this is using clinical records, an idiosyncratic measure, other methods, or combinations of methods.
- That there is public and patient involvement in the operationalization of harm in studies, for instance, consultation with people with lived experience of psychosis regarding what adverse events would be meaningful and important in the monitoring of harm.

These recommendations were used to inform data extraction of harm related outcomes from studies identified for this review.

Quality of Monitoring and Reporting of Harm Indices

To assess the quality of monitoring and reporting of indices of harm, the following questions, adapted from Loke et al. (2007), were addressed for each study extracted:

- Do the researchers provide definitions of the adverse events they monitor, report, or draw conclusions about?
- What method(s) were used for collecting data on adverse events and was the chosen method of data collection reported on clearly?
- Did the study include information on all the important serious adverse events, adverse events, and other indices of harm? Were these serious adverse events and adverse events defined to include relevant events to psychotherapeutic interventions?
- Were there any exclusions of participants from the analysis of harm indices within the study?
- Was the reporting of indices of harm complete and was data regarding different arms of the study kept separate?

Data Extraction and Study Outcomes

Just over a quarter of studies (10/38; 26%) were independently double extracted by SB and BV with the remaining 18/38 studies being extracted by BV only. The results of extraction for the double extracted studies were checked against each other and a small number of conflicts were resolved through discussion before consensus was reached. It is known that single extraction carries a greater risk of extraction errors (Buscemi et al., 2006) and to counteract this, BV systematically re-checked the data extraction of numerical data related to harm for each study to reduce the risk of errors.

The data extracted for this review included key background information about the studies, participants, and intervention and control conditions. The outcomes data extracted related to harm operationalization and indices, which are the focus of this review. This section included: harm defined in the study (yes/no), (if yes) definition of harm, harm reported on in the study (yes/no), serious adverse events defined (yes/no), (if yes) definition of SAEs, adverse events defined in the study (yes/no), (if yes) definition of AEs, SAEs and AEs collapsed (yes/no), consultation with people with personal experience in harm operationalization (yes/no), (if yes) impact of consultation, reporting of harm indicators separated by study arm (yes/no), data collection method for types of harm. Following this, the extraction template included a checklist of harm indices reported on in the study and separated by trial arm, which included: suicides (SAE), hospitalization (SAE), non-suicidal death (SAE), adverse events (AEs), intervention dropout, study dropout, non-completion of treatment, duration of hospitalization events, utilization of crisis and home treatment teams, symptom deterioration on outcome measures, and other. The template included a table for the absolute numbers of participants who experienced any of the harm indices to be summarized by trial arm, with further text boxes providing spaces for further details to be added related to each index (e.g., reasons for intervention dropout). Finally, the template captured the key conclusions of the study overall and any conclusions pertaining to harm.

Data Analysis

The absolute number of participants to experience each harm index was summed across studies to obtain the percentage prevalence of harm for each index by trial arm. For studies where more than two papers had provided data on how many

participants experienced an index, meta-analyses were conducted to determine whether risk differences between trial arms were statistically significant.

The meta-analyses of risk difference in this review followed a similar procedure to that conducted in Wong et al. (2018). Risk difference is defined as the difference between the risk of an outcome in the experimental group and the risk of an outcome in the control group (Higgins et al., 2022). Meta-analyses were conducted to combine the risk difference of individual studies and assess whether risk differences were significant using MedCalc® Statistical Software version 20.027 (2022). Statistical heterogeneity amongst the trials was assessed with a p value < 0.1 being considered to indicate significant heterogeneity (Higgins et al., 2003). Likewise, I^2, the observed total heterogeneity across studies that is due to real heterogeneity rather than chance, was calculated. Larger values indicate increasing heterogeneity whereas a value of 0% indicates no observed heterogeneity (Higgins et al., 2003). For trials in which there was statistically significant heterogeneity, a random effects model was used (DerSimonian & Laird, 1986), otherwise for trials with no significant heterogeneity, a fixed effects model was used (Mantel & Haenszel, 1959). The results of these analyses are presented numerically.

Results

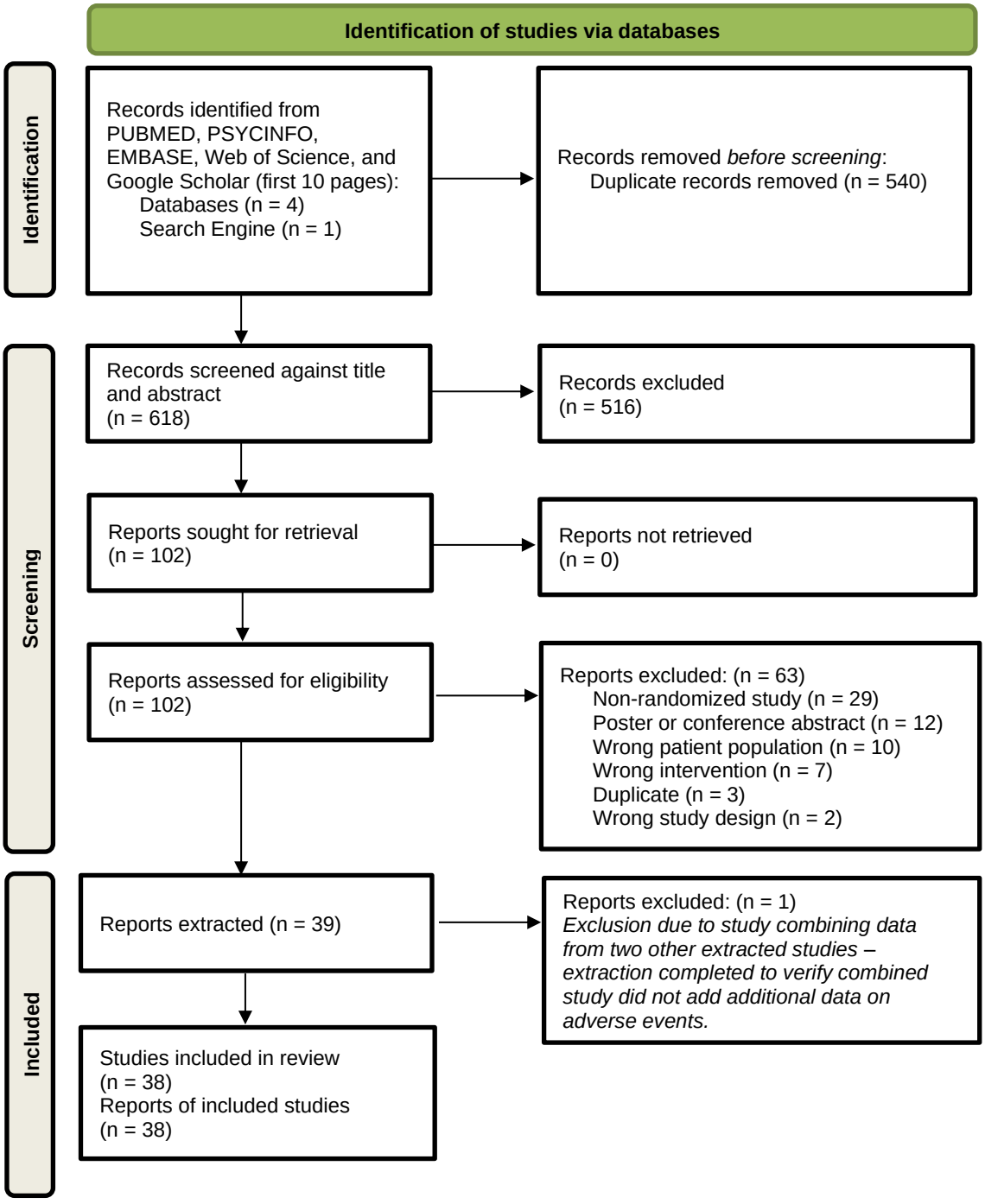
Literature Search and Selection

A total of 1158 references were imported into Covidence from across the four databases. A total of 4 studies were added from a manual search of the first 10 pages of Google Scholar in order to check for gray literature. Covidence automatically removed duplicates prior to screening. All titles and abstracts of the remaining records were double screened by BV and SB. 618 records were screened at this stage resulting in 516 records being excluded. Papers were imported manually to Covidence for the remaining 102 records. These papers were double screened at full text review by BV and SB and assessed according to the inclusion and exclusion criteria. For conflicts, consensus was reached through discussion and re-reviewing of the papers conjointly. A breakdown of the reasons for exclusion is provided in Figure 1. Data was extracted from a total of 39 reports were data extracted using a template developed on Covidence. This captured the items listed in section 2.5 One further report was excluded after data extraction due to this report (Bach et al., 2013) summarizing data from Bach and Hayes (2002) and Gaudiano and Herbert (2006) which were individually

extracted. This was after it had been confirmed that the paper combining the two studies did not add any additional data of relevance to this review. A total of 38 studies were retained for inclusion in this review and fully extracted.

Figure 1

PRISMA flowchart of literature search



Characteristics of Included Studies

This systematic review identified 38 relevant studies. Key characteristics of these studies including the country, study period, sample size, control type, intervention type, mean age, age range, female/male (%), intervention duration, and follow-up period length are provided in Table 3 along with study quality scores.

The total number of participants across the studies was 2638. The sample sizes of the studies reported upon ranged from 13 to 342 participants. 52% of the studies included were randomized controlled trials while the remaining 48% were randomized pilot studies, which reflects the substantial range of sample sizes. The studies were conducted in a variety of countries as follows: UK (n = 8), China (n = 6), USA (n = 5), Hong Kong (n = 4), Australia (n = 3), Spain (n = 3), Germany (n = 2), Taiwan (n = 2), Turkey (n = 2), Canada (n = 2), Egypt (n = 1), Chile (n = 1), and Sweden (n = 1). One study was a multi-site trial conducted across China, Hong Kong, and Taiwan. Participants were recruited from a variety of different study locations, such as psychiatric inpatient wards, community mental health services, early intervention for psychosis services, medium-secure forensic services, psychiatric rehabilitation services, veterans' health administration inpatient wards, psychiatric day or outpatient clinics, clinical psychology services, veterans' affairs psychosocial rehabilitation and recovery centers, as well as via community advertisements and finally the internet in the sole bibliotherapy study.

The mean age of participants ranged from 23.6 years old to 59.76 years old. The mean percentage of female participants was 38% (SD = 20%) and the percentage ranged from 0% to 100%. The number of planned sessions ranged from 4 to 40 sessions while the duration of intervention in weeks ranged from 1 to 26. 12 studies had no follow-up period, whereas for those with a follow-up period this ranged from 3 to 24 months. There was diversity in the types of interventions used in the studies which included the following: Acceptance and Commitment Therapy or ACT (n = 10), Mindfulness-Based Interventions which varied in content (n = 9), Mindfulness-Based Psychoeducation Program or MBPP (n = 6), Acceptance-Based Depression and Psychosis Therapy or ADAPT (n = 2), Person-Based Cognitive Therapy or PBCT (n = 1), Compassion Focused Therapy (n = 1), Mindfulness-Based Stress Reduction or MBSR (n = 1), Mindfulness-Based Cognitive Therapy or MBCT (n = 1), Mindfulness Intervention for Rehabilitation and Recovery in Schizophrenia or MIRRORS (n = 1), Treatment of Resistant Command Hallucinations (n = 1), Mindfulness Ambassador

Program or MAP (n = 1), and Integrated Coping Awareness Therapy or I-CAT (n = 1), yoga with a meditation component (n = 1), and mindfulness bibliotherapy (n = 1).

Table 3

Characteristics of included studies of mindfulness-based interventions for psychosis

Study (Year)	Country	Study Period	Type of Control	Sample Size	Mean Age	Age Range	Female/ Male (%)	Intervention Type	Duration of Intervention (Sessions/Weeks)	Follow-Up Period (Months)	CONSORT Study Quality Score (/22)
Bach and Hayes (2002)	United States	NR	TAU	80	(IA) 39.2 (CA) 39.5	NR	36/64	ACT; individual	4 sessions/2 weeks	4	13
Boden et al. (2016)	United States	NR	TAU	18	53.4	NR	0/100	ACT; individual	4 sessions/variable inpatient stay	No follow-up	7
Böge et al. (2021)	Germany	2018-2019	TAU	40	(IA) 37.71 (CA) 42.74	NR	40/60	MBI; group	12 sessions/4 weeks	3	19
Braehler et al. (2013)	United Kingdom	NR	TAU	40	(IA) 43.2 (CA) 40.0	NR	45/55	CFT; group	16 sessions/20 weeks	No follow-up	16
Budak and Yilmaz (2019)	Turkey	NR	TAU	50	NR	18-61	46/54	Yoga including meditation; group	40 sessions/8 weeks	No follow-up	13
Chadwick et al. (2009)	United Kingdom	NR	Wait List	21	NR	NR	NR	MBI; group	10 sessions/5 weeks	No follow-up	15
Chadwick et al. (2016)	United Kingdom	2012-2014	TAU	108	42.0	18-65	50/50	PBCT; group	12 sessions/12 weeks	10	20

Study (Year)	Country	Study Period	Type of Control	Sample Size	Mean Age	Age Range	Female/ Male (%)	Intervention Type	Duration of Intervention (Sessions/Weeks)	Follow-Up Period (Months)	CONSORT Study Quality Score (/22)
Chien and Lee (2013)	China	2010-2012	TAU	96	25.8	19-41	45/55	MBPP; group	12 sessions/6 weeks	18	14
Chien and Thompson (2014)	China	2010-2013	1. Psycho-education program 2. TAU	107	(IA) 25.1 (CA1) 25.8 (CA2) 26.0	NR	43/57	MBPP; group	12 sessions/24 weeks	24	17
Chien et al. (2017)	China, Hong Kong, Taiwan	2013-2016	1. Psycho-education program 2. TAU	342	(IA) 25.1 (CA1) 25.8 (CA2) 26.0	NR	37/63	MBPP; group	12 sessions/24 weeks	24	21
Chien et al. (2019)	China	2014-2016	1. Psycho-education program 2. TAU	180	(IA) 24.2 (CA1) 25.8 (CA2) 25.4	NR	44/56	MBPP; group	12 sessions/24 weeks	18	21
Davis et al. (2015)	United States	2009-2010	Matched time and attention sessions	34	(IA) 53.2 (CA) 50.1	NR	3/97	MIRRORS; group	16 sessions/16 weeks	6	16
El Ashry et al. (2021)	Egypt	2018-2019	TAU	70	27.69	21-32	0/70	ACT; individual	6 sessions/6 weeks	3	12

Study (Year)	Country	Study Period	Type of Control	Sample Size	Mean Age	Age Range	Female/ Male (%)	Intervention Type	Duration of Intervention (Sessions/Weeks)	Follow-Up Period (Months)	CONSORT Study Quality Score (/22)
Ellett et al. (2020)	United Kingdom	NR	TAU	27	NR	NR	22/78	MBI; group	12 sessions/12 weeks	No follow-up	13
Gaudiano and Herbert (2006)	Australia	NR	Enhanced TAU	40	40.0	NR	38/62	ACT; individual	4 sessions/flexible*	4	19
Gaudiano et al. (2015)	United States	NR	Enhanced TAU	13	(IA) 44.8 (CA) 54.6	NR	54/46	ADAPT; individual	16 sessions/16 weeks	3	14
Gumley et al. (2017)	United Kingdom	NR	TAU	29	46.5	NR	66/34	ADAPT; individual	15 sessions/20 weeks	10	20
Halverson et al. (2021)	United States	2016-2020	TAU	38	(IA) 23.6 (CA) 24.9	NR	47/53	I-CAT; individual	24 sessions/24 weeks	3	17
Jacobsen et al. (2020)	United Kingdom	2015-2018	Social Activity Therapy	50	34.0	18-65	32/68	MBCI; individual	5 sessions (max)/weekly or daily	12	21
Jolley et al. (2020)	United Kingdom	2013-2019	Wait List	44	(IA) 43.3 (CA) 43.1	NR	55/45	ACT; combined group**	6 sessions/4 weeks, 2 boosters	3	16
Lam et al. (2020)	Hong Kong	NR	TAU	52	NR	25-55+	76/24	MBPP; group	8 sessions/8 weeks	3	21

Study (Year)	Country	Study Period	Type of Control	Sample Size	Mean Age	Age Range	Female/ Male (%)	Intervention Type	Duration of Intervention (Sessions/Weeks)	Follow-Up Period (Months)	CONSORT Study Quality Score (/22)
Langer et al. (2012)	Spain	NR	Wait List	23	(IA) 34.7 (CA) 33.9	NR	(IA) 49/51 (CA) 36/64	MBI; group	8 sessions/8 weeks	No follow-up	7
Langer et al. (2020)	Chile	NR	TAU	45	(IA) 24.0 (CA) 23.6	NR	(IA) 38/62 (CA) 5/95	MBI; group	8 sessions/8 weeks	3	15
Lee (2019)	Taiwan	NR	Rehabilitative Interventions	60	(IA) 54.43 (CA) 51.15	NR	NR	MBI; group	8 sessions/8 weeks	3	12
Lopez-Navarro et al. (2015)	Spain	NR	Integrated Rehabilitation	44	(IA) 38.73 (CA) 38.77	NR	18/82	MBI; group	26 sessions/26 weeks	No follow-up	19
López-Navarro et al. (2020)	Spain	2013-2015	Integrated Rehabilitation	52	(IA) 39.42 (CA) 40.14	NR	21/79	MBI; group	26 sessions/26 weeks	No follow-up	17
MacDougall et al. (2019)	Canada	NR	TAU	21	23.71	NR	24/76	MAP; group	12 sessions/12 weeks	No follow-up	18
Mak et al. (2021)	Hong Kong	2015-2016	Social Support	130	(IA) 49.7 (CA) 50.0	NR	14/86	ACT; individual	10 sessions/10 weeks	12	20

Study (Year)	Country	Study Period	Type of Control	Sample Size	Mean Age	Age Range	Female/ Male (%)	Intervention Type	Duration of Intervention (Sessions/Weeks)	Follow-Up Period (Months)	CONSORT Study Quality Score (/22)
Moritz et al. (2015)	Germany	NR	PGMR Manual	90	(IA) 38.11 (CA) 37.46	NR	58/42	Mindfulness bibliotherapy; individual	6 weeks	No follow-up	14
Özdemir and Kavak Budak (2021)	Turkey	2018-2020	1. Psycho-education program 2. TAU	156	(IA) 43.55 (CA1) 43.36 (CA2) 44.51	NR	23/77	MBSR; group	8 sessions/8 weeks	3	16
Shawyer et al. (2012)	Australia	2003-2005	Befriending	43	(IA) 40.0 (CA) 39.6	NR	44/56	TORCH; individual	15 sessions/15 weeks	6	20
Shawyer et al. (2017)	Australia	NR	Befriending	96	(IA) 35.6 (CA) 33.0	NR	39/61	ACT; individual	8 sessions/12 weeks	6	21
Shen et al. (2021)	China	NR	Rehabilitation Interventions	100	(IA) 59.24 (CA) 59.76	NR	32/68	MBI; group	30 sessions/6 weeks	No follow-up	16
Spidel et al. (2018)	Canada	NR	TAU	50	40.4	19-64	52/48	ACT; group	8 sessions/8 weeks	3	13

Study (Year)	Country	Study Period	Type of Control	Sample Size	Mean Age	Age Range	Female/ Male (%)	Intervention Type	Duration of Intervention (Sessions/Weeks)	Follow-Up Period (Months)	CONSORT Study Quality Score (/22)
Tang et al. (2021)	China	NR	TAU	62	(IA) 47.16 (CA) 48.13	NR	100/0	MBCT; group	8 sessions/8 weeks	No follow-up	14
Tyrberg et al. (2017)	Sweden	2013	TAU	22	(IA) 42.5 (CA) 39.0	NR	38/62	ACT; individual	4 sessions; weekly or daily	4	16
Wang et al. (2016)	Hong Kong	2014-2015	1. Psycho-education program 2. TAU	138	(IA) 23.8 (CA1) 24.1 (CA2) 25.0	NR	48/52	MBPP; group	12 sessions/24 weeks	6	22
White et al. (2011)	United Kingdom	NR	TAU	27	(IA) 33.57 (CA) 34.54	NR	22/78	ACT; individual	10 sessions/10 weeks	3	19

Notes: ACT: Acceptance and Commitment Therapy; CFT: Compassion Focused Therapy; MBI: Mindfulness-Based Intervention; PBCT: Person Based Cognitive Therapy; MBPP: Mindfulness-Based Psychoeducation Program; MIRRORS: Mindfulness Intervention for Rehabilitation and Recovery in Schizophrenia; ADAPT: Acceptance-Based Depression and Psychosis Therapy; I-CAT: Integrated Coping Awareness Therapy; MBCI: Mindfulness-Based Crisis Intervention; MAP: Mindfulness Ambassador Program; TORCH: Treatment of Resistant Command Hallucinations; MBCT: Mindfulness-Based Cognitive Therapy; MBSR: Mindfulness-Based Stress Reduction; NR: Not Reported
*Flexible: flexibly implemented sessions where each 1-hr session is stand-alone, containing core mindfulness and acceptance themes.
** Combined Group: the group sessions were provided for service users and their caregivers in combination.

Mindfulness-Based Interventions for Psychosis and Intervention Outcomes

The types of mindfulness-based interventions included 14 distinct interventions which all contained a focus on mindfulness training. Of the 38 interventions, 13 (34%) were delivered individually while 24 (63%) were delivered in a group format. One intervention was delivered as bibliotherapy in a self-help format. The studies examined a range of intervention targets as summarized in Table 4.

Table 4

The range of intervention targets for mindfulness-based interventions

Study	Mindfulness-Based Intervention Target (or Study Outcomes for Pilots)
Bach and Hayes (2002)	a. Believability of positive symptoms. b. Rehospitalization rates.
Boden et al. (2016)	a. Recruitment of 2 eligible participants per week for 40 weeks. b. Occurrence of zero adverse events. c. Patient attendance at 75% of sessions on average.
Böge et al. (2021)	Primary a. Mindfulness ability. Secondary b. Positive and negative symptoms of schizophrenia. c. Depression. d. Social functioning. e. Psychological flexibility. f. Quality of life.
Braehler et al. (2013)	Primary a. Compassion to self. b. Avoidance of symptoms. Secondary c. Depression. d. Positive and negative affect. e. Negative beliefs about psychosis. f. Fear of recurrence.
Budak and Yilmaz (2019)	a. Clinical insight. b. Medication adherence.
Chadwick et al. (2009)	Primary a. Functioning. Secondary b. Mindfulness ability.

Study	Mindfulness-Based Intervention Target (or Study Outcomes for Pilots)
Chadwick et al. (2016)	a. Distress related to voice-hearing. b. Severity of voice-hearing. c. Goals related to CBTp for psychosis.
Chien and Lee (2013)	a. Psychosocial functioning. b. Insight into illness. c. Rehospitalization rates.
Chien and Thompson (2014)	a. Positive and negative symptom severity. b. Psychosocial functioning. c. Social support. d. Insight into illness. e. Rehospitalization rate and duration of readmissions.
Chien et al. (2017)	a. Psychosocial functioning. b. Insight into illness. c. Positive and negative symptom severity. d. Rehospitalization rate.
Chien et al. (2019)	a. Psychosocial functioning.
Davis et al. (2015)	a. Work functioning (performance and weekly hours worked).
El Ashry et al. (2021)	a. Auditory hallucinations physical, emotional and cognitive characteristics. b. Acceptance of auditory hallucinations. c. Ability to act autonomously.
Ellett et al. (2020)	a. Depression.
Gaudiano and Herbert (2006)	a. Frequency, believability, and distress related to psychotic symptoms. b. Level of disability. c. Rehospitalization rates.
Gaudiano et al. (2015)	a. Depression. b. Positive and Negative Symptom Severity. c. Level of Disability. d. Psychological Flexibility.
Gumley et al. (2017)	a. Depression.
Halverson et al. (2021)	a. Positive and negative affect. b. Stress. c. Functioning. d. Quality of life.

Study	Mindfulness-Based Intervention Target (or Study Outcomes for Pilots)
Jacobsen et al. (2020)	Primary a. Recruitment rate relative to benchmark. b. Dropout rate. c. Session completion rate. d. Adverse events and reasons for drop out. e. Qualitative feedback. Secondary f. Rehospitalization rates. g. Time to re-admission. h. Occupied bed days. i. Episodes of care with CRHTT. j. CMHT contact. k. Relapse rate. l.
Jolley et al. (2020)	Primary a. Well-being. b. Distress. Secondary c. Functioning. d. Psychotic symptoms. e. Recovery process.
Lam et al. (2020)	a. Emotion regulation (rumination, cognitive appraisal, suppression).
Langer et al. (2012)	a. Mindfulness ability.
Langer et al. (2020)	a. Cognitive function.
Lee (2019)	a. Negative symptoms of schizophrenia.
López-Navarro et al. (2015)	Primary a. Health-related quality of life. Secondary b. Environmental, social, and physical quality of life. c. Frequency and intensity of psychotic symptoms. d. Mindfulness ability.
López-Navarro et al. (2020)	a. Inhibitory control.
MacDougall et al. (2019)	Primary a. Acceptability measured by attendance and client satisfaction. Secondary b. Recruitment and retention rates. c. Dropout rates.

Study	Mindfulness-Based Intervention Target (or Study Outcomes for Pilots)
	Ancillary a. Psychotic symptom severity. b. Mindfulness ability. c. Wellbeing.
Mak et al. (2021)	a. Smoking abstinence for 7 days. b. Self-reported quit rates. c. Biochemically validated quit rates.
Moritz et al. (2015)	a. Depression. b. Paranoia. c. Obsessive-compulsive symptom severity.
Özdemir and Kavak Budak (2021)	a. Hope. b. Wellbeing. c. Functional recovery.
Shawyer et al. (2012)	Primary a. Compliance with harmful command hallucinations. Secondary b. Illness severity. c. Functioning. d. Distress related to command hallucinations. e. Quality of life.
Shawyer et al. (2017)	a. Positive and negative symptoms.
Shen et al. (2021)	a. Negative symptoms. b. Cognitive function.
Spidel et al. (2018)	a. Psychotic symptom severity. b. Trauma symptom severity. c. Treatment adherence.
Tang et al. (2021)	a. Stigma.
Tyrberg et al. (2017)	Primary a. Rehospitalization rates. Secondary b. Values-based living. c. Psychotic symptom severity. d. Acceptance of voices.
Wang et al. (2016)	Primary a. Functioning. b. Rehospitalization rates. Secondary a. Insight into illness.

Study	Mindfulness-Based Intervention Target (or Study Outcomes for Pilots)
	b. Psychotic symptom severity. c. Progress of recovery.
White et al. (2011)	a. Emotional dysfunction.

Quality of Studies

Studies were given a score out of 22 based on their assessment against the quality standards of the CONSORT statement checklist (Moher et al., 2005). The scores ranged from 7 to 22 with a mean score of 16 (SD = 4). 11/38 (29%) of studies suffered from a risk of detection bias due to lack of blinding of researchers assessing outcomes. On the adverse events item of the CONSORT checklist, only 8/38 (21%) studies explicitly mentioned adverse events.

No studies provided an explicit operationalization of harm although 39% of studies reported on harm without operationalizing this clearly. Similarly, no studies consulted with persons with lived experience in decision-making regarding harm operationalization. 2/38 (5%) provided a definition of serious adverse events. Gumley et al. (2017, p. 145) defined a serious adverse event in accordance with the National Research Ethics Service (NRES) as “any occurrence that (a) result in death, (b) was life threatening, (c) required hospitalization or prolongation of existing hospitalization, (d) resulted in persistent or significant disability or incapacity, (e) was considered otherwise medically significant by the Chief Investigator.” Jacobsen et al. (2020, p.5) defined a collapsed category of serious adverse events and adverse events “as specified by the NHS REC (research ethics committee)” to include “death, hospitalization, disability, birth defect”. Similarly, only 2/38 (5%) of studies defined adverse events, Jacobsen et al. (2020) as already stated and Jolley et al. (2020, pp. 533-534) as “clinically unexpected deterioration in presentation or harm, identified by participants or treatment teams, or other informal support, or the research team, that was attributable to study participation.” Again, only 2/38 (5%) of studies listed lack of monitoring and reporting on harm as a study limitation.

Despite minimal operationalization of harm, SAEs or AEs, 23/38 (61%) of studies separated reporting of harm indices, as operationalized in this review to include therapy dropout, by trial arm. For those that reported on other indices of harm, these

studies also separated reporting by trial arm. With regards to data collection, 10/38 (26%) of studies reported on the method of data collection used for harm indices. Of these, 9/10 (90%) used review of clinical or insurance records (depending on country) to gather this data, particularly with reference to rehospitalization rates, while one study used outcome assessments to collect harm-related data. Böge et al. (2021, p. 139) reported that “after every group session, severe adverse effects were assessed” and reported that no adverse effects were found but they did not specify their definition of SAEs nor did they describe the method of assessing this.

Prevalence of Harm Indices

As shown in Table 5, the percentage of studies reporting on different indices of harms varied substantially, with 0% of studies reporting on side effects of interventions compared to 94.7% of studies reporting on intervention dropout. The mean percentage of studies reporting on any index of harm was 27% (SD = 30%).

Adverse events were idiosyncratically reported across studies without clear operationalizations as stated earlier. In Jacobsen et al. (2020), a total of five adverse events were reported for three participants, one in the intervention arm and two in the control condition. These included one minor assault, three medication overdoses not requiring medical intervention, and one accidental fall, none of which were related to the trial condition. This is, however, illustrative of the range of adverse events which may occur during a trial, and which are unlikely to be captured unless directly monitored despite having relevance to psychotherapeutic interventions. For instance, it is notable that no studies included in this review monitored self-harming behaviors. While not directly reported on as adverse events, Braehler et al. (2013) described that one CFT participant demonstrated an increased preoccupation with the stigma associated with his diagnosis and needed to be offered individual support following post-assessment.

Deaths were reported on in 10/38 (26%) studies. The specific details of these were as follows: one in each arm died without any statement regarding whether death related to the trial (Bach & Hayes, 2002); one person in the intervention arm died of natural causes not related to the trial (Braehler et al., 2013); two people died and their deaths were deemed unrelated to the trial by a Trial Steering Committee (Chadwick et al., 2016); one person died prior to the intervention commencing (Chien & Thompson, 2014); one person died of medical illness (Chien et al., 2017); four people died across

the five-year follow-up period with the earliest death post-dating the intervention by six months, leading to participation in the trial not being implicated (Jolley et al., 2020); and finally, one died of an acute medical problem after allocation (Lam et al., 2020). None of the deaths were linked to trial participation and no suicidal deaths were reported across the studies. However, it was not always transparent whether reported deaths were suicidal or not.

Hospitalisations, as captured here, contains both hospitalization following being in the community and re-hospitalization following recent discharge from inpatient care. Hospitalization rates are summarized from data collected across the entire study period; however, it was not possible to sum rehospitalization rates for all papers. In particular, Chien and Lee (2013), Chien and Thompson (2014), Chien et al. (2017), and Wang et al. (2016) report on rehospitalization data in such a way that it is summed across time periods which do not permit the reader to calculate the total number of rehospitalizations or identify whether a participant has been re-hospitalized just once or more than once. The corresponding author was contacted in February 2022 without response. Hence, this data was not extracted for inclusion in this systematic review.

A range of *a priori* benchmarks were used in those studies reporting on non-completion of treatment as follows: attending fewer than half of the sessions (Chadwick et al., 2009); not completing the minimum eight sessions (Chadwick et al., 2016); absence for more than four sessions (Chien & Thompson, 2014); attending less than 4 sessions (Chien et al., 2017); failure to complete the minimum of five sessions (Chien et al., 2019); attending less than 10 sessions (Gumley et al., 2017); attending less than the minimum of nine sessions, which corresponded to participating in a minimum of one session of each phase of I-CAT (Halverson et al., 2021); not attending the minimum of one session (Jolley et al., 2020); attending less than 6 sessions (Lam et al., 2020); attending less than 50% of the time (Langer et al., 2012); completing less than the minimum of four sessions (Lee, 2019); completing less than 12 sessions (Shawyer et al., 2012); not completing the full eight sessions (Shawyer et al., 2017); and failure to complete five sessions (Wang et al., 2016).

There was only one study (Halverson et al., 2021) which excluded participants from the analysis of indicators of harm and this entailed two in each condition being excluded due to early withdrawal. Across the studies, a wide range of reasons were given for intervention and study dropout. These are broken down by arm. In the intervention arm, this included: feelings of paranoia; recommencing substance misuse;

finding it difficult to be in a group; moving away; risk to the therapist; seeing no benefit to meditation; wanting a break from outpatient care. In the control arm, it included: feelings of paranoia; starting college full time; poor physical health; finding group membership difficult; moving away; assessments made the person feel worse; not wanting to complete the post-measures; command hallucinations contributing to the decision to withdraw. This highlights the diversity of reasons for dropout, with an unaddressed issue being that of causal relatedness of dropout to the intervention.

Outcome measure deterioration was reported in Chien and Thompson (2014) for the control group where scores on the Specific Level of Functioning measure consistently reduced over time. Similarly, Chien et al. (2017) reported mild-moderate deterioration on most outcome measures in the control group, and Ellett et al. (2020) reported one person in treatment as usual (TAU) displaying a clinically meaningful deterioration in depression. Finally, Gaudiano et al. (2015) reported reliable worsening on the reliable change index for one patient each in the intervention and control conditions on the Acceptance and Action Questionnaire – II which measures psychological flexibility. No other studies reported on symptom deterioration for individuals or specified whether they had collected this information.

Table 5

Summary of studies reporting firstly on each index of harm and secondly on overall prevalence of harm per index for the intervention arms (IA) and control arms (CA), including both active and inactive control groups

Index of Harm	Reporting Studies	Percentage of Total Studies	Prevalence of Harm (IA)	Prevalence of Harm (CA)
Suicide	Gumley et al. (2017); Jacobsen et al. (2020)	5.3%	0/41 (0%)	0/38 (0%)
Hospitalization	Lopez-Navarro et al. (2020); Langer et al. (2020); Jolley et al. (2020); Tyrberg et al. (2017); Bach et al. (2002); El-Ashry et al. (2021); Lopez-Navarro et al. (2015); Wang (2016); Gumley et al. (2017); Gaudiano et al. (2006); Jacobsen et al. (2020); Ellett et al.	34.2%	58/383 (15.1%)	150/424 (35.4%)

Index of Harm	Reporting Studies	Percentage of Total Studies	Prevalence of Harm (IA)	Prevalence of Harm (CA)
	(2020); Mak et al. (20211)			
Non-Suicidal Death	Mak et al. (2021); Chien et al. (2017); Chien et al. (2014); Jolley et al. (2020); Bach et al. (2002); Gumley et al. (2017); Lam et al. (2020); Braehler et al. (2013); Jacobsen et al. (2020); Chadwick et al. (2016)	26.3%	8/415 (1.9%)	5/582 (0.9%)
Adverse Events	Lam et al. (2020); Jacobsen et al. (2020); Ellett et al. (2020)	7.9%	3/66 (4.5%)	2/63 (3.2%)
Intervention Dropout	Shen et al. (2021); Lopez-Navarro et al. (2020); Özdemir et al. (2021); Tang et al. (2021); Chien et al. (2013); Langer et al. (2020); Moritz et al. (2015); Boden et al. (2016); Mak et al. (2021); Chien et al. (2017); Jolley et al. (2020); Tyrberg et al. (2017); Bach et al. (2002); El-Ashry et al. (2021); Lopez-Navarro et al. (2015); Wang et al. (2016); Spidel et al. (2018); Shawyer et al. (2017); Chien et al. (2019); Boge et al. (2021); Halverson et al. (2021); Langer et al. (2012); Gumley et al. (2017); Lam et al. (2020); MacDougall et al. (2019); Shawyer et al. (2012); Davis et al. (2015); Gaudiano et al. (2006); Braehler et al. (2013); White et al. (2011); Gaudiano et al. (2015); Jacobsen et al. (2020); Ellett et al.	94.7%	91/1117 (8.1%)	92/1413 (6.5%)

Index of Harm	Reporting Studies	Percentage of Total Studies	Prevalence of Harm (IA)	Prevalence of Harm (CA)
	(2020); Chadwick et al. (2016); Chadwick et al. (2009)			
Study Dropout	Özdemir et al. (2021); Chien et al. (2013); Langer et al. (2020); Mak et al. (2021); Chien et al. (2017); Chien et al. (2014); Jolley et al. (2020); Tyrberg et al. (2017); El-Ashry et al. (2021); Wang et al. (2016); Spidel et al. (2018); Shawyer et al. (2017); Chien et al. (2019); Boge et al. (2021); Halverson et al. (2021); Gumley et al. (2017); Lam et al. (2020); Gaudiano et al. (2006); Jacobsen et al. (2020); Ellett et al. (2020); Chadwick et al. (2016); Chadwick et al. (2009)	55.3%	75/784 (9.6%)	113/1087 (10.4%)
Non-Completion of Treatment	Chien et al. (2017); Chien et al. (2014); Jolley et al. (2020); Lee et al. (2019); Wang et al. (2016); Shawyer et al. (2017); Chien et al. (2019); Halverson et al. (2021); Langer et al. (2012); Gumley et al. (2017); Lam et al. (2020); Shawyer et al. (2012); Chadwick et al. (2016); Chadwick et al. (2009)	36.8%	66/513 (12.9%)	36/754 (4.8%)
Utilization of Crisis and Home Treatment Teams	Jolley et al. (2020); Jacobsen et al. (2020)	5.3%	2/47 (4.3%)	9/44 (20.5%)
Symptom Deterioration	Gaudiano et al. (2015); Ellett et al. (2020)	5.3%	1/20 (5.0%)	2/20 (10.0%)

Index of Harm	Reporting Studies	Percentage of Total Studies	Prevalence of Harm (IA)	Prevalence of Harm (CA)
on Outcome Measures				
Side Effects	No studies.	NR	NR	NR

Note: NR abbreviates not reported.

Meta-analyses of Risk Differences

Meta-analyses of risk difference (RD) were conducted as described in the amended protocol. Meta-analyses were conducted for each suitable index for which two or more studies had reported on it as this is the minimum number for which a meta-analysis can be conducted (Ryan, 2016). The meta-analyses compared the relevant risk differences between the intervention and the control group for the following indices: intervention dropout and hospitalizations. The other indices were not considered suitable for meta-analysis due to either: insufficient numbers of participants to justify a meta-analysis; too much disparity in definitions of the index across studies (or lack of clarity regarding definitions); too much disparity in the method of recording. For example, a meta-analysis was not conducted for symptom deterioration on outcome measures due to the lack of commonality between the outcome measures on which symptom deterioration could occur. Similarly, adverse events were not meta-analyzed due to inconsistency in the definition of adverse events across studies.

For intervention dropout, heterogeneity was not found across the trials (I^2 = 0.00%) and therefore a fixed effects model was used. This demonstrated comparable levels of intervention dropout between mindfulness-based interventions and controls (91/1117 vs 92/1413; RD (95% CI) = 0.0158 (-0.00555 to 0.0371), p = 0.147).

For hospitalization, heterogeneity was found across the trials (I^2 = 83.99%) and therefore a random effects model was used. This demonstrated significantly different levels of hospitalization between the intervention and control groups (58/383 vs 150/424; RD (95% CI) = -0.131 (-0.224 to -0.0381), p = 0.006), indicating there was a higher risk of hospitalization in the control group.

Discussion

The findings of this systematic review and meta-analysis on the safety of MBIs for psychosis offer no indication that mindfulness for psychosis is harmful. Data on harm collected in the reviewed trials suggest that SAEs and AEs occur at similar rates in MBIs and control conditions based on the levels of reporting of these events to date. Findings indicate MBIs may even reduce risk of certain kinds of harm, for instance, hospitalization. These findings echo the tentative findings in Baer et al. (2019) review of MBIs in the non-psychosis literature.

However, a chief finding of the present study is that published randomized trials have paid insufficient attention to the monitoring and reporting of harm and adverse events in research on MBIs for psychosis. For example, only 21% of studies reported on adverse events in some way, with only 5% of studies defining serious adverse events clearly and 5% defining adverse events. Many studies concluded that no adverse events occurred without first providing an adequate definition of adverse events. Likewise, several studies concluded that their chosen mindfulness-based intervention was safe without sufficiently monitoring and reporting harm, which suggests premature conclusions are being drawn regarding the safety of mindfulness-based interventions. Only 5% of studies discussed as a study limitation a lack of monitoring and reporting on harm, which suggests further efforts need to be made to ensure widespread awareness of the need for adequate data collection and reporting on harms.

Whilst therapy drop-out is not a direct index of harm, it is considered in studies of harm in psychotherapy, where it is vitally important to establish the reason for drop-outs, as it could be circumstantial, due to early success of therapy, or due to dissatisfaction with therapy (Lilienfeld, 2007). For the harm-related data obtained for which meta-analysis could be justified, it was found that there were comparable levels of intervention dropout between intervention and control conditions in trials of MBIs for psychosis. However, this result needs to be interpreted cautiously, as while a range of reasons for intervention dropout were provided in the studies included here, how many dropouts were directly related to the intervention itself and its effects versus due to circumstantial events was not sufficiently clearly delineated across the studies. This places marked limitations upon interpreting intervention dropouts as a proxy of harm in trials. It was also found that there was a significantly higher level of risk of hospitalization in control conditions relative to intervention conditions across the trials.

Due to variations in the periods of time over which this data was collected, this also requires interpreting with a degree of caution; however, this index of harm has been more robustly monitored in the literature to date than others. This finding suggests that MBIs may contribute to a reduction in hospitalization rates relative to control conditions.

The index non-completion of therapy was challenging to compare across studies due to the variety in how this was defined. The lack of a clear benchmark for what counts as non-completion means meaningful conclusions could not, at present, be drawn about this aspect of the data.

Some studies drew conclusions which underlined the need for more individualized monitoring of outcomes and whether any beneficial effects or detrimental effects of intervention were experienced. For instance, Bach and Hayes (2002) note that in the ACT condition in their study, one third of delusional participants, who continued to deny symptoms, did not experience any beneficial effect of the intervention. This reflects a substantial proportion of the participants and indicates that nuanced monitoring of who, within the diverse population of people diagnosed with schizophrenia spectrum disorders, benefits most and least from mindfulness-based interventions would greatly inform the understanding of this intervention, its generalizability, and its safety.

A further major issue pertains to the use of clear language around harm and adverse events. For instance, the Cochrane handbook suggests drawing a distinction between adverse events, unfavorable or harmful outcomes that occur during or after an intervention but which are not necessarily caused by it, and adverse effects or harms for which a causal relationship between the intervention and the event is a “reasonable possibility” (Peryer et al., 2022). It would be informative for future trials of MBIs for psychosis to draw this distinction and collect data on both adverse events and adverse effects, with what is classed as each of these specifically defined and absolute numbers of each type of effect and event recorded.

Similarly, Baer et al. (2019) propose that types of harm in MBIs fall into the three categories of program-, participant- and clinician-related effects and it would be useful if future trials demarked these categories and which types of harm data they collect fall into each, to ensure coverage of the different kinds of relevant harm. This could be done using public and patient involvement (PPI), as suggested by Ellett and Chadwick (2021), to determine the most relevant types of harm, which are likely to be

different from those used in medical trials (Duggan et al., 2014). For instance, it is reported in the wider field of mindfulness research that mindfulness practitioners experience common unwanted effects of mindfulness that include greater self-criticism (3.1%), greater emotional pain (2.7%), less motivation in life (1.5%) and a feeling of being alienated from society (4.6%) as reported by Cebolla et al. (2017). Thus, there are clearly more potential unwanted or harmful effects of mindfulness interventions which ought to be organized with respect to which are most relevant or potentially most harmful, and then collected and reported on.

Strengths and Limitations

A strength of this systematic review is that it followed a transparent and reproducible protocol which was amended on PROSPERO to reflect an updated plan. This was justifiable given that the quality of reporting of indices of harm was not known in advance and this systematic approach took a hybrid approach to reviewing adverse events, as stated earlier. The ability to perform meta-analyses was limited by the heterogeneity in definition and data collection methods for indices of harm, as well as the small numbers of participants for which different indices were reported on.

A further strength is that this review used a clear operationalization of harm using indices of harm derived from the recommendations of Ellett and Chadwick (2021). This provides a framework which researchers could utilize in future trials of MBIs for psychosis to ensure they adequately monitor and report upon harm.

A limitation of this systematic review is that it solely focused on the safety of mindfulness-based interventions rather than a detailed discussion of the benefits vs harms of what is known to date. This was decided as previously reviews, such as Jansen et al. (2020), have systematically reviewed the therapeutic outcomes of MBIs for psychosis, however, a systematic review of safety had not been completed previously. There is also insufficient data available on harm for a thorough, weighted, and evidenced discussion of the relative harms and benefits to occur. This study is also limited with regards to space for unpacking the many nuanced differences between the mindfulness interventions delivered across trials. Given the variability in these interventions, the amount of mindfulness involved in the interventions, and the types of exercise completed, all findings should be interpreted with caution due to the diversity of interventions. However, it is important to note that diversity of interventions reflects clinical reality in many fields.

The present focus on randomized trials is both a strength and limitation of the present review and future reviews might include studies using other controlled and uncontrolled studies. Randomized trials control for conditions such as service context, therapy delivery and passage of time, which are critical when trying to assess and interpret data on harm. This is particularly relevant for people with psychosis, for whom the use of MBIs was slow to develop because of isolated findings from uncontrolled case studies (Chadwick, 2014).

Recommendations

Based on the findings of this study, this review offers the following recommendations alongside those already provided in Ellett and Chadwick (2021):

- Broadly across clinical trials for psychological interventions, definitions and operationalizations of harm and adverse events need to be pre-specified in research trials following consultation with PPI to ensure relevancy to the intervention being delivered and the population it is being delivered to. Using the indices of harm framework in this review coupled with a more nuanced delineation of adverse events based on the three suggested factors in Baer et al. (2019) could be a useful starting point.
- It is likely to be useful to draw a distinction between adverse *effects* and adverse *events* and to clearly demark how a conclusion is reached regarding whether any adverse events have a reasonable chance of being causally connected with the intervention (and thus of being adverse *effects* specifically), so that this reasoning process is transparent.
- It would be useful for future trials to seek consistency in the method of data collection for indices of harm as this would permit future meta-analyses of risk differences and robust conclusions to be drawn which may support the case for mindfulness-based interventions for psychosis to become recommended interventions in guidelines such as those by the National Institute for Health and Care Excellence (NICE).

Conclusions

The primary conclusion of this review is that the data on harm collected in trials of MBIs for psychosis to date suggest that these interventions may be safe and may

even reduce risk of certain kinds of harm, for instance, hospitalization. While there is burgeoning evidence supporting the beneficial effects of these interventions, it cannot yet be concluded that MBIs for psychosis are safe given the absence of thorough reporting of harm which precludes a weighted discussion of the benefits versus harms. More broadly, there is an emerging picture that the wider research literature on trials of psychological therapies, such as CBT, appears to be stronger on assessment of beneficial effects and weaker on assessment of harm. Harm and benefit are arguably of equal importance when making decisions about what works for whom and which interventions to recommend in national guidance and deliver in routine care, emphasizing the need to operationalize harm clearly and consistently in psychological interventions in future trials and systematically gather data on the prevalence of harm.

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Looking After NHS Staff and Ourselves: An Evaluation of the Impact of Trauma-Informed Compassionate Leadership Training on Managerial Staff's Confidence and Knowledge During the Pandemic

Service-Related Project

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Proposed Journal for Submission

European Journal of Psychotraumatology (author guidelines in Appendix K)

This journal was chosen as it publishes a range of studies related to understanding, preventing, and treating the consequences of stress and trauma. There journal has a limit of 6000 words.

Abstract

Aims

This study aims to evaluate the effect of training on the confidence and knowledge of NHS Leaders and Managers in implementing guidelines on the "Do's and Don'ts" of a trauma-informed response to staff during the COVID-19 pandemic. It further aims to identify improvements to the training which could enhance its utility prior to wider dissemination.

Method

This evaluative study used a mixed methods approach and followed the Plan-Do-Study-Act (PDSA) cyclical model of service improvement adopted by the NHS. Pre-, post-, and follow-up questionnaires were developed which assessed the level of confidence and knowledge participants had in implementing the "Do's and Don'ts". These questionnaires included qualitative feedback questions related to what participants hoped for from the training, whether they achieved what they hoped, how the training impacted their support for staff wellbeing, and what improvements could be made to the training. Content analysis was used to analyse qualitative data. Paired samples t-tests and repeated measures ANOVAs were used to analyse quantitative data.

Results

There were significant improvements in participants' confidence and knowledge between the pre- and post-training time points. These were not maintained at follow-up, however, there was a high level of attrition between the post-training and follow-up time

points. Most participants reported achieving what they hoped for from the training, including professional development, skills for responsive management, and improved self-care and self-compassion within demanding leadership roles. Participants provided suggestions for enhancing the helpfulness of the training which has contributed to a range of recommendations.

Conclusions

This evaluation demonstrated that training focusing on the “Do’s and Don’t’s” of a trauma-informed response to staff during the pandemic can be effective in enhancing the knowledge and skills of NHS Leaders and Managers. A range of potential improvements could further augment the utility of the training for a wider range of NHS staff.

Introduction

Trauma-informed practice has increasingly been highlighted as essential due to the prevalence of traumatic experiences (WHO, 2013). It is defined as a built-in sensitivity within professional practice to trauma-related distress and problems in individuals receiving care (Sweeney et al., 2016). The COVID-19 pandemic created a widespread context in which a trauma-informed approach to supporting both staff and patients became vital. When healthcare staff are faced with risk to their own or others' lives or are faced with moral dilemmas at work due to limited resources, there is a heightened risk of staff experiencing distress, associated mental health problems, and moral injury (Williamson, Murphy, & Greenberg, 2020). It has been suggested that healthcare staff were particularly vulnerable to the sources of trauma posed by the pandemic, due to exposure in the workplace as well as the concurrent potential exposure in personal lives (Masiero et al., 2020).

A part of the initial response to the coronavirus pandemic, a national Trauma Response Working Group was established to co-ordinate and compile guidance and resources to help managers and clinicians to support staff at risk of exposure to trauma (TRWG, 2020). This included a slide deck summarising rapid guidance for supporting staff during three phases of the pandemic (Billings et al., 2020). These phases are summarised in Table 1 and include a preparation phase, an active phase, and a recovery phase.

Table 1

The phases of a pandemic from Billings et al. (2020)

Phase	Definition
“Prepare” Phase	Staff might be anticipating the peak of healthcare demand and taking action to get ready to manage this.
“Active” Phase	Staff may experience intense periods of work as healthcare demand reaches a peak.
“Recover” Phase	Staff may experience a reduction in demand, but this could be accompanied by moral injury or survivor’s guilt, depending on whether staff experience trauma during an earlier phase.

This rapid guidance provided a range of “Do’s and Don’ts”, as shown in Table 2, which were developed from best practice guidelines and expert clinical opinion. It aimed to inform the provision of a psychological response to stress National Health Service (NHS) staff might experience during the pandemic. The “Do’s” offered a range of suggestions for best practice and the “Don’ts” provided clear guidance to avoid non-evidence-based interventions.

Table 2

The “Do’s and Don’ts” of a trauma-informed response to staff wellbeing during the pandemic from TRWG (2020)

“Do’s” of a Trauma-Informed Response to Staff during the Pandemic	
Do #1	Brief staff in an open and frank way to ensure they are best prepared for what they may face and what they may be asked to do, holding in mind cross-cultural, social, and hierarchical communication.
Do #2	Provide training related to potentially traumatic situations staff may experience. This should involve honest communication of the facts, support to develop skills to cope, and information to enhance awareness of potential mental health sequelae.
Do #3	Be flexible in supporting staff by listening to their individual needs and responding to their indications about what is and is not helpful. Act on

"Do's" of a Trauma-Informed Response to Staff during the Pandemic	
	feedback and, in situations where this isn't possible, communicate clearly about why.
Do #4	Seek to facilitate team cohesion and opportunities for staff to talk to each other.
Do #5	Consider using naturalistic forms of debriefing for staff.
Do #6	Consider providing a buddy system between more and less experienced staff and rotating staff across high-stress and low-stress areas of work.
Do #7	Protect staff members who are vulnerable and seek to minimise personal and professional isolation.
Do #8	Encourage staff to utilise the social and peer support available with their colleagues.
Do #9	Maintain a low threshold for referring staff to wellbeing services while holding in mind that some staff may not need this. It is important to normalise being okay as much as not being okay.
Do #10	Actively monitor and support staff as the crisis situation starts to recede.
Do #11	Ensure that only trained, competent staff deliver psychological interventions.
Do #12	Role model to staff what they need to do to maintain their wellbeing, for instance, ensuring basic needs for rest, sleep, food, drink, and safety are met, and role-modelling self-compassion.
"Don'ts" of a Trauma-Informed Response to Staff during the Pandemic	
Don't #1	Don't offer stand alone and mandatory psychological debriefing which compels staff to discuss distressing events and focus on their feelings as the event took place, as there is evidence that this can be detrimental. Staff Support Debriefs, when offered following an incident, should be voluntary and facilitated by a trained member of staff.
Don't #2	Don't offer interventions for mental health problems which are not recommended, or evidence based.
Don't #3	Don't rush into offering 1:1 intervention too soon as intervening too early can be detrimental. It is recommended within NICE guidelines that there is a period of active monitoring during the first month following a trauma before an intervention is offered (NICE, 2018).

As part of the response to the pandemic, a Trauma Response Group was established by a Mental Health Trust, with members including Leaders and Managers, Learning and Development staff, Clinical staff, and staff from Human Resources. The network developed training based upon this guidance, which focused on improving staff knowledge and confidence with respect to the “Do’s and Don’ts”. This was embedded within the principles of Trauma Informed Care, Compassionate Leadership and a focus on self-compassion using Compassionate Mind Theory (Gilbert, 2010) to consider the potential experience of NHS staff as they strive to respond to the pandemic. Compassionate leadership is defined as the behaviours undertaken by leaders, as carriers of culture, to embody compassion, the desire to alleviate distress in others, in their leadership practice (West et al., 2017). Leading expert in the field Professor Michael West captured the importance of this at a time of crisis given that “connection and compassion are certain, unchanging and provide a safe refuge in the face of this onslaught on health and care systems and our wider communities” (West & Bailey, 2020). Compassionate leadership is suggested to have a positive impact on staff health, wellbeing and engagement, clinical effectiveness and patient safety (West et al., 2017).

The development and delivery of this training is in keeping with aims within the NHS long term plan which aspires to “support improved health and wellbeing of staff” (NHS, 2019b, p. 87) and the Interim NHS People Plan which seeks to foster widespread leadership culture change towards “inclusive and compassionate leadership, so that all staff are listened to, understood and supported” (NHS, 2019a, p. 14). To ensure the training achieved its aims, this evaluation was completed.

Aims of the Evaluation

This evaluation had the following aims:

- To identify if an increase had occurred in both knowledge and confidence related to implementing the “Do’s and Don’ts” using evaluation measures.
- To identify ways in which the training could be improved to better meet the needs of staff.
- To identify if any changes in knowledge and confidence were maintained at three-month follow-up and to elucidate possible factors which may have affected whether improvements were maintained or not.

Method

Design

This project used a mixed methods design where both qualitative and quantitative data was collected using pre-, post-, and follow-up questionnaires. It was approved by the Trust's Quality Improvement and Clinical Audit Manager.

As described earlier the training session was designed by a local Trauma Network at the start of the pandemic based upon a slide-deck of rapid guidance produced by the national COVID-19 Trauma Response Working Group.

17 virtual training sessions were delivered during the pilot, which ran from June 2020-October 2020. This timeframe coincided with the latter end of the first wave and start of the second wave of the pandemic. These sessions were aimed primarily at Leaders and Managers within the Trust.

Participants

Staff were invited to attend virtual training sessions titled "Looking After Staff and Ourselves: Actions to Prevent and Respond to Traumatic Experiences During COVID-19". A range of professional groups attended the training as outlined in Table 4. The pre-training questionnaire was completed by 99 staff members, the post-training questionnaire by 62 staff members, and the follow-up questionnaire by 13 staff members.

Measures

The questionnaire used was developed for purpose. Questionnaires used by Robinson, Griffith, and Gillmore (2019) and Walters, Hogg, and Gillmore (2016) were used to inform the development, with the Plan, Do, Study, Act cycle (Langley et al., 2009) used to underpin the evaluation.

The questionnaire was modified to tailor it to the needs of the pre-, post-, and follow-up data collection points. Questions were used to consider knowledge and confidence of implementing the "Do's and Don'ts", as described in Table 2, in relation to responding to traumatic experiences in staff members during the pandemic. The questionnaires are provided in Appendix M.

The “Do’s and Don’ts” were listed in each questionnaire and participants were asked to rate their current knowledge of the “Do’s and Don’ts” and confidence implementing these on a Likert scale ranging from 1 = (none) to 5 = (substantial).

The pre-training questionnaire asked one qualitative question, the post-training questionnaire asked six qualitative questions, and the follow-up questionnaire asked three further qualitative questions.

Procedure

The NHS recommended model of service improvement, the Plan-Do-Study-Act cycle (Langley et al., 2009; NHS, 2021), was used to underpin the study. This model involves an initial phase of planning for changes, a second stage where these changes are implemented, a third stage where the effects of these changes are studied, and a final stage where the evaluative outcomes are acted upon. This study involved one run of the PDSA cycle, as follows:

- **Plan:** The training was collaboratively developed by a range of professionals. The questionnaires were developed collaboratively by the authors and feedback was obtained from the Trauma Network. Following this, a consultation session was held with a person with lived experience. This was done to ensure that the information sheet and questionnaires used had been informed by a patient perspective in line with keeping patients at the centre of everything in the NHS. The feedback provided was reflected upon and incorporated into modifications in the questionnaires used. This feedback identified a potential change to the training, which was also suggested by participants in their feedback, namely, the incorporation of skills practice into the training. This was not yet implemented at the time of delivery of the pilot training sessions due to time limitations, however, it was planned to include this change in a later iteration of the PDSA cycle.
- **Do:** 17 virtual training sessions were delivered by a range of different professionals within the Trauma Network. These training sessions incorporated didactic sections focused on compassionate leadership and the “Do’s and Don’ts” alongside reflective group discussions.

- **Study:** Participating staff were guided to links to the pre- and post-training questionnaires and asked to complete these immediately prior to and after the training. The follow-up questionnaire was disseminated via email to all participants at the appropriate 3-month mark following the date of the training they completed.
- **Act:** The findings from this evaluation were scheduled to be shared with the Trauma Network through a short presentation feeding back the results, providing an opportunity to consider how to incorporate the feedback into future iterations of the training.

Analysis Plan

Qualitative Analysis

Content analysis, as described in Elo and Kyngas (2008) and Schreier (2014), was used to analyse the data. The analysis plan, based on the method described in these papers, included the selection of an analysis unit, specification of deductive and inductive aspects of the analysis, and selection of a coding strategy. When an initial coding frame had been developed, the frame was discussed to reach agreement about terminology used in the codes and to ensure the coding frame exhibited mutual exclusiveness between codes (Schreier, 2014). The second coder then independently coded the data using this frame, with the first coder then making revisions accommodating changes to the wording of the coding frame. Inter-coder reliability was considered using Cohen's kappa (Burla et al., 2008) for a representative subset of the data.

Trustworthiness. To establish the trustworthiness of content analysis, five criteria are suggested in the literature (Lincoln & Guba, 1985). These include credibility, dependability, conformability, transferability, and authenticity. Table 3 provides a definition of each of these criteria alongside a description of how this study met these criteria.

Table 3

Definitions of the five criteria for trustworthiness in qualitative content analysis and how these were met in this study

Trustworthiness Criteria	Definition	How Criteria Were Met
Credibility	Refers to ensuring participants are clearly described and questions selected to gather data are suitable for answering the research question.	Target audience identified: Participants undertaking the training all held senior NHS staff roles, although these covered a range of settings. The qualitative questions were selected in line with the specific aims of the evaluation.
Dependability	This refers to whether the data is stable over time and under different conditions.	The data was collected at different time points over a four-month period from a wide range of professionals working within different settings in one NHS Trust. That this data could be coded into a relatively small number of subcategories suggests the data to be dependable.
Conformability	This refers to the potential for there to be agreement between two or more coders regarding the data's relevance or meaning.	Conformability was established through coder discussions that identified the meaning of sentences and the relevant coding was typically similar. This was formally assessed using Cohen's kappa.
Transferability	Refers to the degree to which the findings can be generalized to other groups or settings.	Given the range of contexts data was collected from, it could be tentatively

Trustworthiness Criteria	Definition	How Criteria Were Met
		concluded findings would apply across a range of NHS mental health care settings. However, it is not clear findings could be generalized beyond this. Further evaluation would be required to establish with any certainty.
Authenticity	This refers to the degree to which the results are reported such that they show a range of realities.	A wide range of feedback has been categorised which includes both positive statements about the training and criticisms of it. Examples of each are reported in the results section.

Elo et al. (2014) provide a checklist for researchers which includes questions to pose at each stage of the content analysis process to improve trustworthiness. This checklist was utilised to shape each stage of this process.

The decision regarding which unit of analysis to use posed a challenge. With the size of an answer given to a question varying significantly, it was decided that a sentence would be a more suitable unit of analysis to prevent loss of meaning when coding. However, it was noted that a narrow unit could lead to fragmentation, and this was a risk associated with using a sentence as a unit of analysis (Elo et al., 2014).

To further enhance the credibility of the analysis, the intercoder reliability was established for a representative subset of the data using responses for the qualitative question included in the pre- questionnaire. This question had received the most responses. Cohen's kappa was calculated as this accounts for any agreement occurring by chance (Burla et al., 2008).

Quantitative Analysis.

The software SPSS statistics, version 27 (IBM) was used. Data was inspected visually initially, to check for outliers, and to ensure the assumptions of normality and sphericity were met.

Cronbach's alpha was calculated using pre-training responses to the two quantitative measures focused on confidence and knowledge. This was to check for internal consistency of each measure to assess their reliability.

To analyse any changes in confidence and knowledge, a paired samples t-test was conducted on the pre- and post-training data, followed by two repeated measures ANOVA's, one each for confidence and knowledge. Pairwise comparisons were planned for the pre- and post-training data, pre-training and follow-up, and post-training and follow-up data.

Results

Completion Rates

Questionnaire completion rates across professional groups were recorded (Table 4).

Table 4

Completion rates of pre-, post-, and follow-up measures according to professional group

	Completion Rates		
Professional Group	Pre-Training Questionnaire (N = 99)	Post-Training Questionnaire (N = 62)	3 Month Follow-Up Questionnaire (N = 13)
Senior Leaders	24	15	3
Team Managers	40	22	5
Clinicians	32	19	4

	Completion Rates		
Other Senior NHS Staff	3	2	1
Unknown	0	4	0

Qualitative Results

Structuring of the main categories was concept-driven, with generating codes and subcategories data-driven (Schreier, 2014) in order to build the coding frame for qualitative content analysis. Main categories were structured based upon the key concept in the questions asked in the feedback questions of the questionnaires. The main categories include: “Hopes”, “Hope Achievement”, “Identified Action”, “Supporting Staff Wellbeing”, “Most Helpful Aspects of Training”, “Least Helpful Aspects of Training”, “Improvements”, “Actions Following Training”, “Longer Term Care of Staff Wellbeing”, and “Barriers to Training Implementation”. This ensured that the main categories met the criterion of unidimensionality for content analysis, such that each one covered only one aspect of the material (Schreier, 2014).

The total number of sentences coded was 581. The strategy of subsumption was selected to generate codes and subcategories in a data-driven, or inductive, way until saturation was reached and no further new categories were identified (Schreier, 2014). Thus, the criterion of exhaustiveness for content analysis, that all aspects of the material were covered by a category, was met. A table summarising the main categories, subcategories, and codes is provided in Table 5.

Intercoder reliability was calculated using a selected percentage sample of the codes (20.8%). Cohen’s kappa was calculated to assess quality in the coding scheme (Burla et al., 2008). It was used to determine agreement between coders’ coding of the data for the first qualitative question on the pre-training questionnaire, with a satisfactory level of agreement found $\kappa = 0.696$, $p < .001$ (Everitt, 1996).

Table 5

Summary of the main categories, subcategories, and codes generated in the coding frame for the qualitative feedback questions

Main Categories	Frequency, n (%)	Subcategories	Frequency, n (%)	Codes (n)
Hopes	121 (20.8%)	Professional Development	28 (4.8%)	Confidence (3), Knowledge (16), Skills (9)
		Responsive Management	85 (14.6%)	Staff Support (47), Response to COVID-19 (17), Response to Trauma (21)
		Self-Care for Managers	8 (1.4%)	Support for Self (3), Reflective Space (5)
Hope Achievement	58 (10.0%)	Gained	48 (8.3%)	
		Partially Gained	7 (1.2%)	
		Not Gained	3 (0.5%)	
Identified Action	78 (13.4%)	Leadership	21 (3.6%)	Applying Leadership Skills (14), Applying

Main Categories	Frequency, n (%)	Subcategories	Frequency, n (%)	Codes (n)
				Compassionate Leadership (7)
		Embodying Compassion	26 (4.5%)	Apply Compassionate Mind Theory (9), Apply Self and Other Compassion (14), Role Modelling (3)
		Practical Changes	31 (5.3%)	Use Trust and Intranet Resources (12), Establish Staff Support (8), Incorporate into Reflection and Supervision (6), No Actions (2), Continue What We Are Doing (3).
Supporting Staff Wellbeing	57 (9.8%)	Reminders and Validation	18 (3.1%)	Continue Current Practice (11), Keep on Agenda (7)
		Compassion and Wellbeing	39 (6.7%)	Increase in Awareness (8), Self-Compassion (3), Compassionate

Main Categories	Frequency, n (%)	Subcategories	Frequency, n (%)	Codes (n)
				Leadership (16), Consideration of Individual Responses (12)
Most Helpful Aspects of Training	68 (11.7%)	Personal and Professional Development	34 (5.9%)	New Knowledge (8), Compassionate Mind Theory (8), Resources and Reminders (17), Nothing (1)
		Power of the Group	34 (5.9%)	Time to Reflect (9), Hearing and Learning from Other's Experiences (25)
Least Helpful Aspects of Training	62 (10.7%)	Specific Factors of the Training	41 (7.1%)	Content of the Training (22), Length of the Training (9), Online Format (6), No New Learning (4)
		Unhelpfulness of the Whole	21 (3.6%)	Nothing Unhelpful (20), Everything Unhelpful (1)
Improvements	81 (13.9%)	Time Utilization	13 (2.2%)	Adjust Training Length (6), More

Main Categories	Frequency, n (%)	Subcategories	Frequency, n (%)	Codes (n)
				Reflection Time (7)
		Format of the Training	16 (2.8%)	Face to Face (13), Smoother IT (3)
		Group Factors	9 (1.5%)	Wider Attendance (3), Adjust Group Composition (6)
		Content Changes	32 (5.5%)	Refinement (19), More Skills Examples (5), Resource Provision (8)
		Nothing to Improve	11 (1.9%)	
Actions Following Training	18 (3.1%)	Wellbeing of Self and Staff	7 (1.2%)	Self and Other Compassion (3), Reflection (4)
		Further Skills Development	11 (1.9%)	Applications in Supervision (3), Leadership Skills (6), No Actions (2)
Longer-Term Care of Staff Wellbeing	16 (2.8%)	Changes in Supervision	2 (0.3%)	

Main Categories	Frequency, n (%)	Subcategories	Frequency, n (%)	Codes (n)
		Reminder of Compassionate Leadership	8 (1.4%)	
		Raised Awareness	3 (0.5%)	
		Validation	2 (0.3%)	
		No Changes	1 (0.2%)	
Barriers to Training Implementation	4 (0.7%)	Already a Compassionate Manager	1 (0.2%)	
		Training Too Basic	3 (0.5%)	
Unsure	18			
Missing Data	28			

Illustrative Examples

Examples from each subcategory are provided below.

Hopes: Professional Development. Some staff highlighted professional development as a key hope in undertaking the training. This centred primarily on gaining increased knowledge, as asked by Participant 10, “What are the signs, how do I manage it, what do I say [?]”

Hopes: Responsive Management. Many participants sought to become more readily responsive to trauma in either a broad way or specifically during the COVID-19 pandemic, as indicated by Participant 49, “To be better informed about trauma generally but in particular the way trauma has manifested in people in relation to the COVID-19 pandemic”.

Hopes: Self-Care for Managers. A small number of participants sought to focus on self-compassion and self-care within the training, as Participant 17 stated that they wished “to understand how we can continue to support others but more

importantly to think about the way we can support ourselves and each other as leaders".

Hope Achievement: Gained, Not Gained, Partially Gained. Most participants felt they had gained what they hoped for from the training, for instance, Participant 89 said, "Yes – was helpful to know that I've been completing the do's and don'ts right – also good to reflect on managing my own compassion for myself, rather than just thinking of the rest of the team".

Others felt their hopes had been partially gained for different reasons, a key one being given by Participant 77, "I have had a fair amount of trauma training but not specifically in relation to COVID. The peer experience was helpful and the presentation will act as an aide memoire".

However, three participants stated that they had not gained what they hoped from the training. One participant outlined their reason, this being that they did not gain any new knowledge.

Identified Action: Leadership. Some participants listed actions they would take which demonstrated their leaderships skills and compassionate leadership. For example, Participant 27 said they would "look at how I lead and review how to do this compassionately using guidance [and] theory," and participant 95 said they would exhibit, "greater awareness of trauma responses, sharing this with my team to normalise and increase their awareness".

Identified Action: Embodying Compassion. Several participants, such as Participant 91, said they would try to role model self-compassion to their team: "I will try to be more self-compassionate and model the behaviour I encourage for other members of the team in terms of wellbeing".

Identified Action: Practical Changes. Other participants reported practical changes they would make, such as incorporating their learning into changes in supervision practices, as suggested by Participant 99, "get the team to think about where they are within the theory of compassion (threat system/drive system/soothing system) […] maybe use this in supervision, talk to supervisors about this".

Supporting Staff Wellbeing: Reminders and Validation. A small number of participants felt the training validated their current practice and motivated them to continue with it, for instance, Participant 89 said they would "continue with the practice already in place, but supported in knowing that it is being done right".

Supporting Staff Wellbeing: Compassion and Wellbeing. Some participants highlighted that they would seek to consider the individuality of staff and different responses to stress and trauma in their approach to supporting staff wellbeing, with Participant 32 reporting they would be "trying to always remember to really focus on individual staff need alongside other demands and be clear that you have listened and understood".

Others thought about how developing their own self-compassion might improve the way they managed their team:

> I think it's as much about recognising my own needs, it's hard as a manager to put yourself first, I am so aware of my team's struggles that I have focused on them, this has taught me that it's ok to put my needs ahead of others from time to time and I will be a better manager for it (Participant 31)

Most Helpful Aspects of Training: Personal and Professional Development. Participants cited specific aspects of the training, such as knowledge, gained from the training as the most helpful aspect for them. For example, Participant 49 said, "The explanation of the threat, drive and soothing systems and the information around it being normal to experience intrusive thoughts post-incident but that if these persist after one month then there is potentially a problem".

Most Helpful Aspects of Training: Power of the Group. Hearing and learning from the experience of other managers was the most frequently cited helpful aspect of the training, as expressed by Participant 89, "Useful to be able to discuss matters and talk to others in similar positions, knowing that you're all on the same page".

Least Helpful Aspects of Training: Specific Factors of Training. Several participants gave specific feedback about aspects of the training they felt were not as useful to them and changes which may have made it more useful, for instance Participant 47 suggested there were "too many slides and too much focus on PTSD

and big T trauma as opposed to ongoing stress/trauma of working with complexity whilst more isolated/remote working".

Least Helpful Aspects of Training: Unhelpfulness of the Whole. Most participants commented that there was "nothing" they had found unhelpful, with some then elaborating on possible improvements that would have made it even more helpful. For example, Participant 95 reported there was "nothing unhelpful. Might have been good to think about specific examples of adapting communication/delivery of information to be more compassionate, i.e., changing of language, spotting potential threat triggers".

Improvements. A wide range of improvements were suggested by participants. These converged upon changes being suggested for how time was utilized; suggesting the sessions would be better face to face whenever possible; asking for either greater diversity in the group of participants or for it to be team-specific; and finally content changes, with a particular focus on skills examples (Table 6).

Table 6

Example extracts from the evaluation illustrating the improvements suggested by participants

Improvements Subcategory	Illustrative Example
Time Utilization	Much more space for reflection and sharing of good practice and generating ideas (Participant 47)
Format of the Training	Face to face sessions would encourage further discussion and dialogue (Participant 39)
Group Factors	More senior managers doing it […]. Still feels team managers are receiving the training but some of those above were missing and still feels a disconnect with certain managers (Participant 4)

Improvements Subcategory	Illustrative Example
Content Changes	Perhaps spending an hour discussing/sharing best practice and problem solving together as leaders would have been helpful? (Participant 34)
Nothing to Improve	In situation/circumstances nothing (Participant 27)

Actions Following the Training: Wellbeing of Self and Staff. Some participants felt the training led to self and other compassion becoming a priority. For Participant 77 this meant, “I have felt I had permission to prioritise looking after my staff and myself”.

Actions Following the Training: Further Skills Development.

Other participants felt the training enabled them to take action to further develop their leadership skills, for example, Participant 95 “felt more able to talk with my team about their wellbeing and role of threat responses”.

Longer Term Care of Staff Wellbeing: Changes in Supervision.

A few participants mentioned the training contributed to practical changes in the setup of supervision to support staff wellbeing. Participant 32 reported: “We have made changes with supervision and now separated clinical from management/wellbeing. Also started twice weekly peer supervision which can be an arena for reflecting on all challenges”.

Longer Term Care of Staff Wellbeing: Reminder of Compassionate Leadership. A few participants found being reminded of compassionate leadership impacted on their leadership style, as described by Participant 55: “It reminded me that not everyone has the same understanding of issues and speaking with authority may not always be the best strategy, but rather exploratory/validatory methodologies may be more effective at helping staff find solutions to their distress”.

Longer Term Care of Staff Wellbeing: Raised Awareness. An increased awareness of the impact of the pandemic on staff wellbeing emerged for a few

participants, as stated by Participant 75: “It has made me think more about the impact of COVID-19 on usual delivery of service and how this impacts staff”.

Longer Term Care of Staff Wellbeing: Validation. A couple of participants took away an experience of validation for the staff support already in place. Participant 65 said they “found it really validating about the way the team had been thinking about supporting each other”.

Longer Term Care of Staff Wellbeing: No Changes. One participant felt that the training did not change the way they supported staff wellbeing.

Barriers to Training Implementation. Two participants described barriers to the training implementation. One felt they were “already a very compassionate manager” (Participant 77), which meant nothing changed because of the training. Another participant described the training as “too basic”, with improvements possible through discussions about “ideas for best practice amongst the managers present – sharing challenges and solutions” (Participant 34).

Quantitative Results

Internal Consistency of Confidence and Knowledge Measures

The internal consistency of the confidence and knowledge measures was established using the pre-data (N = 99). Each survey consisted of 13 items. Cronbach’s alpha for the confidence measure was $\alpha = 0.92$, indicating excellent internal consistency for this measure. Cronbach’s alpha for the knowledge measure was $\alpha = 0.88$, indicating good internal consistency for this measure.

Changes in Confidence and Knowledge at Pre-, Post- and Follow-Up

Four participants’ data was excluded from the quantitative analysis as the post-training questionnaire only was completed.

Paired samples t-tests with a Bonferonni adjustment to the significance value to correct for the effect of multiple tests on type I error were completed. Data from 58 participants with completed pre- and post-training questionnaires were included in the analysis. All assumptions for a paired samples t-test were met.

A repeated measures ANOVA was completed for the pre-, post- and follow-up data, with 12 full datasets included in the analysis as a result of dropout. All assumptions for a repeated measures ANOVA were met.

The paired samples t-test (N = 58) indicated a significant difference in confidence related to putting the do's and don'ts into practice following the training session ($t_{(57)}$ = -10.998, p < 0.025) with a large effect size d = 1.44. From pre-training to post-training, there was a significant improvement in confidence from M = 43.97, SD = 6.37 to M = 52.60, SD = 5.46.

A significant difference in knowledge related to the do's and don'ts was found between pre- and post-training ($t_{(57)}$ = -9.069, p < 0.025) with a large effect size d = 1.19. There was a statistically significant improvement in knowledge between the pre- and post-training points from M = 44.50, SD = 6.11 to M = 52.24, SD = 5.72.

A repeated measures ANOVA (N = 12) identified a significant difference in confidence over time ($F_{(2, 22)}$ = 6.230, p = 0.007). *Post hoc* analysis with a Bonferonni adjustment highlighted a significant increase in confidence between pre- and post-training from M = 45.25 (95% CI, 41.30 to 49.21) to M = 53.08 (95% CI, 48.87 to 57.30). However, this was not maintained between post-training and follow-up (M = 48.83; 95% CI, 45.54 to 52.13).

Similarly, a repeated measures ANOVA (N=12) identified a significant difference in knowledge over time ($F_{(2, 22)}$ = 4.031, p = 0.032). *Post hoc* analysis with a Bonferonni adjustment indicated a significant increase in knowledge between pre- and post- training from M = 46.92 (95% CI, 43.66 to 50.17) to M = 52.42 (95% CI, 48.77 to 56.07) that was not maintained between post-training and follow-up (M = 50.33; 95% CI, 47.16 to 53.51).

Discussion

This study sought to evaluate a service improvement initiative, using the PDSA method, to improve the wellbeing of staff. It evaluated training developed in the light of guidance on the Do's and Don'ts of responding to trauma experienced by staff during the pandemic (TRWG, 2020), on staff knowledge and confidence with respect to implementing this guidance. These guidelines were developed due to the heightened

risk of healthcare staff experiencing distress as a result of the concurrent risk of exposure to trauma at work and in their personal lives (Masiero et al., 2020). It was found that both confidence and knowledge significantly improved immediately following the training, which aligned with the aims of the evaluation. These improvements were not maintained at follow-up, however, the dropout rate meant limited data was collected at this time point. Despite this, the evaluation identified potential improvements to the training which may increase the longevity of improvements in confidence and knowledge for future iterations of the training.

Impact of Training

Many participants had hoped for greater knowledge or confidence and specific guidance regarding the skills needed to respond effectively to trauma during the pandemic. Most participants achieved what they hoped for from the training and this was reflected in the observed improvements in confidence and knowledge. Notably, one of the most recognised helpful aspects of the training was hearing and learning from others' experiences. Considering improvements, it was commonly requested that more time was allotted to shared reflection on experiences, which may be due to lack of time in busy leadership roles for this activity (Anandaciva, Ward, Randhawa, & Edge, 2018). Based on the suggestions for improvements provided by participants and reflection by the authors, recommendations are provided in Table 7.

Table 7

Recommendations for improvements and actions as a result of this evaluation

	Recommendations
1	The local Trauma Response Group (TRG) could consider the improvements suggested by the evaluation as they look to review the training. This could include providing more skills examples, providing opportunities to discuss best practice, and skills practice within the training session.
2	Facilitators could consider the feasibility of face-to-face sessions in the future, with any restrictions related to the pandemic needing to be considered.

	Recommendations
3	The TRG could consider the potential for reflective spaces to be offered within or after the training, with a view to identifying what type of support training delegates may hope for moving forward.
4	The TRG could consider extending the slide outlining fictitious staff experiences to develop this into case examples for the training.
5	The training could be embedded into Trust Learning and Development structures moving forward so that wider access is possible.
6	The evidence base could be consulted with respect to strategies for maintaining knowledge and confidence in the long-term.
7	The TRG could consider the use of small group work within the training to facilitate delegates engaging in reflection on others' experiences.
8	Alongside verbal acknowledgement of delegates' expertise, written recognition of this could be included within the slides.
9	The TRG could celebrate the usefulness of the training given its rapid development under time pressure at the height of the first wave of the pandemic.

Limitations

A key limitation of this evaluation was that the dropout rate between post- and follow-up questionnaires prevented a clear conclusion being drawn about what happened to confidence and knowledge at the 3-month time point. A remedial strategy could have involved offering a reflective space for managers at the follow-up time point when the questionnaire could also have been administered, rather than requesting completion of this via email. This may have been effective as it would have offered a valued incentive for continued participation (Bankhead et al., 2017). Future evaluative studies may wish to consider such a strategy.

Offering such a reflective space could be a starting point for the next iteration of a PDSA cycle. The Plan Do Study Act cycle was a useful method in this evaluation for ensuring clarity about the intended improvement to be accomplished and for identifying how we would know a change is an improvement, as well as measuring this effect. A further cycle might involve a planning stage which would incorporate feedback from a reflective session with senior NHS staff who experienced the first iteration of the training. This could take the form of a focus group where ways to improve the training could be elaborated upon. For instance, specific suggestions for where to focus skills practice could be obtained. The evaluative measures could be refined to include a self-assessment of change in skills or competencies, as well as confidence and knowledge. The training could then be modified and delivered to a further group of participants and evaluated using the refined measures as part of the next Do phase and the results of this could be studied and acted upon.

A further limitation is that this evaluation did not study whether improved confidence and knowledge translated into effective skill implementation in the workplace. However, as effective skill implementation related to the Do's and Don'ts encompasses such a broad skillset, it would have not been possible to devise a feasible way of measuring this within the scope of this study. A further study may be able to investigate the relationship between self-reported gains in confidence and knowledge regarding trauma-informed compassionate leadership and improved skills implementation in the workplace.

Finally, the evaluation may have missed some of the potential benefits of the training for participants. Facilitators of the training reported that many staff expressed feeling validated by the focus on self-compassion and self-care within the training. This evaluation did not capture whether staff felt more motivated towards self-care and self-compassion and more engaged with these activities following the training and thus it also did not capture whether any such changes persisted at follow-up. A further iteration of the PDSA cycle could consider adapting the evaluative measures to assess any change in self-care practices and self-compassion within participating senior staff. It could also consider ways of assessing how any such changes impact care for staff wellbeing.

Further Developments

Following the completion of the evaluation and dissemination of the results, feedback was received from the Trauma Response Group regarding the potential impact of the findings and further developments of the training:

> This evaluation will be invaluable to use moving forward to revise and improve the training. The use of mixed methods allows us to have rich data to consider in this process. Since the evaluation was completed, we have been providing the training both internally and externally to the Trust. In line with one of the recommendations, this has been provided to e.g., the trust board, CCG boards and CEOs of other trusts. It will also be provided to another trust board in the near future. Alongside this, a booklet has been developed that provides an overview of the training, which has been disseminated both locally and nationally. A recent development is that the training has been adapted to be utilised as slides rather than a facilitated training session as it is to be hosted on the HEE learning hub (Trauma Response Group, 2021)

Conclusions

This evaluation has demonstrated that training focusing on the “Do’s and Don’ts” of a trauma-informed response to staff during the COVID-19 pandemic can be effective in enhancing the knowledge and confidence of NHS Leaders and Managers. There was insufficient data at follow-up to permit a robust conclusion to be drawn about the longevity of these enhancements. However, the qualitative feedback from participants supports that they largely gained what they hoped to achieve from this training with respect to professional development, knowledge for responsive management, and improved self-care within demanding leadership roles. The improvements suggested by participants have enabled several recommendations to be developed which may support the wider dissemination and utility of this training.

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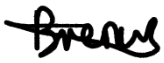
Statement from Candidate	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature.								

Signed		**Date**	19th May 2022

Dehumanisation in Voice Hearers: The End of the Continuum

Main Research Project

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Date: 20th May 2022

Word Count: 5981

Proposed Journal for submission

Behavioural and Cognitive Psychotherapy (author guidelines in Appendix A)

This journal was chosen as it publishes studies involving many kinds of research methods, which contribute to the theory, practice, and evolution of cognitive and behaviour therapy. There is usually a 5000 word limit for original research, however, this was extended upon discussion with the journal in order for this qualitative study to be submitted for the 50th anniversary edition of the journal by invitation to Professor Paul Chadwick (see Appendix B).

Data Access Statement

Qualitative data is not available due to the sensitive nature of the interview data and to protect the confidentiality of participants.

Authorship Statement

I am the author of this thesis and the work delineated here was carried out by myself. Input and feedback on written drafts was received from my co-author. Please see the above declaration table for further information.

Commentary Text

Research into the experience of dehumanisation and its relationship to mental health disorders and distress is in its infancy within the field of clinical psychology. To date, the authors know of no other studies which have examined the experience of dehumanisation in voice-hearers. There has, however, been research conducted into the experience of dehumanisation in alcohol-use disorders, which was the first instance of the concept of dehumanisation being explored within the field of clinical psychology.

Social psychology has a rich theoretical and experimental literature regarding dehumanisation and there are multiple theories in existence which propose to define dehumanisation. Two such theories have provided a theoretical background from which to explore the experience of dehumanisation in voice-hearers within this research, namely, Haslam's bidimensional model of dehumanisation and Livingstone Smith's theory of dehumanisation. It is important to acknowledge that there are other theories relating to dehumanisation, such as Fiske's stereotype content model. These theories have many similarities and some key differences, but all have a degree of utility in making sense of dehumanising attitudes. However, at present, there is little research into what it is like for people to feel dehumanised and what internal perceptions people have of the process of becoming dehumanised, which represents an important space within the literature which this study has sought to start addressing.

This study thus offers insight into the phenomenological aspects of feeling dehumanised from the perspective of self-identifying voice-hearers. It is possible that the emphasis of the themes developed through reflexive thematic analysis may have

been different had the sample included voice-hearing participants diagnosed with psychotic disorders and currently accessing NHS services and thus this is an important population for future research in this area to sample. The authors also considered that the themes developed in this study may have been entirely different within a cultural context in which the experience of voice-hearing is valued or even prized. It is therefore important for readers to hold in mind the cultural context within which this research was conducted and in which participants were embedded.

Overall, this study represents a contribution to a new strand of research within clinical psychology into the experience of dehumanisation in those who hear voices and it represents the starting point for further exploration of this in those with psychosis.

Abstract

Background

Meta-dehumanization and self-dehumanization have been identified as relevant phenomena for developing a deeper understanding of distress related to psychosis. Chadwick (2019) has previously argued that people with psychosis typically feel "dehumanised and set apart by their experiences of psychosis and trauma" and frames mindfulness for psychosis as a humanising therapeutic process. Exploring the experience of dehumanisation in voice hearers was selected as a useful starting point in understanding dehumanisation in people with psychosis.

Method

Qualitative data was obtained through twenty semi-structured interviews with self-identifying voice hearers and analysed using reflexive thematic analysis. This followed the recursive six phase procedure of Braun and Clarke (2022), and this was conducted from a critical realist, contextualist position.

Results

Reflexive thematic analysis of participant's experiences produced a core theme, Dehumanisation as the End of Experiential Continua, and six subthemes: Extent of Distressing Sensory Fragmentation; Sense of Belonging with Other Humans; Integrity of Self as a Private, Coherent Entity; Sense of Worth as a Human Being; Strength of Personal Agency; and Trust in Own Credibility and Reliability. Two further themes, The Push and Pull of Dehumanising Forces and Reclaiming Life through Humanising Forces, were identified.

Conclusions

Reflexive thematic analysis of voice hearers' accounts identified self-dehumanisation as the endpoint where six experiential continua coalesce. Movement along these continua was affected by a range of interpersonal, intrapersonal, and societal forces over time, including dehumanising attitudes of others and voice malevolence and omnipotence.

Key Words

Voice-hearing; Psychosis; Thematic Analysis; Qualitative; Voices

Introduction

"I've always thought that only nasty, horrible people would have voices, that's why I've got voices, because you're just not a human being, you're not worthy of not having voices" (Sue, a voice hearer; Chadwick, 2019, p. 319).

Our understanding of psychosis and, consequently, interventions to reduce the distress induced by psychotic experiences, have undergone a paradigm shift over the last 50 years. Work by Bentall (1990) and Boyle (1990) led to a fundamental shift away from a medicalised syndrome-based model of schizophrenia to a symptom-based approach to psychosis, one which emphasised the continuum of voices and delusions with normal human experiences (Strauss, 1969).

From here, there was a rapid expansion of research into cognitive behavioural therapeutic approaches to psychosis, in particular the cognitive therapy for delusions, voices, and paranoia developed by Chadwick et al. (1996). This focused on targeting the distress of psychotic symptoms, rather than the symptoms themselves, where distress was not a direct consequence of psychotic phenomena but was associated with the meaning given to symptoms.

The limitations of a symptoms-based approach led to a transition to a person-based approach in Person-Based Cognitive Therapy (PBCT) for psychosis (Chadwick, 2006). This involved five important changes to cognitive therapy for psychosis as it was. It emphasised, firstly, radical collaboration to develop Rogerian person-centred therapeutic relationships, where the therapist accepts the unconditional worth of a person, no matter their sensory perceptions, beliefs, or feelings. Secondly, it organised therapy with the concept of the Zone of Proximal Development (Vygotsky, 1978), identifying four focal domains of development: symptomatic meaning, relationship with internal experience, schemata, and symbolic self. Thirdly, it utilised mindfulness to transform relationship with sensory experience and meaning. Fourth, it incorporated conceptualising and working with the self in three primary ways, namely, the premise of the self as a process, addressing self schemata, and aiming for self-acceptance. Finally, PBCT focused on promoting metacognitive understanding across all four domains of development and metacognitive insight into the self as a "complex, contradictory and changing process" (Chadwick, 2006, p. 19). The development of PBCT subsequently led to the evaluation of mindfulness- and acceptance-based

approaches to psychosis as effective interventions for reducing psychosis-related distress (Chadwick, 2014; Chadwick et al., 2005; Jansen et al., 2020).

Ultimately, what could be more central to such person-centred approaches than their humanising features, their recognition and respect for the humanity of the person at the heart of therapy? Chadwick (2019, p. 317) has argued that people with psychosis typically feel “dehumanised and set apart by their experiences of psychosis and trauma” and frames mindfulness for psychosis as a humanising therapeutic process, which ameliorates self-dehumanisation through supporting people to recognise universality with others and develop self-acceptance (Abba et al., 2008). Individuals with early psychosis tend to perceive themselves as inferior to and of lower social rank than matched controls (Allison et al., 2013), suggesting the possibility of perceiving themselves as less human than others. It is also possible that everyday experiences of dehumanisation could directly contribute to the onset and maintenance of post-psychotic depression and social anxiety, given the relationship of these to experiences of entrapment by voices, humiliation, shame, and social marginalisation (Birchwood, Iqbal, et al., 2000; Birchwood et al., 2007).

Dehumanisation is theoretically defined as the attitude or perception of another person or group as less than human (Haslam & Loughnan, 2014) and excluded from the moral consideration that the rest of humanity warrants (Opotow, 1990). Being seen as less than human can be with respect to uniquely human (animalistic dehumanisation) or essentially human (mechanistic dehumanisation) characteristics, the former including self-control and rationality and the latter including emotionality, warmth, and agency (Haslam & Loughnan, 2014). A recent alternative theory is that dehumanisation is the cognitively dissonant attitude that another person is simultaneously less than human but also still human in some respects, albeit uncannily or dangerously so (Livingstone Smith, 2021).

Meta-dehumanisation is the perception of being dehumanised by others, for instance, believing that others perceive you, or a group you belong to, as lacking essentially or uniquely human characteristics ((Bastian & Haslam, 2010; Kteily et al., 2016), and self-dehumanisation is the self-perception of being less than human (Bastian & Crimston, 2014). These concepts from social psychology have been usefully applied in mental health research. For example, research with alcohol-use disorders found that stigma awareness is associated with meta-dehumanisation, and self-stigmatisation is closely lined with self-dehumanisation (Fontesse, Stinglhamber, et al.,

2021); and that self-dehumanisation mediates the relationship between meta-dehumanisation and increased anxiety, depression, and decreased drinking refusal self-efficacy (Fontesse, Demoulin, et al., 2021). A theoretical model has been proposed suggesting the possibly antecedents, protective factors, and consequences of dehumanisation in those with alcohol-use disorders (Fontesse et al., 2019).

Meta-dehumanization and self-dehumanization may be relevant phenomena for developing a deeper understanding of distress related to psychosis. In Western society, psychosis and schizophrenia-spectrum disorders are associated with the most negative stereotypes and lowest expectancy of recovery (Wood et al., 2014) and stigmatising representations continue to be prevalent in the media (Bowen et al., 2019). It is also possible that the relationship people have with their voices is dehumanising (Chadwick & Birchwood, 1994). The distress psychotic voice-hearers' experience has been linked to their appraisal of the omnipotent power voices' hold and the consequent sense of entrapment by their voices (Birchwood et al., 2002). This is supported by the finding that degree of subordination in relation to a voice often parallels subordination in social relationships (Birchwood et al., 2000). Thus, exploring the experience of dehumanisation in voice-hearers may be a useful starting point for exploring this with people experiencing psychosis,

Aim

The present study was aimed at understanding what constitutes the experience of feeling dehumanised in voice-hearers and what factors influence the development and mitigation of this experience, with a view to opening the pathway to further exploring the role of dehumanisation in distressing psychosis.

Research Question

How do people hearing voices describe the subjective experience of feeling dehumanised and conversely, the experience of feeling humanised? What specific experiences contribute to feeling dehumanised or humanised?

Method

Design

This research uses reflexive thematic analysis of qualitative data gathered through semi-structured interviews. The research has been quality assessed against Braun and Clarke's tool for evaluating reflexive thematic analysis (Braun & Clarke, 2021). The ontological and epistemological stances were decided at the proposal stage and the analysis was conducted in a theoretically coherent manner with the selected stances. A critical realist, contextualist stance was adopted. The critical realist ontological stance proposes that a real world exists, however, it is only knowable through subjective, situated perception (Braun & Clarke, 2013). Compatibly, the contextualist epistemological stance proposes that all knowledge arises from a context, which includes the era and society in which the research was conducted, and the researchers' own subjectivity. It suggests that knowledge can be provisionally true within a given context (Tebes, 2005). The analysis assumed the lived experience of participants was real but that access to this was only possible through the inherently subjective lens of the researcher. It also assumed that, within the context the specific research was conducted, it could produce provisionally true results.

Participants

Participants were recruited using convenience sampling from Hearing Voices Network groups, the research advertising platform MQ Participate, and Twitter. Convenience sampling outside of NHS settings and minimally restrictive inclusion criteria were used to recruit a heterogeneous sample.

The inclusion criterion for this study was: currently self-identifying as experiencing at least one distressing voice. The exclusion criteria for this study were: being below the age of 18 at the time of recruitment and being unable to speak English. The criterion related to language was in place due to a shared understanding of language and meaning being important for reflexive thematic analysis. No criterion was in place regarding diagnosis. The target analysis sample was 15-20 participants. A larger sample size was selected as the information power of the sample was expected to be lower due to low sample specificity, a cross-case analysis method, and broad research questions (Malterud et al., 2016), while the use of semi-structured interviews

and a blend of inductive and deductive coding using established theories of dehumanisation and voice-hearing was expected to enhance information power.

All participants were given an electronic copy of the information sheet and had the opportunity to ask questions prior to participating. Informed written consent was obtained for all participants via an online system, Qualtrics. Following interview completion, all participants received an electronic debrief sheet and a £10 voucher to compensate for their time

Data Collection

Interviews were conducted remotely and audio-recorded, eighteen via video call and two via telephone, based on participants' preference. Interviews were conducted and transcribed by the primary researcher (BV) (Appendix C). The wording of the interview schedule, information sheet, and consent form were reviewed with a Person with Personal Experience of psychosis to improve accessibility and sensitivity and minimise any potential distress due to the emotive and sensitive nature of the research topic. Data collection took place May-September 2021.

Ethical Statement

This study was given ethical approval by the University of Bath Psychology Research Ethics Committee (PREC Reference: 20-249; February 2021). The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS. All participants were provided with the information sheet, given an opportunity to ask questions, gave written consent, and consented verbally at the start of their interview.

Reflexive Thematic Analysis

Braun and Clarke's (2002) six-step recursive and reflexive procedure was followed for the analysis. Reflexive thematic analysis was selected as it permits a theoretically informed research question with an experiential focus alongside a blend of inductive and deductive coding (Braun & Clarke, 2006, 2022). This was suitable given the pre-existing rich literature investigating voice-hearing, as well as the growing literature theorising and exploring dehumanisation. A further strength of the method

was its ability to explore recurrent patterns of meaning across a heterogeneous sample, while noticing instances of individuality.

The analysis was conducted using NVivo Version 12 (2020). The themes developed were analytical and each theme and subtheme was comprised of both inductive and deductive codes. The primary researcher familiarised with the transcripts through multiple readings, annotating, and two iterations of coding. Initial themes and subthemes were developed and mapped through discussions between BV and PC about the clustering of codes.

Following this, BV reviewed the clustering of codes under themes for a second time, merged two subthemes, and revised the theme names. BV moved recursively backwards and forwards between the interviews, extracts, codes, subthemes, and themes to check the evidence for the themes and subthemes, their boundaries and coherence. Theme definitions were written for each theme and subtheme to outline their central organising concept and boundaries. Finally, theme names were refined, extracts were selected and woven into the narrative of the results.

Reflexivity

BV had some experience of working with voice-hearers clinically in inpatient and community settings and had previously completed historical research into the recovery movement for those with psychosis. PC had extensive experience of working with voice-hearers clinically and through research. Both researchers felt curiosity and concern about the subjective experience of dehumanisation in voice-hearers.

Validity, Generalisability, and Transferability

Final theme checking was completed by BV to verify the validity of themes against the content of interviews. Throughout the analysis, BV kept a reflexive log which recorded positions, assumptions, and influences throughout the research process.

BV sought to enhance analytic generalisability by developing a theoretically oriented analysis (Braun & Clarke, 2022), identifying analytic themes that are relevant to all or many participants through blended inductive and deductive coding (Polit & Beck, 2010). The context, participants, and circumstances of the study are described

such that the reader is enabled to assess the transferability of the research to other contexts (Braun & Clarke, 2022).

Results

Participants

Twenty voice-hearers participated, eleven men and nine women (none identified as non-binary). Eight participants identified as Black British, four as White British, two as Mixed (White and Black) British, one as Mixed (Black British and Chinese), two as Asian Indian, two as Asian Other, and one as White Other, European. Eleven participants were 18-24, four were 25-29, one was 30-34, one was 40-44, one was 50-55, one was 60-65, and one was 70+. Nineteen participants disclosed how long they had heard voices for. Participants reported having heard voices on average for 11 years, with a range of 1 - 70 years. The average length of an interview was 37 minutes (range 17 – 82 minutes).

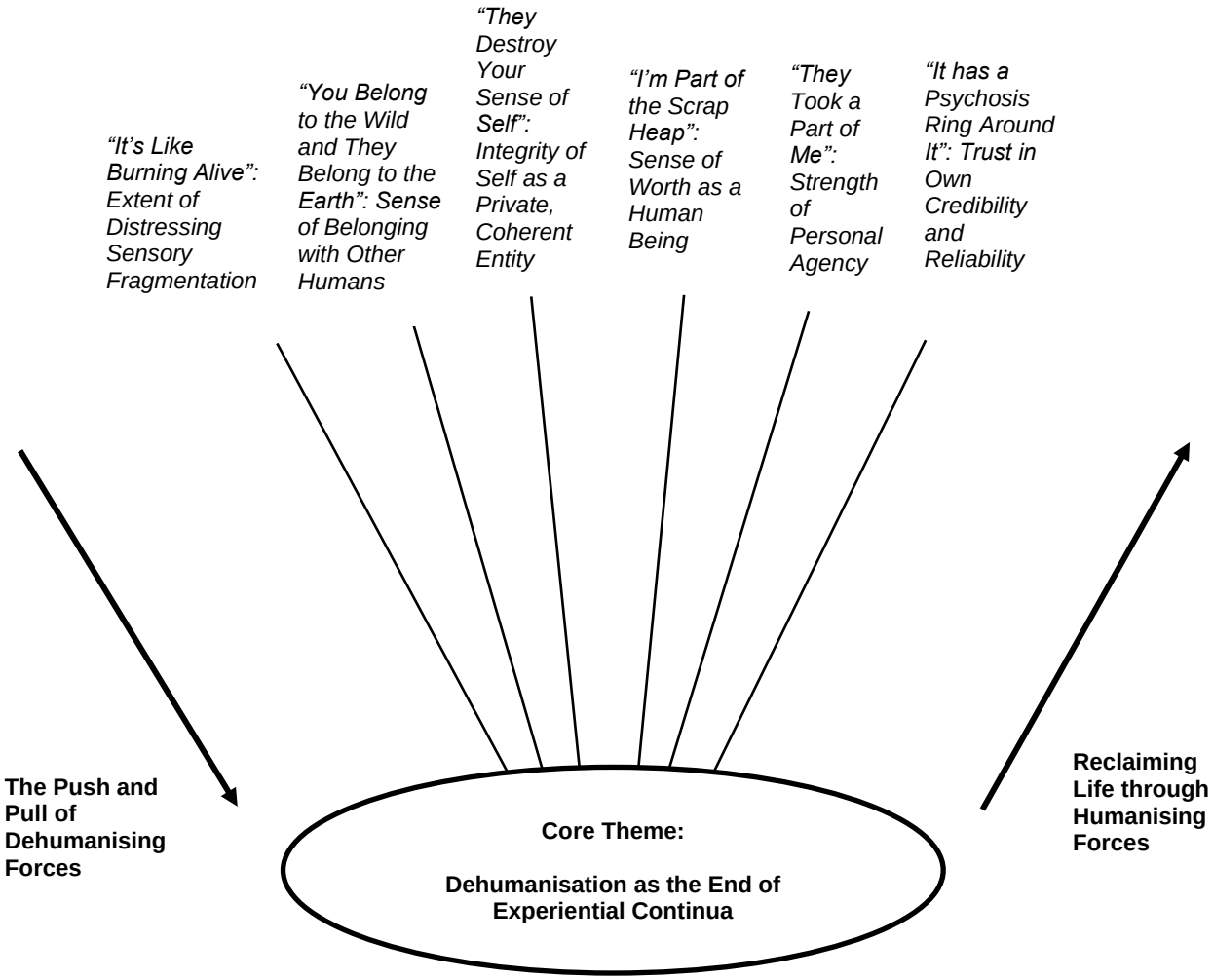
One participant was recruited via the Hearing Voices Network, four participants were recruited via Twitter, and fifteen via, MQ Participate. A further fourteen potential participants expressed interest but did not respond to invitation to schedule an interview.

Themes

Six different kinds of experiential changes were identified as constituting feeling dehumanised for voice-hearers. These changes represented the loss of some essentially human quality or capability. Feeling humanised involved these changes reversing. A range of societal, interpersonal, and intrapersonal forces were shared by participants as either moving them towards feeling dehumanised or moving them away from this. See Figure 1 for the map of themes and subthemes and Table 1 (Appendix I) for the codes underpinning these.

Figure 1

Map of themes and subthemes



1. Core Theme: Dehumanisation as the End of Experiential Continua

Voice-hearers' descriptions of feeling dehumanised indicated six key psychological processes (sub-themes): that is, distressing sensory fragmentation, lower self-worth, lower sense of belonging with others, less sense of themselves as private and coherent, weaker personal agency, and loss of trust in themselves and their credibility. There was substantial intra- and inter-personal variation within each, and hence these six subthemes were conceptualised as being like continua.

A central unifying core theme emerged, that of Dehumanisation as the End of Experiential Continua. Thus, whilst for different participants, different combinations of the six sub-themes were more important than others, in moments of self-

dehumanisation, participants experienced a facet of each continuum, like rivulets coalescing into one stream. And there was a strong and consistent sense that dehumanisation was the end of each continuum, the end of the line so to speak.

Two further themes were developed which related to humanising and dehumanising forces – that is, forces which moved people along continua either towards or away from feeling dehumanised.

1.1. "It's Like Burning Alive": Extent of Distressing Sensory Fragmentation

Participants expressed that voice-hearing often felt inexplicable and terrifying at first and that this contributed to feeling, at worst, not human for having "lost it" (P12). The experience of voice hearing was often perceived as alien initially, and for some continued to feel alien to the self and difficult to reconcile, as P1 said, "these are alien voices that I'm hearing, they're not my own voice […] they do seem to know what's going on in my mind, but they're still alien to me".

Some participants reported extreme distress with strong sensory qualities, with one participant describing voice-hearing as like a "traumatising attack" (P17), and another describing the intensity as "like pouring out of my skin […] it's like burning alive" (P8). Others reported that they, during their recovery, managed to start experiencing their voices as a harmless event in the mind, which related to starting to feel human again:

> I can now say to the men, you know, I don't believe you or, you know, if they're making a threat, I can say, "ah, that's just an empty threat, you can't follow through on that (P4)

1.2. "You Belong to the Wild and They Belong to the Earth": Sense of Belonging with Other Humans

Voice-hearers reported feeling alone with the experience of voices, alongside feeling rejected from valued social groups or from society. The feeling of not being acceptable to other people contributed to a sense of defeat and thoughts about removing the self from humanity, or already being in some way removed:

> When you try to fit into the society and to your friends and you try your level best to be the one person they used to know before the voices came […] and it

> doesn't matter the efforts you make the people they're just like "no, no, no, we cannot accept you here" […] it makes you feel like you're not a person anymore, like you belong to the wild and they belong to the earth, and you are in the wild, you are just one, you are just you, you're not a person, you're no one else (P12)

One participant (P20) reflected that he perceived himself as belonging towards the bottom of the hierarchy of beings and felt he could never move up this hierarchy regardless of what he did: "I've just come to the understanding that I'm just less of a person because of it, I'm the subset of the subset of people". He noted the importance of his intersection here of hearing voices and being from a minority ethnic group, which he felt compounded his position.

Others believed that their struggle to match the behaviour and achievements of others deprived them of belonging with other humans:

> [I] view myself like less of a person because I can't make decisions like a normal person, I can't carry on with my life, I can't do the same as other people, I feel like undignified, I feel like I'm not fit to be alive (P19)

1.3. "They Destroy Your Sense of Self": Integrity of Self as a Private, Coherent Entity

Voice-hearing impacted on participants sense of the integrity of their self and identity, with this initially feeling destroyed or diminished for some. Those with more malevolent or incongruent voices experienced them as more destructive towards their sense of self. This loss of a sense of a coherent, integrated self contributed to feelings of being less of a person or not quite human, as P4 reported, "the thing I always emphasise about these kinds of experiences is how initially they completely destroy your sense of self," and as described by P14, "it has really diminished my personality […] really affected my character and my reputation".

Some described feeling that their mind was no longer a private place and felt a strong sense that their voices could abuse access to their mind, or impact on activities which were integral to their sense of self, as indicated by P19, "they just heard my decisions, what I want to do, and they do contrary".

1.4. "I'm Part of the Scrap Heap": Sense of Worth as a Human Being

Many participants described feeling a loss of self-worth due to their experience of voice-hearing and associated impacts, as P15 expressed, "most of the time the voices dehumanise me I feel like I'm not enough". P20 highlighted a similar feeling:

> I'm not gonna leave the scrap heap because I know I can't really, if I think about it my reality is the scrap heap, but I will be at the top of the scrap heap rather than towards the bottom […] for me it was very much I'm already not human, as it is, I'm just this thing (P20)

Some reported feeling exhausted and defeated by the constant fight to prove their own worth, with the eldest person in the study (P1) reporting that this fight had continued for decades by saying, "I always have to challenge myself to believe that I am really a worthwhile person. […] I have to sort of deploy arguments like that to prove that I'm not a worthless person, as the voices keep insisting".

Others noted feeling inadequate as a human being compared to other people and feeling less capable than others, and some perceived their voices and other people as in agreement about the kind of criticism they deserved:

> The men would be swearing at me telling me that I was rubbish in various flowery language sometimes commanding me to kill myself so […] yeah almost kind of taking on board and believing what they were saying about me you know internalising all of that (P4)

1.5. "They Took a Part of Me": Strength of Personal Agency

Voice-hearers shared feeling a loss of control or influence over their lives and an impact of hearing voices on how strong they perceived their personal agency to be:

> I didn't want to do this, they took a part of me […] why do you have to act like that lunatic if you say you are not? When you're trying to defend yourself, you yourself just say yourself like "okay I think I'm a lunatic now, because I haven't controlled it" (P10)

Experiencing voices taking over their actions and choices or reducing their ability to perform valued behaviours and activities contributed to this reduced sense of

agency. P1 reported needing to exert high levels of focus to stop himself performing behaviours his voices wanted him to do, for example, “I concentrate hard as I’m able to do and force myself not to do it […] I lose a bit on the swimming front, because I never swim out of my depth”.

Experiencing fighting the voices as ineffective further weakened people’s sense of their own agency. Many noted impacts on their functioning in valued areas of their lives and some felt unable to meet their own expectations as well as those of the voices, as P9 said, “You have tried everything every possibility not that you cannot, you cannot achieve it you feel like demoralised you feel low […] you feel less of a human”.

1.6. “It Has a Psychosis Ring Around It”: Level of Trust in Own Credibility and Reliability

Voice-hearers cited losing trust in their own credibility, believability, and decision-making capabilities, through the influence of voices, the control voices have over their actions, and through the “psychosis ring” (P20) other people place around what they say and do. This contributed to a feeling of not being human, for instance, for P8, “the guilt, the frustration, the assessing my life, and they just um I just perceive myself as the worst, worst creature in the planet really”.

One participant described failing to catch a rat leading to this kind of doubt in their mind:

> Because there wasn’t anything […] nothing came in the front room, it’s like my brother says to me, “Well, you know, it’s because of your illness” and I’m kind of going, “Is it or is it not?” And it’s like I’m trying to figure it out […] now what I say has a psychosis ring around it (P20)

Facets of this include not feeling free to allow their minds to be unoccupied (“I always have to be doing something”, P1), losing a sense of being able to rely on themselves acting authentically (“I’m not able to make right decisions”, P19), and experiencing voices as out of control (P17): “at first, I didn’t really appreciate myself, I felt maybe like I’d lost it, um, I am losing my mind […] then I didn’t feel like a human being”.

2. The Push and Pull of Dehumanising Forces

Participants reported a wide range of forces moving them up and down these experiential continua. Particularly, dehumanising attitudes held by other people, which incorporated both animalistic and mechanistic dehumanisation, as well as seeing people as uncanny, bizarre, or dangerous, had a powerful effect on how dehumanised voice-hearers felt in their interactions with other people, as illustrated by P4 when he said, “in the early phases I felt people were treating me as less than human […] somebody who was slightly irrational, a bit bizarre”. These attitudes connected to ostracism and stigma. For example, with regards to interactions with friends, P14 expressed, “they make me feel like I’m odd one out and I’m not a human […] in short, they dehumanise me,” and P15 highlighted, “I told my friend about my experience with the voices I hear and all she could tell me was that I was going crazy no such things existed and you see how a close friend can share something so delicate with and she turns out to tell you that it’s not possible […] so I tend to feel bad”.

There appeared to be a process whereby meta-dehumanization became self-dehumanisation. Meta-dehumanization was by voices, by other people, or both, as described by P15, “one criticises me, some encourage me […] but mostly they dehumanise me, they discourage me badly,” and P18, “I think the voices they’re the same as the people, you know, and the society, I hate it”.

Many reported that verbal abuse, relentless pressure, and the omnipotence and malevolence of voices contributed to their feeling of being dehumanised:

> Three evil men basically erm they kind of so they torment me sort of deride me […] the persecutory type of experiences and I think initially they almost had a sort of a god-like quality to them […] kind of all powerful and difficult to resist (P4)

Some reported experiencing a felt sense that voices deliberately and maliciously sought to compound trauma in their life, adding an additional layer to abuse, as indicated by P1, “the bad voices sort of capitalised on that and made my life even more of a misery”.

Participants also experienced several situations in which they observed society largely perceiving them as unwelcome or beyond hope, as well as situations where purported protectors perpetuated prejudice:

> You tell people in the outside world that you've got mental health issues, that's one thing. That's one level of stigma. If you further admit that, by the way, I hear voices as well, then you get a lot of opprobrium directed at you […] people say that you must be a bad person, you're dangerous […] we can't trust what you say (P1)

3. Reclaiming Life through Humanising Forces

Voice-hearers reported a range of forces which helped them to feel human again or retain their belief in their humanness in the first instance. These included consistent acceptance by others, which helped with feeling a sense of belonging and safety with other people, as P17 experienced with his family, "they understand how it is for me and they're always there and accepting my problem and maybe they give me so much love and understanding".

Reclaiming personal agency and control over life through effective coping, engagement with meaningful activities, helping others earlier in their recovery from distressing voices, helped with progressively feeling human again for participants such as P1, "I'm living with myself as I am, and learning to cope with the voices, and perhaps more importantly teaching other people how to cope with the voices".

Those who felt human had managed to develop a tolerance towards social rejection, a sense of being on their own side, or a perception of the voice-hearing experience as special and uniquely human, which was how P5 conceptualised it, "the fact that I can hear voices and my friends and maybe close relatives cannot hear […] I think it's unique, but I have not had anything extraordinary that has made me feel inhuman, I just feel normal".

Changes in voices or the perception of voices, such that they had diminished authority or were perceived as an event in the mind, was helpful in strengthening a sense of agency and regaining trust in self, as well as integrating the sensory experience of voices and gaining distance from the experience, as indicated by P10, "that was the big thing, like after I accept this thing, like you are able to control this, like you make yourself the controller" and by P4:

> Re-assert some authority myself over them […] that kind of power dynamic is the key thing that's evolved over time but initially I was absolutely terrified by

> these experiences […] I felt very unsafe both from myself and from my family (P4)

Recognition that abusive voices were immoral in their behaviour and recognition that voices might be trauma manifesting itself were powerful ways in which people began to make sense of the voice-hearing experience and respond to it in a more self-compassionate way. Similarly, engagement in safe group contexts helped with increasing belonging, as was the case for P4, “the more then that I was able to leave the house to feel safe again […] that sort of reintroduction to society meant that I was more kind of socially acceptable”.

Voices which were perceived as empowering, guiding, benevolent, were also identified as humanising forces, as P6 noted, “it was lack of trust, lack of support, people not being there, people who are pushy […] I think I had this kind of support from the voice”.

Those who held onto a sense of their humanness had stuck close to others who accepted and supported them with the challenges of hearing voices, as P10 emphasised, “they have been with me throughout uh it’s without them I don’t know if I would be where I am like they were I say number one who came let me say to my rescue”.

Immersion in benign nature was helpful in enabling participants to feel human again and reducing the level of threat they experienced, as shared by P8, “being in safe place and nature […] time to be as safe as I could be […] that’s how I’m dealing with it”.

Belief and trust in a part of the self that was vital, permanently present in the background, and able to provide hope in coping with voices, was also important for participants in feeling human again, as shown by a metaphor P1 was taught by a psychologist, “I decided I would believe there is a little spark, a little light that never goes out, metaphorically speaking, inside you,” and by P12:

> Not giving up on myself, even if others they gave up on me, and trying my level best to, even if they’re challenging, I kind of come up with a new challenge that it’s hard for them to overpower me on that, I think I have an upper hand now and I have an advantage over them (P12)

Discussion

First proposed by Strauss (1969), the continuum model proposes that psychotic experiences such as voices and 'delusions' lie on continua functions with ordinary human experience and behaviour. From its beginnings, cognitive therapy for psychosis has been underpinned by a continuum model (Chadwick & Lowe, 1990), as described in the introduction. This normalising framework contrasts with traditional psychiatric approaches which have emphasized discontinuity, framing psychosis as lying on the far side of an 'abyss'. The continuum model raises an interesting question – that is, if at one end lie everyday counterparts to voices (Peters et al., 2016) and persecutory beliefs (Ellett et al., 2003), then what lies at the far end of the continuum of ordinary human experiences? Distressing clinical voices and psychosis certainly were reported as powerful forces contributing to both meta-dehumanisation and self-dehumanisation. However, for the participants in the present study, distressing psychotic experience is not the end of the line - it is self-dehumanisation that lies at the end of the continuum.

Reflexive thematic analysis of participant's experiences identified six experiential continua which coalesce at the point of self-dehumanisation – that is, sensory fragmentation, belonging with other humans, integrity of self as a private and coherent entity, worth as a human being, personal agency, and trust in one's own credibility and reliability. These align with and extend the literature.

Losing trust in the reliability of one's own sensory and perceptual experience, and one's overall credibility, echoes research showing how voice-hearers are often perceived as "unreliable narrators" and start to doubt their own credibility (Harris et al., 2022). Reduced perception of agency has previously been found to be associated with dehumanisation. For instance, Formanowicz et al. (2018) found, in a non-clinical sample, that agency attributions are primary determinants of humanness attributions, such that where agency is not attributed, humanness is not. Losing a sense of being the author of one's actions and lives has long been posited as central to a loss of hope in people with psychosis and increasing sense of personal agency is a key mechanism in recovery (Bjornestad et al., 2017). Again, the present study suggests that fundamental to feeling dehumanised as a voice-hearer is destruction of a person's sense of having a coherent sense of identity coupled with loss of their self-worth. An essential element of our perception of ourselves as human is our being in possession of a self. A systematic review of qualitative research found that individuals with

psychosis struggle to maintain a coherent sense of self, reflected in changes in narrative identity towards detached narration and disjointed events, underpinned by consistent suffering across life stages (Cowan et al., 2021). Overall, loss of trust in oneself in different ways, appears to connect all six experiential continua, and highlights the dehumanising effect of this loss.

Some participants described feeling propelled towards the end of the continua by voices and psychosis, and difficult interactions and experiences with other people, whereas for others it felt like a gradual erosion. Voice omnipotence, malevolence, and omniscience (Chadwick & Birchwood, 1994) were recognised as powerful dehumanising forces; to a lesser extent, guiding and benevolent voices could be humanising forces. As is to be expected, societal prejudice and stigma emerged as dehumanising forces, and several participants reported perceiving some mental health professionals to embody these negative dehumanising attitudes. Social psychological research shows how social ostracism closely relates to meta- and self-dehumanization (Bastian & Haslam, 2010). In research on mindfulness for psychosis, universality commonly emerges as the single most important therapeutic group factor (Chadwick et al., 2009; Chadwick et al., 2005).

These continua relate closely to the focal points of intervention in PBCT (Chadwick, 2006), such as negative self- and other- schemata, metacognitive insight regarding the self as a process, relationship with symptomatic meaning, and self-acceptance. Destruction of a person's sense of self, of worth and belonging, perceptions of oneself and one's sensory experiences as untrustworthy and one's agency as unreliable or weakened, are all relevant to the proposed mechanisms of change within PBCT. It may be that part of what PBCT acts to ameliorate is, fundamentally, the experience of dehumanisation.

The qualitative findings of this study suggest a complex web of relationships between voice-related meta-dehumanisation, other-related meta-dehumanisation, and self-dehumanisation. It will be important for future research to disentangle these relationships and how they link to distress and coping in voices and psychosis and to concomitant depression, suicidality, and social anxiety. It will be important to examine how established interventions for distressing voices and psychosis might affect movement along the six experiential continua, and whether therapies might be refined to address more directly one or more of these. The six continua might also inform

development of measures of self-dehumanisation in voice-hearing and psychosis, and future research will determine if the themes have wider clinical utility.

A strength of this study was that participants exhibited a wide range of ages and ethnicities and an almost even balance of binary genders. This may enhance the transferability of the findings to other contexts. However, given that the sample was obtained by convenience and limited to those self-identifying as voice-hearers, participants were primarily those not at the peak of their distress related to voice-hearing. In keeping with a critical realist and contextual stance, the present research accepts as real the voice-hearers lived experience and the analysis reflects the subjective, culturally, and temporally situated research context, where knowledge is provisionally true within a given context.

Conclusion

Clinical cognitive approaches to psychosis are founded in a continuum model. The present study suggests that it may not be distressing psychotic experience that lies at the end of the continuum of normal human experiences, but rather self-dehumanisation. Reflexive thematic analysis of voice-hearers' accounts identified self-dehumanisation as the end of continua, a point where six experiential continua coalesce. Movement along these continua was affected by a range of interpersonal, intrapersonal, and societal forces, including dehumanising attitudes of others and voice malevolence and omnipotence. This extension of current conceptualisations of psychosis-related distress may open pathways to research exploring how cognitive therapy and mindfulness-based interventions for psychosis could be adapted to address self-dehumanisation.

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Commentary Text

The key development and extension identified in this study relates to how these different aspects of experience contribute to feeling dehumanised for voice-hearers. The themes developed in this study are conceptualised as experiential continua which voice-hearers described themselves as reaching the end of when they felt dehumanised and moving back along when they began to feel humanised. The themes closely relate to experiences in voice-hearers and people with psychosis which have been extensively explored within the psychosis research across disciplines, such as agency, identity, and sense of belonging. The study also highlighted that prejudice and discrimination within society still manifest in interpersonal interactions which voice-hearers describe and affect how human voice-hearers perceive themselves to be.

It is important to note that it is not possible to establish causal relationships in a qualitative study, although it is possible to report on what people experienced contributing to their distress. Thus, the findings related to dehumanising and humanising forces cannot be interpreted as causal or thought of in a mechanistic framework but can be considered as part of the narrative voice-hearers' shared regarding how feeling dehumanised developed and how it was then mitigated over time.

Considering the relationship between my main research project and literature review project, I have reflected on the importance of psychological distress being considered as a type of harm, appropriately operationalised, and then more systematically monitored in clinical trials of interventions. For instance, dehumanisation could be usefully operationalised as a type of psychological harm for monitoring in clinical trials of interventions aimed at reducing distress in voice-hearers or those with psychosis.

Overall, this study helped to elaborate on distressing experiences of dehumanisation in voice-hearers which, it has been previously identified, may be ameliorated by mindfulness. Further research is required to establish this conclusively, however.

Executive Summary

My main research project and literature review have focused on how we might understand and ultimately reduce and prevent harm and distress to people experiencing psychosis. My main research project aimed to do this by qualitatively analysing interview data from voice-hearers to develop an understanding of what constitutes and contributes to their experiences of dehumanisation. My literature review aimed to systematically review clinical trials of mindfulness for psychosis to evaluate the safety of these interventions and the quality of reporting of harm data, making recommendations for how this could be improved to ensure a robust benefits versus harms analysis is possible. My service-related project had a different focus in that it sought to evaluate training delivered to managerial staff in the NHS to improve confidence and knowledge in providing a trauma-informed compassionate leadership approach to staff during the pandemic.

My main research project sought to develop a deeper understanding of the distress experienced by voice-hearers. It identified meta-dehumanization and self-dehumanization as relevant phenomena for deepening this understanding. This was identified as a new avenue for research into the experience of and amelioration of distress in psychosis based on observations by Professor Paul Chadwick that people with psychosis typically feel dehumanised by their experiences and his observations that mindfulness for psychosis can be experienced as humanising. Qualitative data was obtained through semi-structured interviews with twenty participants, all of whom self-identified as voice hearers. This data was analysed using reflexive thematic analysis, which was conducted from a critical realist, contextualist position. Reflexive thematic analysis of participants' experiences produced a core theme, Dehumanisation as the End of Experiential Continua, and six subthemes: "It's Like Burning Alive": Extent of Distressing Sensory Fragmentation; "You Belong to the Wild and They Belong to the Earth": Sense of Belonging with Other Humans; "They Destroy Your Sense of Self": Integrity of Self as a Private, Coherent Entity; "I'm Part of the Scrap Heap": Sense of Worth as a Human Being; "They Took a Part of Me": Strength of Personal Agency; "It has a Psychosis Ring Around It": Trust in Own Credibility and Reliability. Two further themes, The Push and Pull of Dehumanising Forces and Reclaiming Life through Humanising Forces, were identified. The analysis of voice-hearers' accounts identified self-dehumanisation as the end of continua, a point where six experiential continua coalesce. Movement along these continua was affected by a range of interpersonal, intrapersonal, and societal forces, including dehumanising

attitudes of others and voice malevolence and omnipotence. It is hoped that this extension of current conceptualisations of psychosis-related distress has the potential to open pathways to research exploring how cognitive therapy and mindfulness-based interventions for psychosis could be adapted to address self-dehumanisation.

My literature review project aimed to systematically review randomised clinical trials of mindfulness for psychosis to evaluate the safety of these interventions. It had been identified in the research literature that the potential harmful outcomes of mindfulness-based interventions are under-researched. Likewise, this is true of research into other psychological interventions and represents a problem in clinical trials within psychology. The internal and external supervisors for this project, Professor Paul Chadwick and Dr Lyn Ellett, had previously developed recommendations for how harm might be operationalized in research into the safety of mindfulness-based interventions for psychosis, which were utilized within this study to operationalize harm, meta-analyse harm outcomes data, and evaluate the quality of reporting of harm. Systematic searches of the databases PUBMED, PSYCINFO, EMBASE, and Web of Science were conducted along with manual searches of the gray literature and of reference lists of included studies. This identified 38 studies for inclusion in the review. Data regarding harm operationalization and outcomes was extracted and the percentage prevalence of harm for each index was obtained by trial arm. Meta-analyses of risk differences were conducted for intervention dropout and hospitalization, the only two indices out of a total of ten indices which had sufficient data for meta-analysis to be performed. It was found that the percentage of studies reporting on each index of harm varied greatly as did the prevalence of harm across each index. Reporting of harm was inconsistent across studies and the quality of data collection and reporting varied. It was found that there was a higher risk of hospitalization in control arms compared to intervention arms and that there were comparable levels of intervention dropouts across both trial arms. It was possible to conclude that mindfulness-based interventions for psychosis may be safe and may even reduce risk of certain kinds of harm such as hospitalization. Recommendations were made for how future research can systematically and consistently collect and report data on harm in clinical trials of mindfulness for psychosis and other interventions to permit weighted analyses of benefits versus harms.

Finally, my service-related project sought to evaluate the effect of training on the confidence and knowledge of NHS managers and leaders in implementing guidelines on the “Do’s and Don’ts” of a trauma-informed response to staff during the

pandemic. It sought to identify improvements to the training that could aid its wider dissemination. This study used a mixed methods approach and followed the Plan-Do-Study-Act (PDSA) cyclical model of service improvement adopted by the NHS. Pre-, post-, and follow-up questionnaires were used to assess the level of confidence and knowledge participants had in implementing the “Do’s and Don’ts”. Content analysis was used to analyse qualitative data, while paired samples t-tests and repeated measures ANOVAs were used to analyse quantitative data. It was found that there were significant improvements in participants’ confidence and knowledge between pre- and post-training, however, these were not maintained at follow-up. Notably, there was a high level of attrition between post-training and follow-up. Qualitatively, most participants reported achieving what they hoped for from the training, including professional development, skills for responsive management, and improved self-care and self-compassion within demanding leadership roles. Participants provided valuable suggestions for enhancing the helpfulness of the training which has contributed to a range of recommendations. These recommendations have been used to inform the wider dissemination of the training.

Acknowledgements

Firstly, I would like to thank all the clients I have worked with over the course of training. I have learnt the most from you of anyone and have been struck by and grateful for your openness, courage, and strength. Thank you for working with me and letting me be your psychologist.

I would like to acknowledge the kindness, care, and support of all my placement supervisors during training: Liam Williams, Emma Hartley, Lynne Hopkinson, Cara Haines, Juliet Chastney, Christina White, Annabel Goodall, Anna Fussell, and Rosie Banting. I have appreciated everything you have taught me and all your guidance and support.

I would like to thank my research supervisor, Paul Chadwick, for being a thoughtful, compassionate supervisor, for being helpful and present whenever I have needed, and for giving me the space to progress with research at my own pace. I have valued the insights of our discussions, our mutual excitement by ideas, and the creative, reflexive process of doing qualitative research together.

I would like to thank my external supervisor, Lyn Ellett, for sharing your knowledge and guidance for my systematic review.

I would also like to thank Emma Griffith and Chris Gillmore for all your support and enthusiasm in supervising my service-related project.

I am grateful for the compassion and encouragement provided by my clinical tutors, Emma Griffith and Vuokko Wallace, throughout training. Thank you for offering me your presence and kindness and for listening to me and believing in me.

I have appreciated having a lovely group of people in our cohort to share training with. I wish we had had more time together during the pandemic and can't wait to celebrate finishing training with you. You are an incredible group of people.

I would especially like to thank Ellen Huish for proof-reading my final portfolio and for being such a caring friend throughout training. You have made the experience infinitely better.

I give so much thanks to my fiancé, Dave, for being patient, understanding, and incredibly caring throughout training, for being there no matter what, and for taking on so much of the care of our pets and home while I've been finishing this portfolio.

To my wider family and friends, thank you for being there. Special thanks go to Jo, Leah, and Amber - thank you for always being the best of friends, being so supportive and bringing fun and laughter to help with finishing the course.

Finally, I would like to thank my mum and dad for their unconditional support and love, for encouraging me to be whoever I wanted to be and teaching me fortitude and grit in the face of life's difficulties. Anything I ever achieved is because of you.

Appendices

Appendix A

Behavioural and Cognitive Psychotherapy Instructions for Authors (Chosen Journal for Main Research Project)

Instructions for authors

EDITORIAL OFFICE

Professor Paul M Salkovskis – *Editor*

Editorial Office: journal.office@babcp.com

Editorial Statement

Behavioural and Cognitive Psychotherapy is an international multidisciplinary journal for the publication of original research of an experimental, or clinical nature that contributes to the theory, practice and evaluation of cognitive and behavioural therapies. As such the scope of the journal is very broad, and articles relevant to most areas of human behaviour and human experience which would be of interest to members of the helping and teaching professions will be considered for publication.

As an applied science the concepts, methodology and techniques of behavioural psychotherapy continue to change. The journal seeks both to reflect and to influence those changes. While the emphasis is placed on empirical research, articles concerned with important theoretical and methodological issues as well as evaluative reviews of the behavioural literature are also published. In addition, given the emphasis of behaviour therapy on the experimental investigation of the single case, the journal from time to time publishes case studies using single case experimental designs.

For the majority of designs this should include a baseline period with repeated measures; in all instances the nature of the quantitative data and the intervention must be clearly specified. Other types of case report can be submitted for the Brief Clinical Reports section.

Articles should concern original material that is neither published nor under consideration for publication elsewhere. This applies also to articles in languages other than English.

Preparing Your Manuscript

Articles must be under 5,000 words at the point of submission, excluding references, tables and figures. Manuscripts describing more than one study may exceed no more than 6000 words but please make this clear in your cover letter.

Brief Clinical Reports should be no more than 1800 words (see more information below).

Please note that we currently do not usually accept studies carried out on student samples unless there is a clear indication of generalisability to clinical populations.

The journal strongly encourages blind review. Authors who want a blind review should indicate this at the point of submission of their article, omitting details of authorship and other identifying information from the main manuscript. Authors who do not omit this information will be assumed as submitting a non-blinded manuscript.

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Article Types

Main
Reports of original research employing experimental or correlational methods and using within or between subject designs. Review or discussion articles that are based on empirical data and that have important new theoretical, conceptual or applied implications.

Empirically Grounded Clinical Interventions
This section is intended for reviews of the present status of treatment approaches for specific psychological problems. It is intended that such articles will draw upon a combination of treatment trials, experimental evidence and other research, and be firmly founded in phenomenology. It should take account of, but also go beyond, treatment outcome data.

Brief Clinical Reports
Material suitable for this section includes unusual case reports and accounts of potentially important techniques, phenomena or observations; for example, descriptions of previously unreported techniques, outlines of available treatment manuals, descriptions of innovative variations of existing procedures, details of self-help or training packages, and accounts of the application of existing techniques in novel settings. The BCR section is intended to extend the scope of the clinical section. **Submissions to this section should be no longer than 1800 words and should include no more than six references, one table or figure, and an extended report that contains fuller details. There are no restrictions on the size or format of the extended report as it will be published online only.** It may, for instance, be a treatment manual, a fully detailed case report, or a therapy transcript. If a submission is accepted for publication as a Brief Clinical Report, the author(s) must be prepared to send the fuller document to those requesting it, free of charge. The extended document will also be mounted on the journal's website as a PDF format (the document will not be copyedited).

Study Protocols
Protocols of proposed and ongoing trials in behavioural and cognitive therapies will be considered. Your study must be registered and have ethical approval, and proof of this will be required. The abstract should be structured under the following four headings; Background, Aims, Method, Discussion.

Please use the Standard Protocol Items: Recommendations for Interventional Trail (SPIRIT) checklist for protocols of randomised controlled trials (see the reporting standards section below). Manuscripts should be under 2000 words at the point of first submission, and include no more than 15 references, and no more than three tables/figures in total. A PDF with additional, unlimited text, figures and tables may be included designated for online only publication.

Style Guide

The following should be included in all manuscripts:

Title page
This should be a separate file to the main text to ensure blind review.

The title should phrase concisely the major issues. Author(s) to be given with departmental affiliations and addresses, grouped appropriately. A running head of no more than 40 characters should be indicated.

The following statements should be included on the title page:

Acknowledgements
You may acknowledge individuals or organizations that provided advice, support (non-financial).

Conflict of Interest
Authors should include a Conflicts of Interest declaration in their title page. Conflicts of Interest are situations that could be perceived to exert an undue influence on an author's presentation of their work. They may include, but are not limited to, financial, professional, contractual or personal relationships or situations. Conflicts of Interest do not necessarily mean that an author's work has been compromised. Authors should declare any real or perceived Conflicts of Interest in order to be transparent about the context of their work. If the manuscript has multiple authors, the author submitting the title page must include Conflicts of Interest declarations relevant to all contributing authors.

Example wording for your Conflicts of Interest declaration is as follows: "Conflicts of Interest: Author A is employed at company B. Author C owns shares in company D, is on the Board of company E and is a member of organisation F. Author G has received grants from company H." If no Conflicts of Interest exist, your declaration should state "Conflicts of Interest: None".

Data Availability Statement
This is a brief statement about whether the authors of an article have made the evidence supporting their findings available, and if so, where readers may access it. More information on Data Availability Statements and example statements can be found here. Please note that if you are not making your data publicly available, we ask you to state the reason why in your cover letter to the Editor.

Financial support
Please provide details of the sources of financial support for all authors, including grant numbers. For example, "This work was supported by the Medical research Council (grant number XXXXXXX)". Multiple grant numbers should be separated by a comma and space, and where research was funded by more than one agency the different agencies should be separated by a semi-colon, with "and" before the final funder. Grants held by different authors should be identified as belonging to individual authors by the authors' initials. For example, "This work was supported by the Wellcome Trust (A.B., grant numbers XXXX, YYYY), (C.D., grant number ZZZZ); the Natural Environment Research Council (E.F., grant number FFFF); and the National Institutes of Health (A.B., grant number GGGG), (E.F., grant number HHHH)". Where no specific funding has been provided for research, please provide the following statement: "This research received no specific grant from any funding agency, commercial or not-for-profit sectors."

Main Text (anonymised with no author information)
This should be uploaded as a .doc file with the following running order. The following format is based on APA style which should be followed throughout: http://www.apastyle.org/

Abstract
Should consist of no more than 250 words and structured under the following five headings: Background, Aims, Method, Results, and Conclusions. Include up to six key words that describes the article.

Main Text
This should contain the sections **Introduction** (including overview and theoretical background), **Method** (participants, design, data analyses and Ethical Statement- see below), **Results** (described in detail with summary figures and tables), **Discussion** (including conclusions and limitations).

Ethical statements
All papers should include a statement indicating that authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS. Authors should also confirm if ethical approval was needed, by which organisation, and provide the relevant reference number. If no ethical approval was obtained, the authors should state what governance arrangements were in place (e.g. audit committee approval).

References
Please use APA style for the in-text citations and references. In the reference list there is an additional requirement that author names be listed in **bold face**. For example:

Grady, J. S., Her, M., Moreno, G., Perez, C., & Yelinek, J. (2019). Emotions in storybooks: A comparison of storybooks that represent ethnic and racial groups in the United States. *Psychology of Popular Media Culture, 8*(3), 207–217. https://doi.org/10.1037/ppm000...

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Tables and Figures
Manuscripts should usually not include more than five tables and/or figures. These should not be included in the body of the manuscript text but uploaded as individual files.

Use text anchors to show their intended position within the paper within the manuscript.

Numbered figure captions should be provided.

Tables should be provided in editable Word format. They should be numbered and given explanatory titles

Figures
Colour figures are free of charge for online published articles but if authors wish figures to be published in colour in the print version the cost is £200.

Numbered figure captions should be provided.

All artwork should be submitted as separate TIFF format files.

Please follow this link for further guidance on artwork.

Supplementary Information – Online only
Where unpublished material e.g. behaviour rating scales or therapy manuals are referred to in an article, copies should be submitted as an additional document (where copyright allows) to facilitate review. Supplementary files can be used to convey supporting or extra information to your study, however, the main manuscript should be able to 'stand-alone'. Supporting documents are reviewed but not copyedited on acceptance of the article. They can therefore be submitted in PDF format, and include figures and tables within the text. There is no word limit for supporting online information.

Reporting Standards

Behavioural and Cognitive Psychotherapy supports standardised reporting practices, consult the following table to ensure your submission meets the reporting standards for your manuscript type. Please include the relevant supporting information (such as diagrams and checklists) with your submission files. See http://www.equator-network.org/reporting-guidelines/ for more information on manuscript types not described below.

The journal also encourages clarity in describing interventions sufficient to allow their replication through the use of the Template for Intervention Description and Replication Checklist (TIDieR).

Randomised Controlled Trial	CONSORT	http://www.consort-statement.org/
Systematic reviews and Meta-Analysis	PRISMA	http://www.prisma-statement.org/
Study Protocols	SPIRIT	http://www.spirit-statement.org/

Suggested Reviewers

During the submission process, you will be asked to indicate your preferred and non-preferred reviewers, and the reasons for your choices.

Preferred reviewers:

- Should not have a conflict of interest (such as a recent or current close working relationship, or from the same institution)
- At least half of the list should be international to yourself
- Please consider early career researchers as well as field leaders
- Please suggest both niche experts and those with wider knowledge of the subject

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- May have personal or subjective bias to your work which disregards the scientific merit
- May have seen or commented on the submitted manuscript, or prior versions.

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Behavioural and Cognitive Psychotherapy encourages authors to identify themselves using their ORCID iD when submitting a manuscript to the journal. ORCID provides a unique identifier for researchers and, through integration in key research workflows such as manuscript submission and grant applications, provides the following benefits:

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Behavioural and Cognitive Psychotherapy believes in the importance of transparent and reproducible research. We therefore strongly encourage all submissions to include

a Data Availability Statement to describe whether the materials that underpin the findings of the manuscript have been made available to readers, and if so, where. This policy will be encouraged from August 2020 and made mandatory by January 2022. For more information on including a data availability statement and making data available please see the information on the Research Transparency page.

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Appendix B

Journal Submission Emails

-----Original Message-----
From: Behavioural and Cognitive Psychotherapy <onbehalfof@manuscriptcentral.com>
Sent: 10 May 2022 19:20
To: Paul Chadwick <pdjc20@bath.ac.uk>
Subject: Behavioural and Cognitive Psychotherapy - BCP-02102-22

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10-May-2022

Dear Prof. Chadwick

Your manuscript entitled "Dehumanisation in Voice Hearers: The End of the Continuum" has been successfully submitted online and is presently being given full consideration for publication in 'Behavioural and Cognitive Psychotherapy'.

Your manuscript ID is BCP-02102-22.

Please mention the above manuscript ID in all future correspondence or when calling the office for questions. If there are any changes in your postal address or e-mail address, please log in to Manuscript Central at https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fmc.manuscriptcentral.com%2Fbabcp&data=05%7C01%7Cbv278%40bath.ac.uk%7Cfc18dd512b7a4ef3977608da32bdc3ec%7C377e3d224ea1422db0ad8fcc89406b9e%7C0%7C0%7C637877808787474839624%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=pDWhFh91ANMx2JMHoGQt%2BMK%2F2yM79ILwmxiNsVmuLw8%3D&reserved=0 and edit your user information as appropriate.

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Thank you for submitting your manuscript to 'Behavioural and Cognitive Psychotherapy'.

Sincerely

'Behavioural and Cognitive Psychotherapy'
Editorial Office

-----Original Message-----
From: Behavioural and Cognitive Psychotherapy <onbehalfof@manuscriptcentral.com>
Sent: 11 May 2022 10:14
To: Paul Chadwick <pdjc20@bath.ac.uk>
Subject: Behavioural and Cognitive Psychotherapy - BCP-02102-22 has been unsubmitted

CAUTION: This email came from outside of the University. To keep your account safe, only click on links and open attachments if you know the person who sent the email, or you expected to receive this communication.

11-May-2022

Dear Prof. Chadwick

Thank you for your submission to the BCP anniversary issue. Given that the paper is for the 50th anniversary special issue, can you please contextualise the paper in the way mindfulness treatments have developed over this period. That means a couple of pages more. Also some reflections towards the end of the discussion. Paul suggests that you reduce the number of quotations (convention says two per theme). If you add this you can have up to 6K words. Please note that it will of course go out to review once you have modified. Paul would also be very happy to discuss this further with you if that would be helpful.

Your manuscript, BCP-02102-22, entitled "Dehumanisation in Voice Hearers: The End of the Continuum" has been unsubmitted to 'Behavioural and Cognitive Psychotherapy'.

In addition to the above, we have recently updated our Instructions for Authors and now ask that in their Ethical Statement authors state that they have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS. Would you be willing to add this?

Please view the instructions to authors to complete your submission and re-submit the manuscript for consideration of publication. You may contact the Editorial Office if you have further questions.

Sincerely

Lindsay Flook

'Behavioural and Cognitive Psychotherapy'
Editorial Office

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Appendix C

Semi-Structured Interview Question for Main Research Project

1. Please could you start by telling me a bit about what your experience of hearing a voice or voices is like?
2. How has hearing voices affected how you live your life?
3. How has your experience changed over time?
4. Do you think hearing voices has changed your experiences of how other people see you?
   4.1. In what ways?
   4.2. How else has it changed how people are with you?
   4.3. How have those experiences made you feel?
5. How has hearing voices changed how you view yourself?
   5.1. In what ways?
   5.2. How else has it changed how you see yourself?
   5.3. Have there been any positive changes?
6. Have you ever felt that other people view you as less of a person because you hear voices?
   6.1. What experiences have contributed to this?
   6.2. How have you reacted to and responded to these experiences?
7. Has hearing voices ever made you feel less of a person?
   7.1. In what ways?
   7.2. Can you tell me more about that?
8. Has that feeling of being less of a person changed?
   8.1. How does that feeling affect you day-to-day?

Appendix D
Ethical Approval for Main Research Project

From: psychology-ethics <psychology-ethics@bath.ac.uk>
Sent: 03 February 2021 09:14
To: Bethany Venus <bv278@bath.ac.uk>
Cc: Paul Chadwick <pdjc20@bath.ac.uk>
Subject: 20-249

Dear Bethany

Full title of study: Understanding the Experience of Dehumanisation in People who Hear Voices: A Reflexive Thematic Analysis
PREC reference number: 20-249

On behalf of the Committee, I am pleased to confirm that you have received a favourable ethical opinion for the above proposal from the Psychology Research Ethics Committee.

However please be aware that a researcher (or supervisor in the case of UG or Masters students) is responsible for ensuring full GDPR compliance. Please seek further advice from dataprotection-queries@lists.bath.ac.uk if you have any concerns.

Under current Covid restrictions, if you are proposing lab based or field research involving in-person testing you will also need to get approval from the Psychology Research Restart Group (PRRG) before you can start to gather data. More information can be found here:

https://wiki.bath.ac.uk/display/PC/Psychology+COVID-19+Home

If you intend to display recruitment posters/materials, please ensure you obtain the appropriate permission to do so from those who manage the location(s) you choose.

Please inform PREC about any substantial amendments made to the study if they have ethical implications.

Please make sure you quote your unique PREC code, 20-249, in any future correspondence.

Rebecca Wise
On behalf of Psychology Research Ethics Committee

P psychology-ethics
Thu 29/04/2021 16:07
To: Bethany Venus
Cc: psychology-ethics

Application Form for an Ame...
30 KB

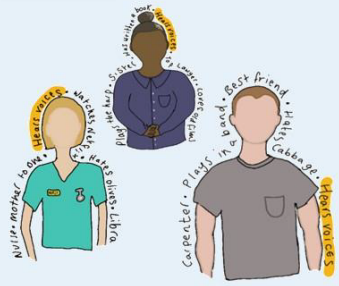
Hi Beth,

I have reviewed your amendment request and am taking Chairs Action to approve it.

Best wishes,
Chris Ashwin
Chair of PREC

Appendix E
Research Advertisement for Main Research Project

UNIVERSITY OF BATH



Artwork by Juliet Young

Experiences of People who Hear Voices

Do you hear voices or have you heard them in the past?

Has hearing voices changed how you see yourself?

Would you be willing to discuss your experiences in a one hour interview via telephone or the internet?

Are you over the age of 18 years old and able to speak English fluently?

I am looking to talk to people who hear voices and whose experience of hearing voices has affected how they see themselves and how they believe others see them.

This research is being conducted by Beth Venus, a Trainee Clinical Psychologist at the University of Bath.

This research is being supervised by Professor Paul Chadwick.

Would you like to find out more information about participating in this study?

If so, please contact me via:

dehumanisationstudy@bath.ac.uk

Or via:

[redacted]

Interviews for this study will end on January 31st 2022. The study may end prior to this date if sufficient interviews are completed.

Ethics Code: **20-249.** If you have any concerns related to your participation in this study please direct them to the Chair of the Department of Psychology Research Ethics Committee, email: psychology-ethics@bath.ac.uk.

Appendix F
Information Sheet for Main Research Project

INFORMATION SHEET
Understanding the Experience of People who Hear Voices: A Reflexive Thematic Analysis

Who am I?

My name is Beth Venus, and I am a Clinical Psychologist in Training within the Department of Psychology at the University of Bath. This study is part of my clinical psychology training. This research is being supervised by Professor Paul Chadwick at the University of Bath.

What is this study about?

Some people who hear voices have said that the experience of hearing voices can lead them to feel less of a person – to feel dehumanised in some way by their experiences. To feel dehumanised is to feel less human in some way. People who hear voices have also said that some experiences and relationships help them to feel more human again. In this study, participants will be invited to discuss the ways in which hearing voices has led them at times to feel dehumanised and things in their lives that have reduced the dehumanising impact of voices in a one-to-one interview with myself via Microsoft Teams or telephone.

What will I be asked to do?

You will be asked to attend an interview with myself online. You will be asked to share and discuss experiences you may have had which have led to a feeling of being dehumanised. There are no right or wrong answers to the questions I will ask, and I will listen compassionately and attentively to the experiences that you share.

If the interview cannot be conducted online for any reason, we can arrange to conduct this via telephone.

The interview will be conducted within a private space to protect your confidentiality. I would ask that you also identify a suitably private and confidential space where you feel safe and comfortable to talk.

The interview will last for a maximum one hour. If you need a break during this time, it will be possible to arrange this.

Upon completion of the interview, you will be given £10 in the form of an Amazon voucher as a thank you for participation.

In the event that the interview is being conducted via Microsoft Teams and we face internet connectivity interviews, I would ask your permission for me to call you via telephone to continue the interview.

The interview will be recorded to enable me to listen to the recording again later. This is to permit me to analyse the interviews I have conducted to identify themes across participants to answer the research question.

If you wish to, you may request a copy of the interview schedule to read which would then be sent to you 30 minutes prior to the interview taking place.

Do I have to take part?

Participation in this research is entirely voluntary and you will be asked to sign a consent form if you decide you wish to participate. You are free to make your own decision about whether you wish to participate. Should you decide you do wish to take part, then we will agree a convenient time and date for the interview to take place.

If at any point during the interview you wish to not answer a question, then you may decline to answer. If at any stage during the interview you begin to find it difficult to continue, we may have a further discussion regarding consent to ensure you are fully satisfied you consent to participate. Should you wish to discontinue the interview at any point, it will be possible to do this.

What will happen to the recording?

The audio recording will be stored securely as a file within an encrypted and password protected folder which only myself and my supervisor will have access to. The interview will be transcribed to allow me to analyse the information gathered. Transcription will be completed within 6 weeks of completion of your interview after which point the audio recording will be destroyed.

What will happen to the information I provide?

When the audio recording has been transcribed into a written format, any potentially identifying details, including your name, will be removed. The interview information will not be linked in any way to contact details that you provide, and these will be stored separately to prevent you from being identified. You have the right to withdraw your data from the study within two weeks of completion of the interview. After this point, your contact details will be deleted.

Following completion of this study, the information you have provided to me during the interview will be kept safely and anonymously by the University of Bath. If you give your consent, this information may be used by other researchers, provided the University of Bath grant approval and strict rules governing confidentiality of your information are followed. Again, your name and any other personally identifiable information will never be used or given to anyone else.

Can I withdraw from the study once I have taken part?

Following completion of the interview, you will have two weeks within which you can withdraw from the study. After two weeks, analysis of the interview information will have commenced and after this point it will not be possible to withdraw from the study.

What will happen to the results of this research?

What you share with me will be used to inform themes which will help us to understand what experiences contribute to feelings of dehumanisation in people who hear voices. I may use short extracts taken from what you have told me, however, these would not identify you. The research findings may be subsequently published in research journals or used in presentations. If you would like to be sent a summary of the research findings, this can be arranged for you. The overall aim of the research is to guide future research into what could ameliorate feelings of dehumanisation.

University of Bath Privacy Notice

The University of Bath privacy notice can be found on the following webpage: https://www.bath.ac.uk/corporate-information/university-of-bath-privacy-notice-for-research-participants/.

What do I do if I would like to participate or have further questions?

You are free to contact me, Bethany Venus, or my project supervisor, Professor Paul Chadwick, to arrange a mutually convenient time or to discuss any questions you might have. You may also ask for questions to be addressed via email if you are happy to receive an answer in a written format. Please use the email address below to get in touch:

Email Address: dehumanisationstudy@bath.ac.uk
Telephone: 07561 829 431.

If you have any concerns related to your participation in this study please direct them to the Chair of the Department of Psychology Research Ethics Committee, email: psychology-ethics@bath.ac.uk.

Research Ethics Code: 20-249

Thank you!

Many thanks for taking the time to read this information sheet and consider participation in this research. I would be delighted if you were willing to participate.

Appendix G
Consent Form for Main Research Project

University of Bath
Department of Psychology
Bethany Venus, Clinical Psychologist in Training
bv276@bath.ac.uk

CONSENT FORM

Understanding the Experience of Dehumanization in People who Hear Voices: A Reflexive Thematic Analysis

Please answer the following questions to the best of your knowledge.

	YES	NO
DO YOU CONFIRM THAT YOU:		
☐ Have experienced or are currently experiencing at least one voice?	☐	☐
☐ Are over the age of 18 years old?	☐	☐
☐ Can speak English fluently as either a first or second language?	☐	☐
HAVE YOU:		
☐ been given information explaining about the study?		
☐ have had opportunity to read the information sheet provided?	☐	☐
☐ had an opportunity to ask questions and discuss this study?	☐	☐
☐ received satisfactory answers to all questions you asked?	☐	☐
☐ received enough information about the study for you to make a decision about your participation?	☐	☐
DO YOU UNDERSTAND:		
that you are free to withdraw from the study:		
☐ before and during the interview?	☐	☐
☐ within two weeks of completion of the interview?	☐	☐
that you are free to withdraw your data:		
☐ within two weeks of completion of the interview?	☐	☐
☐ without having to give a reason for withdrawing?	☐	☐

I hereby fully and freely consent to my participation in this study

I understand the nature and purpose of the procedures involved in this study. These have been communicated to me on the information sheet accompanying this form.
I understand and acknowledge that the investigation is designed to promote scientific knowledge and that the University of Bath will use the data I provide for no purpose other than research.
I understand that the data I provide will be kept **confidential and secure**, and that on completion of the study my data will be **anonymized** by removing all links between my name or other identifying information and my study data. This will be done by the end of May 2022 at the latest, and before any presentation or publication of my data.
I understand that the University of Bath may use the data collected for this project in a future research project but that the conditions on this form under which I have provided the data will still apply.

Participant's signature: _____ Date: _____

Name in BLOCK Letters: _____

University of Bath
Department of Psychology
Bethany Venus, Clinical Psychologist in Training
bv276@bath.ac.uk

Final consent
Having participated in this study

I agree to the University of Bath keeping and processing the data I have provided during the course of this study. I understand that these data will be used only for the purpose(s) set out in the information sheet, and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Regulation.

Participant's signature: _____ Date: _____

Name in BLOCK Letters: _____

If you have any concerns related to your participation in this study please direct them to the Department of Psychology Research Ethics Committee, via email: psychology-ethics@bath.ac.uk.

Appendix H
Debrief Sheet for Main Research Project

DEBRIEFING INFORMATION

Understanding the Experience of Dehumanization in People who Hear Voices: A Reflexive Thematic Analysis

Thank You
Thank you for taking part in this research project which has been exploring experiences of dehumanization in people who hear voices. Your contributions to this research are very much appreciated.

The Value and Implications of this Research

It is hoped that this research will enable the development of an understanding of the type of societal, interpersonal, and intrapersonal factors which lead to people who hear voices feeling dehumanised. This may inform future research to enable us to alleviate such feelings of dehumanisation and reduce stigma. It will help to inform professionals of factors which might enable a person to feel more or less protected from dehumanisation and it could provide important information for professionals supporting individuals who hear voices to recover.

Further Support

It is possible that the experiences discussed during this research may have raised some distressing thoughts and feelings for you. If this is the case, then the following sources of support and information may be helpful for you.

Sources of Support

Samaritans: www.samaritans.org | 08457 90 90 90 | jo@samaritans.org
Samaritans is a 24-hour confidential helpline that is open 365 days a year.

Rethink Advice Line: 0300 5000 927
The Rethink Advice Line is open Monday – Friday, 10.00am – 1.00pm. This offers practical advice and information.

Hearing Voices Groups: https://www.hearing-voices.org/ | info@hearing-voices.org
You can use this website to find out if there are any Hearing Voices Groups in your area and email the address provided to make contact.

If you are currently receiving care from a mental health care provider, whether within the NHS or privately, then you may find it helpful to seek support from this provider. If you feel you need to receive further care, a helpful starting point may be to arrange an appointment with your GP.

Sources of Information

Mind: https://www.mind.org.uk/information-support/types-of-mental-health-problems/hearing-voices/about-voices/

The charity Mind provides information on hearing voices and how to manage this

experience.

Rethink Mental Illness: https://www.rethink.org/advice-and-information/about-mental-illness/learn-more-about-symptoms/hearing-voices/

The charity Rethink Mental Illness also provides useful information on the experience of hearing voices and possible types of treatment for this when it is distressing.

Questions?

Thank you once again for participating in this research. If you would like to speak to us about the project, then please do get in touch using the details below.

Email Address: bv278@bath.ac.uk

You can also speak to the supervisor of the project, Professor Paul Chadwick.
Email Address: pdjc20@bath.ac.uk

Telephone Number: 01225384350

IMPORTANT: Withdrawal

Should you wish to withdraw from the study, please note you have 2 weeks following completion of the interview in which to do this. After this point, your interview will have been transcribed, personally identifiable information will have been removed, and analysis will have commenced.
……

……

I confirm I have received £10 Amazon voucher for participating in the University of Bath research study “Understanding Experiences of Dehumanisation in People who Hear Voices”.

Signed……

Date……

Researcher’s Signature……..

Date……

If you have any concerns related to your participation in this study please direct them to the Chair of the Department of Psychology Research Ethics Committee, email: psychology-ethics@bath.a.uk.

Appendix I
Summary of Themes, Subthemes, and Codes for Main Research Project

Table 1

Summary of themes, subthemes, and codes

Themes	Subthemes	Codes
Dehumanisation as the End of Experiential Continua	"It's like Burning Alive": Extent of Distressing Sensory Fragmentation	Enhanced concentration due to managing voices Entrapped by voice hearing Grounding to let the wave of voices pass Inexplicability of the sensory experience Perceiving self as having alien or bizarre sensory experiences Sensory intensity of distress related to voice-hearing Voices as harmless events of the mind
	"You Belong to the Wild and They Belong to the Earth": Sense of Belonging with Other Humans	Concealment of voice-hearing from others Feeling alone with the experience of voices Feeling defeated by multiple exclusions Feeling insignificant in interactions with services Feeling judged regardless of disclosure Feeling not important enough to receive help Feeling you should remove yourself from humanity Feeling unable to relate to others Feeling unable to trust others enough to disclose Feeling unacceptable to others Intersection of race with mental health as a doubly disconnecting stigma Loss of social information Perceived risk of abandonment from humanity Reduced social risk-taking Sticking close to others to protect self from voices The dark bottom of the hierarchy of beings
	"They Destroy Your Sense of Self": Integrity	Deconstruction of sense of self

Themes	Subthemes	Codes
	of Self as a Private, Coherent Entity	Disparity between own narrative and recorded narrative in services Erosion of identity Fear of exposure due to voices being audible Impact of loss of work on identity Incongruence between voices and self Loss of privacy of own mind Personality has been diminished by voice-hearing Voice-hearing obscures knowing yourself Voices alter both valued and devalued personal qualities Voices help to know yourself better
	"I'm Part of the Scrap Heap": Sense of Worth as a Human Being	Conceding to verbal abuse of voices Constant fight to prove own worth Feeling a mismatch with gendered societal expectations due to impact of voices Feeling like a worthless person Feeling your best is not enough to count you as human Feelings of inadequacy relative to others Felt pain of not enough-ness From meta- to self-dehumanization Loss of dignity Moral distress related to voices Society's hierarchy of beings as immutable Voice-hearing as a uniquely human capability Expectations of others of greater than ordinary capabilities
	"They Took a Part of Me": Strength of Personal Agency	Concealment of true self constrains functioning Defeat when trying to build a successful life Feeling unable to get it right Futility of fighting the voices Impact of voices on ability to function Loss of control and agency over life Ongoing attempts to fight voices Unable to meet voices' expectations Voices as barrier to meeting own expectations

Themes	Subthemes	Codes
		Voices driving values incongruent action
		Voices as empowering and protective
	"It has a Psychosis Ring Around it": Trust in Own Credibility and Reliability	Loss of reliance on self to act authentically
		Loss of trust in own credibility
		Need to downplay experience to others
		Not being free to allow mind to be unoccupied
		Shock of voice-hearing coming out of nowhere
		Voice-hearing as an experience out of own control
		Improved coping with voices over time
		Retention of trust in yourself
The Push and Pull of Dehumanising Forces		Absence of genuine acceptance from others
		Attitude of voices – questioning your credibility, trustworthiness, decision-making capacity
		Attitude of others – being seen as uncanny, bizarre, or dangerous
		Attitude of others – questioning your credibility, trustworthiness, decision-making capacity
		Being taken advantage of by others
		Belief of voices and others – you lack agency
		Cultural beliefs about voice-hearing as deviant
		Dehumanising content of voices' speech
		Dehumanising messages in socio-political actions
		Discreditation through invisibility of voice-hearing
		Doubt in your credibility as a weapon
		Experience of services compounding trauma
		Lack of witness to trauma
		Meta-dehumanisation as an observable category change others' make
		Ostracism from family members and friends
		Own perception of wider society – increasing discrimination

Themes	Subthemes	Codes
		Own perception of wider society – unwilling to understand
		Perception of others – you are a different person now
		Perception of others – you are beyond change or hope
		Perception of others – you lack warmth
		Perception of others – you are less able than the average human
		Prejudice unchallenged by purported protectors
		Relentless omnipotent and malevolent voices
		Social rejection and stigma
		Verbal abuse by voices
		Voice-related meta-dehumanization contributing to other-related meta-dehumanization
		Voices as a source of pressure
		Voices compounding moral distress
		Voices maliciously compounding trauma
		Voices and others agree on criticisms
Reclaiming Life through Humanising Forces		Acceptance invokes greater control over voices
		Ambivalence about voice-hearing
		Change in voice origin beliefs
		Consistent valuing and acceptance by important others
		Determination to prove others' dehumanising attitudes wrong
		Devaluation of the judgement of voices and others
		Distance from voice-hearing through humour
		Empowerment through meaningful work and activities
		Exercising choice in response to voices
		Experience of transformational moments
		Exposure of voice-hearing to aid others
		Finding a fresh start
		Forging common humanity and hope with peers
		Immersion in benign nature
		New possibilities for personal achievement
		Non-judgemental content of voices

Themes	Subthemes	Codes
		Others reframing voice-hearing experience
		Positive experiences of disclosure
		Raising awareness of voice-hearing to help others
		Reciprocity with the natural world
		Reclaiming authority and agency
		Recognition of own human rights
		Recognition of current persecution as manifestation of past trauma
		Recognition of the immorality of abusive voices
		Recognition of positive qualities of other voice-hearers
		Reintegration and belonging with others
		Religious practice as source of strength
		Safety of a group
		Self-acceptance and self-appreciation
		Successful coping with voices
		Tolerating standing alone
		Voice-hearing as source of support for decision-making
		Voices as protection from loneliness
		Voices having or developing lower authority
		Withdrawal for self-protection
		Withdrawal to regain control over voices

Appendix J
Clinical Psychology Review Instructions for Authors (Chosen Journal for Literature Review Project)

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:
• E-mail address
• Full postal address

All necessary files have been uploaded:
Manuscript:
• Include keywords
• All figures (include relevant captions)
• All tables (including titles, description, footnotes)
• Ensure all figure and table citations in the text match the files provided
• Indicate clearly if color should be used for any figures in print
Graphical Abstracts / Highlights files (where applicable)
Supplemental files (where applicable)

Critical Issues

- Ensure manuscript is a comprehensive review article (empirical papers fall outside the scope of the journal)
- Ensure that literature searches and reviews are as up to date as possible and at least to 3 months within date of submission
- Manuscript has been 'spell checked' and 'grammar checked'
- All references mentioned in the Reference List are cited in the text, and vice versa
- Permission has been obtained for use of copyrighted material from other sources (including the Internet)
- A competing interests statement is provided, even if the authors have no competing interests to declare
  • Journal policies detailed in this guide have been reviewed
- Referee suggestions and contact details provided, based on journal requirements
- Ensure manuscripts do not exceed 50 pages, including references and tabular material, unless you have obtained prior approval of the Editor in Chief for an exception
- Ensure Highlights do not exceed 3 to 5 bullet points with a maximum of 85 characters, including spaces, per bullet point

Failure to follow these guidelines may result in your manuscript being returned for reformatting prior to further consideration by the journal.

For further information, visit our Support Center.

Before You Begin

Ethics in publishing

Please see our information on Ethics in publishing.

Declaration of interest

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. Examples of potential competing interests include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding. Authors must disclose any interests in two places: 1. A summary declaration of interest statement in the title page file (if double anonymized) or the manuscript file (if single anonymized). If there are no interests to declare then please state this: 'Declarations of interest: none'. 2. Detailed disclosures as part of a separate Declaration of Interest form, which forms part of the journal's official records. It is important for potential interests to be declared in both places and that the information matches. More information.

Submission declaration and verification

Submission of an article implies that the work described has not been published previously (except in the form of an abstract, a published lecture or academic thesis, see 'Multiple, redundant or concurrent publication' for more information), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, including electronically without the written consent of the copyright-holder. To verify originality, your article may be checked by the originality detection service Crossref Similarity Check.

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Language (usage and editing services)

Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's Author Services.

Use of inclusive language

Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Content should make no assumptions about the beliefs or commitments of any reader; contain nothing which might imply that one individual is superior to another on the grounds of age, gender, race, ethnicity, culture, sexual orientation, disability or health condition; and use inclusive language throughout. Authors should ensure that writing is free from bias,

stereotypes, slang, reference to dominant culture and/or cultural assumptions. We advise to seek gender neutrality by using plural nouns ("clinicians, patients/clients") as default/wherever possible to avoid using "he, she," or "he/she." We recommend avoiding the use of descriptors that refer to personal attributes such as age, gender, race, ethnicity, culture, sexual orientation, disability or health condition unless they are relevant and valid. When coding terminology is used, we recommend to avoid offensive or exclusionary terms such as "master", "slave", "blacklist" and "whitelist". We suggest using alternatives that are more appropriate and (self-) explanatory such as "primary", "secondary", "blocklist" and "allowlist". These guidelines are meant as a point of reference to help identify appropriate language but are by no means exhaustive or definitive.

Author contributions

For transparency, we encourage authors to submit an author statement file outlining their individual contributions to the paper using the relevant CRediT roles: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Visualization; Roles/Writing - original draft; Writing - review & editing. Authorship statements should be formatted with the names of authors first and CRediT role(s) following. More details and an example.

Changes to authorship

Authors are expected to consider carefully the list and order of authors **before** submitting their manuscript and provide the definitive list of authors at the time of the original submission. Any addition, deletion or rearrangement of author names in the authorship list should be made only **before** the manuscript has been accepted and only if approved by the journal Editor. To request such a change, the Editor must receive the following from the **corresponding author**: (a) the reason for the change in author list and (b) written confirmation (e-mail, letter) from all authors that they agree with the addition, removal or rearrangement. In the case of addition or removal of authors, this includes confirmation from the author being added or removed. Only in exceptional circumstances will the Editor consider the addition, deletion or rearrangement of authors **after** the manuscript has been accepted. While the Editor considers the request, publication of the manuscript will be suspended. If the manuscript has already been published in an online issue, any requests approved by the Editor will result in a corrigendum.

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Authors must provide three mandatory and one optional author disclosure statements. These statements should be submitted as one separate document and not included as part of the manuscript. Author disclosures will be automatically incorporated into the PDF builder of the online submission system. They will appear in the journal article if the manuscript is accepted.

The four statements of the author disclosure document are described below. Statements should not be numbered. Headings (i.e., Role of Funding Sources, Contributors, Conflict of Interest, Acknowledgements) should be in bold with no white space between the heading and the text. Font size should be the same as that used for references.

Statement 1: Role of Funding Sources
Authors must identify who provided financial support for the conduct of the research

and/or preparation of the manuscript and to briefly describe the role (if any) of the funding sponsor in study design, collection, analysis, or interpretation of data, writing the manuscript, and the decision to submit the manuscript for publication. If the funding source had no such involvement, the authors should so state.

Example: Funding for this study was provided by NIAAA Grant R01-AA123456. NIAAA had no role in the study design, collection, analysis or interpretation of the data, writing the manuscript, or the decision to submit the paper for publication.

Statement 2: Contributors
Authors must declare their individual contributions to the manuscript. All authors must have materially participated in the research and/or the manuscript preparation. Roles for each author should be described. The disclosure must also clearly state and verify that all authors have approved the final manuscript.

Example: Authors A and B designed the study and wrote the protocol. Author C conducted literature searches and provided summaries of previous research studies. Author D conducted the statistical analysis. Author B wrote the first draft of the manuscript and all authors contributed to and have approved the final manuscript.

Statement 3: Conflict of Interest
All authors must disclose any actual or potential conflict of interest. Conflict of interest is defined as any financial or personal relationships with individuals or organizations, occurring within three (3) years of beginning the submitted work, which could inappropriately influence, or be perceived to have influenced the submitted research manuscript. Potential conflict of interest would include employment, consultancies, stock ownership (except personal investments equal to the lesser of one percent (1%) of total personal investments or USD$5000), honoraria, paid expert testimony, patent applications, registrations, and grants. If there are no conflicts of interest by any author, it should state that there are none.

Example: Author B is a paid consultant for XYZ pharmaceutical company. All other authors declare that they have no conflicts of interest.

Statement 4: Acknowledgements (optional)
Authors may provide Acknowledgments which will be published in a separate section along with the manuscript. If there are no Acknowledgements, there should be no heading or acknowledgement statement.

Example: The authors wish to thank Ms. A who assisted in the proof-reading of the manuscript.

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You are requested to identify who provided financial support for the conduct of the research and/or preparation of the article and to briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication. If the funding source(s) had no such involvement, it is recommended to state this.

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Submission

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It is important that the file be saved in the native format of the word processor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the word processor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier). Note that source files of figures, tables and text graphics will be required whether or not you embed your figures in the text. See also the section on Electronic artwork.
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Manuscripts should be prepared according to the guidelines set forth in the most recent publication manual of the American Psychological Association. Of note, section headings should not be numbered.

Manuscripts should ordinarily not exceed 50 pages, *including* references and tabular material. Exceptions may be made with prior approval of the Editor in Chief. Manuscript length can often be managed through the judicious use of appendices. In general the References section should be limited to citations actually discussed in the text. References to articles solely included in meta-analyses should be included in an appendix, which will appear in the on line version of the paper but not in the print copy. Similarly, extensive Tables describing study characteristics, containing material published elsewhere, or presenting formulas and other technical material should also be included in an appendix. Authors can direct readers to the appendices in appropriate places in the text.

It is authors' responsibility to ensure their reviews are comprehensive and as up to date as possible (at least to 3 months within date of submission) so the data are still current at the time of publication. Authors are referred to the PRISMA Guidelines (http://www.prisma-statement.org/) for guidance in conducting reviews and preparing manuscripts. Adherence to the Guidelines is not required, but is recommended to enhance quality of submissions and impact of published papers on the field.

Appendices

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential title page information

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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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Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements
Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

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References

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Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

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Appendix K: European Journal of Psychotraumatology Instructions for Authors (Chosen Journal for Service-Related Project)

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Contents list

About the journal

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Please include all relevant safety precautions; and cite any accepted standard or code of practice. Authors working in animal science may find it useful to consult

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All articles submitted to EJPT must:

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- justify single sex studies
- discriminate between sex and gender (mostly for human research)
- analyze how sex or gender impact the results
- discuss sex and gender issues when relevant

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Appendix L
Quality Improvement Team Approval Letter for Service-Related Project

NHS
Avon and Wiltshire
Mental Health Partnership
NHS Trust

Bethany Venus

University of Bath

Carla Carter
Quality Improvement &
Clinical Audit Manager
AWP NHS Trust
Victoria Centre
53 Downs Way
Swindon SN3 6BW

T: 01793 327876
Or dial reception on:
01793 327800

Date June 2020

Dear Beth

Re: "The New Normal": An Evaluation of Trauma-Informed Working within AWP.

I am pleased to confirm approval of your Service Evaluation by AWP NHS Trust.

Please note that this approval has come from AWP's Quality Team and not AWP's Research and Development Team. However, we do expect a good level of governance will be achieved from the ethical scrutiny by your University as well as adherence to general ethical principles for the protection of patients. The specific ethical principles and patient protection laws to be followed are:

- **Consent** – It is important that potential participants are not coerced to take part in the project. They have the right to refuse to take part and to withdraw at any point and this is explained via an information sheet provided prior to any engagement or data gathering such as surveys or interviews. This information sheet will often lead to the signing of a consent form by participants agreeing to take part in your Project.

- **Anonymity** – Participants need to know whether their anonymity will be protected and if so how this will be carried out. This will also be documented within your participants' information sheet/consent form.

- **Data protection and privacy** – You need to consider how you are going to ensure that your data is stored safely and that participant privacy is protected. Again this should be stipulated within your participants' information sheet/consent form. You will need to adhere to the Data Protection Act (2018) and the General Data Protection Regulation (GDPR).

Jess Hillier (jess.hillier@nhs.net) has been assigned as your allocated AWP Quality Team Facilitator. Please contact this Facilitator if you have any queries or require further support or information during your project. They will email you at regular intervals for updates, so that progress of your project can be updated on our central project database, and fed into Trust

committees. You will be assigned an AWP Project Reference Number by your Facilitator once we have confirmation that data collection has commenced and the project has actually started.

The importance of dissemination of all Service Evaluation or Quality Improvement work cannot be over emphasised. For this reason, the findings of all Projects should be shared with the Quality Team so that we can make judgements regarding risk and champion and disseminate the results across the rest of the Trust so that good practice can be shared and replication kept to a minimum. Reports may require approval by Locality Governance Groups if specific actions or improvements are required following your findings or particularly, if you wish to gain external publication, you will require AWP approval of your final report before doing so. Therefore, please share draft copies of your report with your Facilitator so that presentation and approval at Governance Groups can be arranged. Once you have an approved final version of your report, please ensure you send a copy to your allocated Facilitator.

If you do need any further support or information, please contact your Facilitator or myself, quoting the title of your project.

Yours sincerely

[redacted]

Carla Carter
Quality Improvement and Clinical Audit Manager

Appendix M
Pre-, Post-, and Follow-Up Measures for Service-Related Project

Trauma Working Group Covid-19 Response Training Session Evaluation
Pre-Training Measure

Thank you very much for taking the time to complete this evaluative measure. The feedback provided will be invaluable for informing and improving future training sessions. Please take the time to complete the questions below as honestly as possible. Some of the questions asked within this measure may seem unexpected to begin with, however, the rationale for these questions being asked will become clear after completion of the training session.

Background Information
Staff Identifier: ……
What is your current job role within the team?
……
……..
Which setting do you currently work in?
……
……..
What do you hope to gain from the training session today?
……
……
……
……
……
……

The national Covid-19 Trauma Response Working Group have advised of do's and don'ts with respect to delivering a trauma-informed response to staff during the pandemic. Similarly, the King's Fund has noted that, during a complex and difficult time such as the Covid-19 pandemic, several qualities are especially important for compassionate leaders. This section asks about your knowledge and confidence with respect to these do's and don'ts and qualities of compassionate leadership.

How do you rate your knowledge of and confidence putting into practice for the following items:

Do's and Don'ts	I rate my current knowledge as:					I rate my confidence putting this into practice as:				
	None	**Little**	**Some**	**Moderate**	**Substantial**	**None**	**Little**	**Some**	**Moderate**	**Substantial**
Facilitating team cohesion and connectedness										
Encouraging staff to engage in peer support										
Monitoring staff who are particularly vulnerable										
Identifying distress in										

a staff member										
Training in specific skills staff need to prepare them to cope with potentially traumatic situations										
Communicating with staff during the Covid-19 pandemic										
Promoting staff's attention to basic physical needs and role-modelling this										
Adjusting the way people work to reduce stress (e.g. buddying)										
Understanding when and how to refer people to psychological support										
Being aware of and using the principles of trauma-informed care										
Understanding the phases we may need to go through during the Covid-19 pandemic										
Understanding how										

to lead in a compassionate way										
Knowing how a compassionate approach to yourself may help reduce stress during the pandemic										

Thank you for completing this questionnaire.

Post-Training Measure

Thank you very much for taking the time to complete this evaluative measure. The feedback provided will be invaluable for informing and improving future training sessions. Please take the time to complete the questions below as honestly as possible.

Staff Identifier: ……
Did you gain what you hoped to from the training session?
……
……
……
……

The national Covid-19 Trauma Response Working Group have advised of do's and don'ts with respect to delivering a trauma-informed response to staff during the pandemic. Similarly, the King's Fund has noted that, during a complex and difficult time such as the Covid-19 pandemic, several qualities are especially important for compassionate leaders. This section asks about your knowledge and confidence with respect to these do's and don'ts and qualities of compassionate leadership.

How do you rate your knowledge of and confidence putting into practice for the following items?

Do's and Don'ts	I rate my current knowledge as:					I rate my confidence putting this into practice as:				
	None	**Little**	**Some**	**Moderate**	**Substantial**	**None**	**Little**	**Some**	**Moderate**	**Substantial**
Facilitating team cohesion and connectedness										
Encouraging staff to engage in peer support										
Monitoring staff who are particularly vulnerable										

Identifying distress in a staff member										
Training in specific skills staff need to prepare them to cope with potentially traumatic situations										
Communicating with staff during the Covid-19 pandemic										
Promoting staff's attention to basic physical needs and role-modelling this										
Adjusting the way people work to reduce stress (e.g. buddying)										
Understanding when and how to refer people to psychological support										
Being aware of and using the principles of trauma-informed care										
Understanding the phases we may need to go through during the Covid-19 pandemic										

Understanding how to lead in a compassionate way										
Knowing how a compassionate approach to yourself may help reduce stress during the pandemic										

Finally, please reflect upon your experience of the training session and answer the following questions:

Please identify at least one action you will take as a result of today's training:

1. ……
   ……
2. ……
   ……
3. ……
   ……

Do you think this training, in relation to compassionate leadership and the do's and don'ts, will inform the way you support staff wellbeing?

Yes ☐

No ☐

In what ways do you think it will inform this?

……
……
……
……

What was most helpful aspect of today's training?

……
……
……
……

What was the least helpful aspect of today's training?

……
……
……
……

What do you think could be improved about this training session?

……
……
……
……

Thank you for completing this questionnaire.

<u>Follow-Up Measure</u>

Thank you very much for taking the time to complete this evaluative measure. The feedback provided will be invaluable for informing and improving future training sessions. Please take the time to complete the questions below as honestly as possible.

Staff Identifier: ……

Please reflect upon your experience in the time since you attended the Trauma Response Working Group training session:

What actions did you take following the training?

……
……
……
……

Did the training, in relation to compassionate leadership and the do's and don'ts, inform the way you have supported staff wellbeing over recent months?

Yes ☐
No ☐

In what ways do you think it informed this?

……
……
……
……

If it did not inform the way you have supported staff wellbeing, what do you think were barriers to this?

……
……
……
……

The national Covid-19 Trauma Response Working Group have advised of do's and don'ts with respect to delivering a trauma-informed response to staff during the pandemic. Similarly, the King's Fund has noted that, during a complex and difficult time such as the Covid-19 pandemic, several qualities are especially important for compassionate leaders. This section asks about your knowledge and confidence with respect to these do's and don'ts and qualities of compassionate leadership.

How do you rate your knowledge of and confidence putting into practice for the following items?

Do's and Don'ts	I rate my current knowledge as:					I rate my confidence putting this into practice as:				
	None	**Little**	**Some**	**Moderate**	**Substantial**	**None**	**Little**	**Some**	**Moderate**	**Substantial**
Facilitating team cohesion and connectedness										
Encouraging staff to engage in peer support										
Monitoring staff who are particularly vulnerable										

Identifying distress in a staff member										
Training in specific skills staff need to prepare them to cope with potentially traumatic situations										
Communicating with staff during the Covid-19 pandemic										
Promoting staff's attention to basic physical needs and role-modelling this										
Adjusting the way people work to reduce stress (e.g. buddying)										
Understanding when and how to refer people to psychological support										
Being aware of and using the principles of trauma-informed care										
Understanding the phases we may need to go through during the Covid-19 pandemic										

Understanding how to lead in a compassionate way										
Knowing how a compassionate approach to yourself may help reduce stress during the pandemic										

Thank you for completing this questionnaire.

Appendix N
Consent Form for Service-Related Project

University of Bath
Department of Psychology
Bethany Venus, Clinical Psychologist in Training

Avon and Wiltshire Mental Health Partnership NHS Trust

UNIVERSITY OF BATH

CONSENT FORM

"The New Normal": Looking After Staff and Ourselves.

Please answer the following questions to the best of your knowledge

HAVE YOU:

• been given information explaining about the study?	☐	☐
• had an opportunity to ask questions and discuss this study?	☐	☐
• received satisfactory answers to all questions you asked?	☐	☐
• received enough information about the study for you to make a decision about your participation?	☐	☐

DO YOU UNDERSTAND:

that you are free to withdraw from the study and free to withdraw your data prior to anonymization

• at any time?	☐	☐
• without having to give a reason for withdrawing?	☐	☐

I hereby fully and freely consent to my participation in this study

I understand the nature and purpose of the procedures involved in this study. These have been communicated to me on the information sheet accompanying this form.
I understand and acknowledge that the investigation is designed to promote scientific knowledge and that the University of Bath will use the data I provide for no purpose other than research.
I understand that the data I provide will be kept **confidential**, and that on completion of the study my data will be anonymised by removing all links between my name or other identifying information and my study data. This will be done by <insert date>, and before any presentation or publication of my data.
I understand that the University of Bath may use the data collected for this project in a future research project but that the conditions on this form under which I have provided the data will still apply.

Participant's signature: _____ Date: _____

Name in BLOCK Letters: _____

Final Consent

Having participated in this study

I agree to AWP and the University of Bath keeping and processing the data I have provided during the course of this study. I understand that these data will be used only for the purpose(s) set out in the information sheet, and my consent is conditional upon AWP and the University complying with its duties and obligations under the Data Protection Regulation.

Participant's signature: _____ Date: _____

Name in BLOCK Letters: _____

If you have any concerns related to your participation in this study please direct them to the Department of Psychology Research Ethics Committee, via email: psychology-ethics@bath.ac.uk.

Appendix O
Information Sheet for Service-Related Project

Participant Information Sheet

***Study Name*:** An evaluation of training aimed at preventing and responding to traumatic experiences during COVID-19.

***Study Description*:** This evaluation is being conducted to determine the effect of this training session upon staff's knowledge and confidence with respect to preventing and responding to traumatic experiences during the COVID-19 pandemic. The feedback obtained from staff members who participate in these sessions will be invaluable with respect to understanding the benefits and limitations of the session and ways it could be enhanced and further tailored to need going forwards.

Consent and Confidentiality: Consent to participate in this study is asked for at the start of the evaluation measures provided on Ourspace. You will be asked to read through some statements with respect to consent and to tick to confirm you have:

- Been provided with an information sheet and been given the opportunity to ask questions.
- Understood the information you have been provided with.
- Given consent to participate in the study.

All the data collected from you will be confidential and will be anonymized. There will be no record that links the data collected from you with personal data with which you could be identified. Your RVN number is asked for to enable linking of data across the pre-, post- and follow-up measures for analysis: these will be exchanged for anonymized identifiers as soon as the data is collected.

This evaluation will be written up as part of the requirements for the Doctorate in Clinical Psychology and will be published via the University Library as a result, as well as being submitted for publication in a journal. The findings may also be submitted for presentation at a conference.

Note that you are free to withdraw from the study at any time prior to data anonymization, without having to give a reason. In addition, you can decide not to consent to having your data included in further analyses.

***Eligibility Requirements*:** Employees of Avon and Wiltshire Mental Health Partnership NHS Trust.

***Duration*:** 10 minutes per measure for 3 measures, the first of which will be conducted prior to the session, the second of which will be conducted immediately after the session, and the final one of which will be conducted 3 months after the session as a follow-up.

***Investigators*:** The effects upon knowledge and confidence as a result of this training is being evaluated by Bethany Venus, Clinical Psychologist in Training at the University of Bath, as part of a project being conducted by the AWP Trauma Response Working Group, led by Dr Emma Griffith and Dr Chris Gillmore.

Approval: Approval has been obtained from AWP Quality Improvement and Information Governance.

Contact: Should you have any questions related to this evaluation, please email Beth Venus at **b.venus@nhs.net** or **bv278@bath.ac.uk**.

If you have any concerns related to your participation in this study please direct them to the Chair of the Department of Psychology Research Ethics Committee, email: psychology-ethics@bath.ac.uk.