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Executive Summary: **754 words**

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Abstracts Summary

A summary of abstracts can be found below. These are also included with each individual component.

Critical Review of the Literature Abstract

Effectiveness of Dialectical Behaviour Therapy for Anger and Aggressive Behaviour in Adults: A Systematic Review and Meta-Analysis

Anger and aggression have major health and safety implications, and effective treatment is critical. This review examined the effectiveness of Dialectical Behaviour Therapy (DBT) to reduce these outcomes in adults. Literature searches identified 16 eligible studies for the systematic review, of which 12 were included in meta-analyses. Pre-post evaluations showed small effects for DBT in reducing anger (*g* = -0.37; 95% CI [-0.65, -0.10]) and aggressive behaviour (*g* = -0.45; 95% CI [-0.60, -0.31]). DBT was superior to other active interventions in reducing anger (*g* = -0.29; 95% CI [-0.56, -0.01]*)* but no difference was found for aggressive behaviour (*g* = -0.04; 95% CI [-0.25, 0.16]). Little evidence was found for additional improvement when combined with medication. We conclude that DBT may be an effective treatment for both anger and aggressive behaviour. Limitations and future directions are discussed.

Service Improvement Project Abstract

Understanding and Improving the Experience of Young People and Families in The Oxfordshire CAMHS Crisis Service

Background: The Oxfordshire CAMHS Crisis service provides support for children and young people (CYP) experiencing acute mental health crisis. Since 2013 there has been no comprehensive evaluation of the service, nor any consultation with service users about their experience. This mixed-methods project aimed to understand service users' experience of the service and priorities for crisis care, service performance against available standards for care, and how care could be improved.

Method: Survey data were received from 34 parents and eight CYP who accessed the service within a 13-month period. Semi-structured interviews were also conducted with nine parents and three CYP. Quantitative data were analysed using descriptive statistics and qualitative responses were thematically analysed.

Results: Service users particularly valued 24/7 access to support and most participants reported that staff were warm in interactions. There was some discrepancy between CYP and parents' reports of what was received. Six themes were highlighted from qualitative data: staff warmth and understanding, parents need support, service access, need for improved liaison, clearer service information, and the importance of a long-term approach.

Conclusions: Several recommendations are made for how care could be improved. Further research is needed into crisis care for CYP to inform evidence-based practice. Limitations and future directions are discussed.

Theoretically Driven (Main) Research Project Abstract

Tell Me Something New: The Contribution of Self-Compassion to our Current Understanding of Hearing Voices

Objectives: This study aimed to test key predictions of the compassion model of voice hearing. It also aimed to assess whether self-compassion offers any additional understanding of voice-related distress and voice content than mood and negative self-schema, which are central parts of established cognitive-models.

Design: A within-group observational design.

Methods: Fifty-six adults who currently hear voices completed an online survey. The survey included measures of self-compassion, negative self-schema, mood, voice-related distress, and soothing/critical voice content. Twenty-five of these participants also completed a follow-up measure of voice content. Correlation, hierarchical regression, and mediation analyses assessed relationships between variables.

Results: Higher self-compassion was associated with lower voice-related distress and critical voice content, with a large effect size. It was also the only variable significantly associated with soothing voice content. Critical voice content was found to mediate the effect between self-compassion and voice-related distress. Self-compassion remained associated with voice-related distress and soothing voice content, even when mood and negative self-schema were controlled for; however, this was not significant when predicting voice content at follow-up.

Conclusions: These findings suggest that self-compassion offers an additional understanding of the variance in voice-related distress and soothing voice content than is already offered by mood and negative self-schema. Increasing self-compassion in therapy may lead to significant clinical benefits, including reduced voice-related distress and a switch from critical to soothing voice content. Further research is needed to assess directions of causality.

Critical Review of the Literature (CRL)

Title: Effectiveness of Dialectical Behaviour Therapy for Anger and Aggressive Behaviour in Adults: A Systematic Review and Meta-Analysis

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Journal Rationale: This journal has an impact factor of 5.54. It has previously published systematic reviews of aggression-related outcomes, and of DBT as an intervention (Duarte, Lloyd, Kotas, Andronis, & White, 2019; Papalia, Spivak, Daffern, & Ogloff, 2019).

Abstract

Anger and aggression have major health and safety implications, and effective treatment is critical. This review examined the effectiveness of Dialectical Behaviour Therapy (DBT) to reduce these outcomes in adults. Literature searches identified 16 eligible studies for the systematic review, of which 12 were included in meta-analyses. Pre-post evaluations showed small effects for DBT in reducing anger (*g* = -0.37; 95% CI [-0.65, -0.10]) and aggressive behaviour (*g* = -0.45; 95% CI [-0.60, -0.31]). DBT was superior to other active interventions in reducing anger (*g* = -0.29; 95% CI [-0.56, -0.01]*)* but no difference was found for aggressive behaviour (*g* = -0.04; 95% CI [-0.25, 0.16]). Little evidence was found for additional improvement when combined with medication. We conclude that DBT may be an effective treatment for both anger and aggressive behaviour. Limitations and future directions are discussed.

Key Words

DBT; dialectical behaviour therapy; anger; aggression; aggressive behaviour; violence

Public Health Significance Statement

Effective treatment for anger and aggressive behaviour is essential. This review suggests that DBT may be an effective intervention to reduce these outcomes. Findings also suggests that DBT may be more effective than other interventions to reduce anger, but not aggressive behaviour.

Introduction

Anger is an important and adaptive emotion (Novaco, 2016). Physical aggression is also often associated with anger (Fernandez & Johnson, 2016) and can be important in situations of threat and survival. However, anger and aggression can become problematic. Aggressive behaviour may result in harm to others, and maladaptive anger is associated with a range of adverse outcomes including cardiac problems (Everson-Rose et al., 2014; Williams et al., 2001), marital distress (Fernandez & Johnson, 2016), and higher chronic pain intensity (Bruehl et al., 2012; Fernandez & Johnson, 2016). Within psychological therapy, higher self-reported anger is also predictive of treatment dropout (Wnuk et al., 2013). Thus, anger and aggressive behaviour are essential outcomes to address in practice and research.

To explore approaches to change these outcomes, it is first important to understand the construct of anger. Spielberger's state-trait theory proposes that state anger is the universal experience of the emotion, including subjective feelings of anger and physiological activation (Spielberger et al., 1983, 1995). State anger occurs in response to specific situations and in discrete periods of time. Conversely, trait anger refers to an individual's propensity towards anger over time. People with high trait anger are proposed to experience it more frequently and intensely (Spielberger et al., 1983, 1995) and this has been supported by research (Deffenbacher et al., 1996).

It is important to distinguish between subjective angry feelings (anger experience) and how that anger is expressed (anger expression) (Fernandez & Johnson, 2016). Whilst anger experience and expression often co-occur, they are distinct (Fernandez & Johnson, 2016; Spielberger et al., 1995). Spielberger and colleagues have distinguished between three types of anger expression with factor-analytic research: 1) anger-in (suppressing angry feelings); 2) anger-out (expression using verbal or physical aggression); and 3) anger-control (attempts to

control the experience and expression of anger) (Spielberger et al., 1995). The state-trait anger theory predicts that individuals with higher trait anger will also show more maladaptive anger expression due to the increased intensity of anger (Spielberger et al., 1983). In support of this, individuals with higher trait anger have been shown to be more aggressive in response to situations, and more likely to engage in intimate partner violence (Deffenbacher et al., 1996; Shorey et al., 2011; Tafrate et al., 2002).

Fernandez and Johnson (2016) propose that anger expression is central to distinguish functional and problematic anger. They suggest that physical and verbal aggression are of highest importance, as these often result in harm to others. Indeed, reducing aggression is a priority in clinical practice to protect the safety of clients, families, and staff. Thus, whilst the other forms of anger expression are acknowledged, this review will focus on anger-out specifically, and this will be referred to as 'aggressive behaviour'.

Despite the impact and safety implications of anger and aggressive behaviour, there are currently no clear national recommendations for psychological interventions. Several therapeutic approaches have been explored in this area (Gillions et al., 2019; Saini, 2009), and the most frequently studied is Cognitive Behavioural Therapy (CBT) (Lee & DiGiuseppe, 2018). A previous meta-analysis found that CBT yields medium effect sizes when compared to other conditions in the treatment of anger and aggressive behaviour (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). They concluded that CBT may be most effective for difficulties with anger expression. As the treatment is not universally effective, other approaches to these difficulties have continued to be explored. One approach which has received less attention is Dialectical Behaviour Therapy (DBT).

Dialectical Behaviour Therapy (DBT)

DBT is a treatment that derived from CBT, and has gained a wealth of clinical and research interest since the publication of Marsha Linehan's first manual (Linehan, 1993). The manualised therapy was originally developed to treat individuals with a diagnosis of borderline personality disorder (BPD), a diagnosis characterised by dysregulation of emotions and behaviour (American Psychiatric Association, 2013; Linehan, 1993). The treatment is based on a skills-deficit model that assumes individuals lack important skills for emotional regulation, interpersonal effectiveness, and distress tolerance (Linehan et al., 1994). Thus, it aims to provide individuals with skills to regulate emotions more effectively (Linehan, 1993, 2014b). Since the model development, emotion dysregulation has also been found to be associated with several other mental health difficulties. In line with this, DBT has since been shown to be effective for individuals with various presenting problems, including bipolar disorder (Eisner et al., 2017), eating disorders (Klein et al., 2013; Safer & Jo, 2010) and major depressive disorder (Harley et al., 2008; Lynch et al., 2003).

The DBT model of emotion includes the individual's cognition, biochemistry, physiological responses, action urges, and behaviours (Crowell et al., 2009; Linehan, 2014b). The model's definition of emotion regulation also includes regulation of both the person's emotional arousal and emotion-driven behaviour (Linehan, 2014b). Thus, DBT aims to address both the experience and expression of emotions.

When DBT was developed, the available treatments of the time were focused on changing experiences rather than learning to tolerate them (Linehan & Wilks, 2015). DBT was developed to include acceptance skills in addition to change skills, and it was hoped that the balance of these would be more validating of clients' experiences and distress (Linehan & Wilks, 2015). The acceptance and change strategies are introduced with the philosophical concept of

dialectics, which is the process of bringing together things that are seemingly opposite (Linehan & Wilks, 2015). Change strategies are used at the level of both cognition (e.g., “check the facts”, “myths about emotions”) and behaviour (e.g., “opposite action”, “TIPP”). Skills teaching is delivered in a group setting and is organised into four modules: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance (Linehan, 2014b).

The standard DBT intervention described in the treatment manual includes four core components: weekly group skills training, weekly individual therapy, between-sessions skills coaching, and a staff consultation team. As a hierarchical therapy, the individual therapists are asked to prioritise client behaviours in the following order: 1) decreasing life threatening behaviours; 2) reduce therapy interfering behaviours); 3) decrease quality-of-life interfering behaviours; and 4) increase behavioural skills (Linehan, 2014b). The recommended length of treatment is 12 months, and individuals are expected to complete the skills training group twice in this time. The original group programme is 24-weeks, however the updated manual offers a range of possible schedules and suggests that the length is adapted as appropriate for the population and setting (Linehan, 2014a).

There is strong evidence for the effectiveness of standard DBT in the treatment of BPD, particularly in the reduction of suicidal and parasuicidal behaviours (Panos et al., 2014). In support of the model, identified mechanisms of change include changes in emotion regulation, skills use, and therapeutic alliance (Neacsiu et al., 2010; Rudge et al., 2020). DBT skills training has also been evaluated as a standalone treatment and found to lead to meaningful change in several outcomes. For example, randomised controlled trials (RCTs) have shown skills training alone to be associated with reduced affective instability, treatment dropout, and improved emotion regulation (Linehan, 2014a; Soler et al., 2009; Van Dijk et al., 2013).

DBT and Anger

As outlined above, DBT was developed as a treatment for dysregulation of emotions and behaviour; it was not developed to treat anger or aggression as a standalone difficulty. However, given the focus on increasing tolerance and regulation of emotions and behaviour, and that intense and inappropriate anger is part of the diagnostic criteria for BPD (American Psychiatric Association, 2013), there is strong rationale to suggest that DBT may be an effective treatment for difficulties with both the experience and expression of anger. Indeed, Linehan (2014) references several studies in the treatment manual to suggest that DBT is an effective treatment for anger and aggression; however, no recent and specific systematic review or meta-analysis has been conducted to understand the current evidence of the effectiveness of DBT in reducing these outcomes.

Two broad meta-analyses have explored the effectiveness of psychological interventions in anger and aggressive behaviour. However, they have not distinguished dialectical behavioural therapies, instead referring to groups of interventions as 'cognitive-behavioural' or 'skills -based', and thus conclusions cannot be drawn about DBT specifically (Lee & DiGiuseppe, 2018; Saini, 2009).

One systematic review explored the use of DBT in treating anger and aggressive behaviour, and identified 21 studies for inclusion (Frazier & Vela, 2014). The authors concluded that most studies reported a decrease in anger and aggressive behaviours, and that this was preliminary evidence for the effectiveness of DBT in reducing these outcomes. However, the review employed broad inclusion criteria including participants of all ages, non-standardised outcome measures, and adaptations to DBT that deviated from the treatment manual. In addition, a more recent systematic review concluded that there was inconclusive evidence for the effectiveness of DBT in reducing in aggressive behaviour (Gillions et al., 2019). This review

also included several studies that had adapted the intervention and did not review any outcomes relating to the experience of anger.

To summarise, there is no available review of studies that maintain high fidelity to the treatment manual in the reduction of anger and aggressive behaviour. Previous reviews suggest that DBT may be effective in reducing anger, though the effect on aggressive behaviour appears inconclusive. Meta-analyses are needed to pool the available evidence and assess effectiveness. In this paper, we conduct a systematic review and meta-analysis of available studies to evaluate the effectiveness of DBT in reducing anger and aggressive behaviour, when delivered according to the manual. We firstly aimed to assess whether manualised DBT is effective in reducing anger and aggressive behaviour amongst adults in all treatment settings. We secondly aimed to compare manualised DBT to other active interventions in these outcomes, to better understand the specific contribution of DBT.

Method

This systematic review was informed by the Cochrane guidance for rapid reviews (Garritty et al., 2020). It follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRSIMA) guidelines (Page et al., 2021). The study protocol was registered on PROSPERO a priori (registration number: CRD42021232929).

Search Strategy and Eligibility Criteria

A literature search was conducted using Embase, Medline, Psycinfo, Scopus and Web of Science databases. The strategy included search terms on all databases and MESH headings where possible. Search terms were as follows: “DBT or “dialectical behavio* therap*"” combined with “violen* or aggress* or anger or angry or "challenging behavi*" or conflict or “antisocial behavio*” or rage or agonistic or fight* or attack*”. Limits were applied to only include studies written in English and published after 1993. The references of similar reviews

(Frazier & Vela, 2014; Gillions et al., 2019; Lee & DiGiuseppe, 2018; Saini, 2009) and all eligible papers were also hand searched for additional studies.

Eligible studies included those with an adult sample (all participants over 18 years of age) and a clinical population (individuals experiencing mental distress and/or receiving care from mental health services). Studies were included if they evaluated the delivery of a DBT intervention which followed the treatment manual (Linehan, 1993, 2014a). This included interventions with any combination of the four treatment components, providing that the skills group was delivered as a minimum and all four skills modules were taught. Eligible study designs included randomised controlled trials (RCTs), non-randomised controlled trials (NRCTs), pre-post designs, and case series. As there is minimal evidence comparing DBT with control conditions in the treatment of anger and aggression to date, comparator conditions for the meta-analysis were any conditions with an active therapeutic intervention. This included treatment as usual or other intervention conditions, providing that active input was offered. Eligible outcomes were standardised measures of anger, verbal and physical aggression to others, and aggression to property. This included both subjective self-reports (e.g. State–Trait Anger Expression Inventory-2 (STAXI-2) (Spielberger, 1999)) and behavioural measures (e.g. Overt Aggression Scale (OAS) (Yudofsky et al., 1986)). Measures needed to include a pre and post assessment as a minimum, to allow for evaluation of change in pre-post scores. Eligible studies were published in a peer-reviewed journal, in English, during or after 1993.

Studies were excluded if the sample included individuals under the age of 18, non-clinical populations, or learning disability populations. Studies were also excluded if the DBT intervention deviated from the treatment manual. The only exception was change to treatment duration, as this is acceptable within the guidance (Linehan, 1993, 2014a). Case studies were also excluded, as was qualitative research, grey literature, and non-empirical research. Studies

were not eligible if there was no English translation available. Studies published prior to 1993 were excluded because they pre-dated the publication of the first DBT manual. Measures of aggression towards the self (i.e. self-injury) were also not eligible for inclusion.

Screening Process

Two independent authors (HG and MR) independently assessed eligibility of the first 25% papers using titles and abstracts, with a good level of agreement (99.0%, $\kappa = 0.76$, $p<.0001$) suggesting a low risk of bias. All potentially eligible papers and any discrepancies at this stage were included in full text screening and HG screened all remaining titles and abstracts.

The same two authors independently assessed the first 35% of full-text papers for eligibility, with 100% agreement ($\kappa = 1.00$, $p<.0001$). This screening was for inclusion in the systematic review, and any papers with the additional necessary information would also be included in the meta-analysis. HG completed the remaining screening of full-texts and contacted authors when key eligibility information was missing.

Data Extraction and Quality Assessment

Data from included studies was extracted into a standardised spreadsheet. HG extracted data from all included studies, and MR also extracted data from the first 50%. Extracted data included: sample (N, gender, age, ethnicity, eligibility criteria), setting, design, DBT intervention (including duration and treatment elements), comparator conditions, anger and/or aggressive behaviour measures used, and relevant reported findings. Where possible, means and standard deviations were extracted for pre and post time points of all eligible measures to include in meta-analyses. If means or standard deviations were not reported in any study materials, authors were contacted to provide the necessary data. If no response was received within the deadline of three months, the papers were included in the systematic review only.

The quality of the included studies was assessed using the QualSyst tool for quantitative studies (Kmet et al., 2004). This tool employs a range of criteria for assessment, including whether the study has a clear aim, uses robust outcome measures, is adequately powered, and controls for potential confounds. Ratings are provided on a 3-point scale (0 = no, 1 = partial, 2 = yes) and some items are not applicable for all designs. Each study achieves a 'summary score', which is the sum of points awarded to the study divided by the number possible to achieve (i.e. without non-applicable items). Summary scores can range from 0.0 to 1.0. Two raters (HG and MR) independently assessed the quality of the first six studies (37%), with an excellent degree of reliability (k = .89, p<.0001). The remaining studies were assessed by HG.

Data Analysis

Standardised mean differences (SMDs) were firstly calculated for the difference before and after DBT (pre-post), and secondly for DBT compared to other active interventions. The decision to calculate the pre-post effect in addition to the between-group effect was made due to the limited number of available studies with comparator conditions, and follows examples of previous reviews (e.g., Kothgassner et al., 2021). The pre-post treatment effect was calculated using means, standard deviations, and sample sizes before and after DBT treatment. Between-group SMDs were calculated from means and standard deviations from each condition at post-treatment. All SMDs were calculated using Hedge's g to minimise bias from smaller sample sizes (Cumming, 2011). Hedge's g was interpreted as small ≥ 0.20, moderate ≥0.50, and large ≥0.80 (Cohen, 2013). Negative estimates of Hedges g in pre-post analyses indicates reduction in scores during treatment, and in between-group analyses indicates superiority of DBT against the comparator condition. Meta-analyses were employed to pool SMDs and heterogeneity was explored using the I^2 value (low ≥25%, moderate ≥50%, high ≥75%) (Higgins et al., 2003), the X^2

statistic and prediction intervals. The meta-analyses used fixed-effect models, or random-effects if I^2 >50% to account for heterogeneity (Deeks et al., 2021).

Measures of anger and aggressive behaviour were analysed separately. Where multiple measures of one of these constructs were reported in a single paper, the most frequently used measure was prioritised to minimise heterogeneity. If studies reported multiple subscales from a single measure separately, they were combined for the initial overall meta-analysis. Subgroup analyses were also performed on STAXI subscales, which measures anger experience and expression according to Spielberger's theory (Spielberger et al., 1983, 1995). Funnel plots were not used to assess for asymmetry where there were fewer than 10 included studies (Sterne et al., 2011). All analyses were calculated using Stata v17 (Stata Corp, 2021).

Results

Study Selection

Figure 1 shows a flowchart of study identification and selection (Page et al., 2021). The initial search was conducted on 20th July 2021 and updated on 6th June 2022. These searches retrieved 2422 records and three further studies were identified from reference lists of similar reviews. 1793 records were retained after removal of duplicates. A total of 66 papers were identified for full-text review after title and abstract screening. The review of full-text reports identified a total of 16 studies for inclusion in the systematic review. Of these, 12 were also included in the meta-analysis. Descriptive details of all included studies are presented in Table 1.

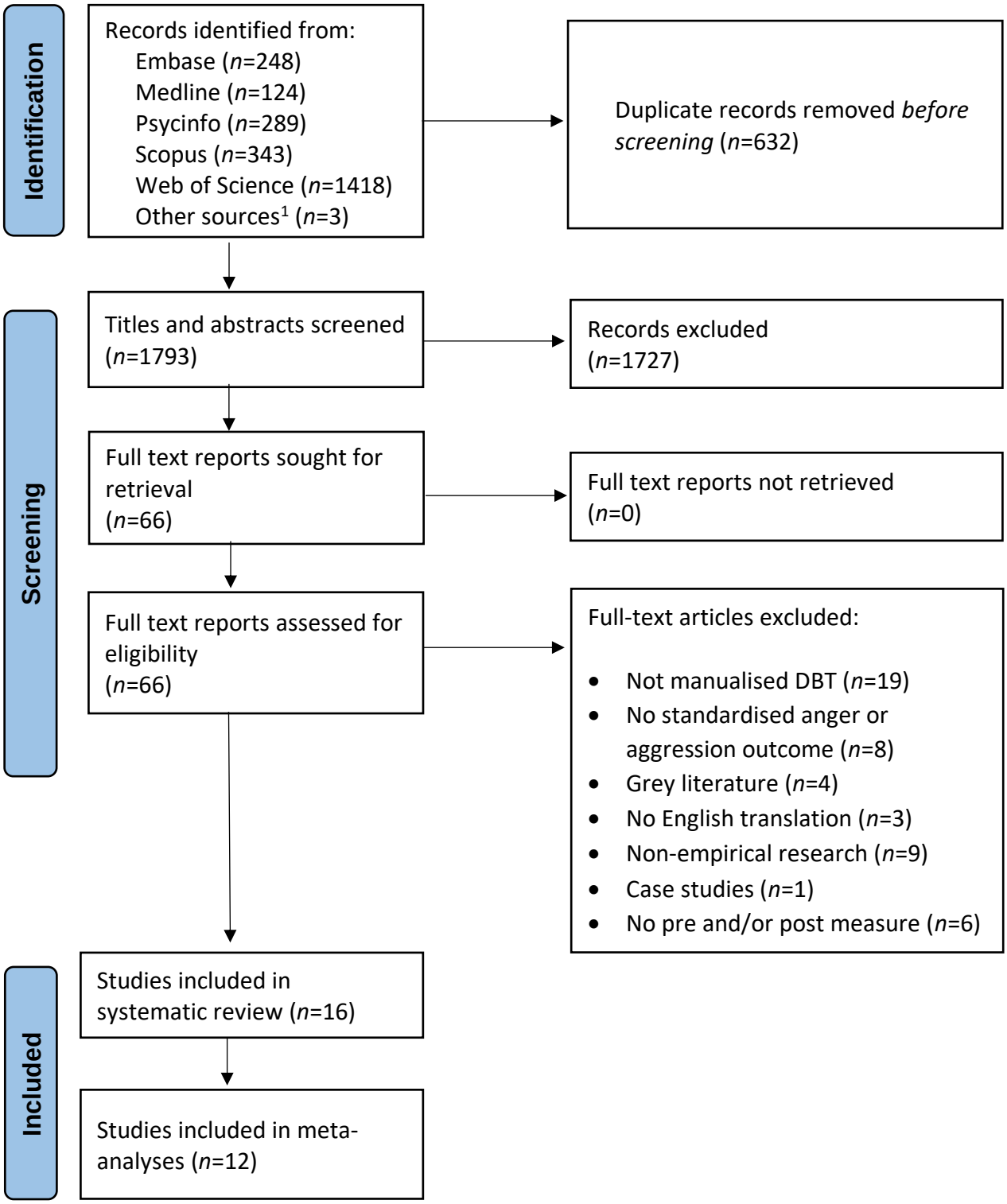
Study Characteristics

The study pool included 11 RCTs, 2 NRCTs, and 3 pre-post designs. Studies were published between 1994 and 2021, and all were conducted in high income countries. The samples were largely female (M=82% where whole sample data reported). Where ethnicity

data were provided, most participants identified as white or Caucasian. Most (*n*=12) evaluated DBT as an intervention with a BPD sample, including BPD comorbid with an eating disorder (Navarro-Haro et al., 2021) and Attention Deficit Hyperactivity Disorder (ADHD) (Prada et al., 2015). Most evaluated outpatient delivery of DBT (*n*=13), and the remaining three were conducted in a forensic psychiatry setting. For a detailed description of comparator conditions, see Appendix A.

Figure 1

Study Flowchart



Note. This figure presents study selection as per PRISMA guidelines (Page et al., 2021).

[1]Additional studies identified from reference lists of previous reviews.

As can be seen in Table 1, a range of tools were used to assess anger and aggressive behaviour. The most frequently employed measure was variations of the State–Trait Anger Expression Inventory (STAXI) (*n*=9) (Spielberger, 1991), which measures anger experience and expression according to Spielberger et al. (1983)'s state-trait theory. The revised version of this measure (STAXI-2) (Spielberger, 1999) was only used by two studies (Navarro-Haro et al., 2021; Prendergast & McCausland, 2007) despite being the preferred version (Fernandez et al., 2015). For a full list of outcome measures, see Appendix B.

DBT Interventions

DBT interventions varied in length, ranging from 1 month (Prada et al., 2015) to 12 months (Clarkin et al., 2007; Feigenbaum et al., 2012; Fox et al., 2015; Linehan et al., 1994; McMain et al., 2009, 2012; Moulden et al., 2020; Neacsiu et al., 2014). All papers reported a skills group conducted once per week as a minimum. One intensive intervention involved four skills group sessions per week (Prada et al., 2015). Two studies evaluated skills group only interventions (Neacsiu et al., 2014; Soler et al., 2009), one of which also included a single individual crisis planning session (Neacsiu et al., 2014). Only six papers reported all four therapy components and a 12-month intervention (Feigenbaum et al., 2012; Fox et al., 2015; McMain et al., 2009, 2012; Moulden et al., 2020; Neacsiu et al., 2014).

As planned a priori, no interventions with adaptations that deviated from the manual were included. However, one study reported that the intervention was delivered in Spanish (Navarro-Haro et al., 2021), and one made language and cultural adaptations to fit the Australian context (Prendergast & McCausland, 2007). Two studies reported additional ward input during DBT treatment, which did not include psychological interventions (Fox et al., 2015; Moulden et al., 2020).

Two studies were authored by the developer of DBT, Marsha Linehan (Linehan et al., 1994; Neacsiu et al., 2014). Eight papers reported that some or all of the study therapists had completed DBT training at intensive level (Feigenbaum et al., 2012; Fox et al., 2015; Koons et al., 2001; McMain et al., 2009, 2012; Moulden et al., 2020; Prendergast & McCausland, 2007; Simpson et al., 2004). Seven reported use of adherence coding to ensure fidelity to the DBT model (Clarkin et al., 2007; Fox et al., 2015; Koons et al., 2001; McMain et al., 2009, 2012; Neacsiu et al., 2014, 2018).

Study Quality

We assessed the quality of all studies included in the systematic review using the Qualsyst tool (Kmet et al., 2004). The mean summary score was 0.77 (range = 0.59 to 0.92). The mean summary score for studies included in the meta-analysis was 0.76. The mean scores for each methodological aspect were all 1.0 or above (maximum possible score 2.0). The lowest scores were for participant blinding (where applicable) (M=1.00), inadequately powered studies (M=1.13) and variance estimates (M=1.19). Highest scores were for investigator blinding (where applicable) (M=2.00), choice of outcome measures (M=1.88), and drawing appropriate conclusions (M=1.75). For more details, see Appendix C.

The Effectiveness of DBT in Treating Anger and Aggressive Behaviour

The remainder of this section will summarise findings on the effectiveness of DBT in reducing scores of anger and aggressive behaviour. Some studies reported both anger and aggression outcomes, so will appear in both sections.

DBT and Anger

The following analyses evaluated the effectiveness of DBT in reducing measures of anger. Two studies could not be included in this quantitative analysis because the necessary data were not provided (Clarkin et al., 2007; Tomlinson & Hoaken, 2017). Both studies reported

no change over time in anger scores (the first included a mid-treatment data point, the latter was a pre-post analysis).

We firstly conducted a random-effects meta-analysis on the within-group effect of DBT where all anger outcomes were combined. A significant reduction was found for combined outcomes of anger post-treatment for DBT, compared with combined anger measures before treatment (Hedge's g = -0.37, 95% CI [-0.65, -0.10], n=7, I^2=54%, p<.0001) (see Figure 2). This suggests a small but significant effect of DBT in reducing anger scores.

The above findings remained significant in a subgroup analysis of trait anger measures (Hedges' g = -0.39, 95% CI [-0.56, -0.22], n=5, I^2=0.0%, p<.0001). However, there was no significant difference found in a subgroup analysis of state anger outcomes (Hedges' g = -0.33, 95% CI [-0.86, 0.19], n=3, I^2=79.8%, p=.213) (see Figures 3 and 4). This suggests that DBT is effective at reducing self-reported trait, but not state anger.

Next, we considered the effectiveness of DBT compared to other active interventions. A fixed-effects meta-analysis revealed significant differences between DBT against other active interventions for combined anger outcomes (Hedges' g = -0.29, 95% CI [-0.56, -0.01], n=4, I^2=49%, p=.0432) (see Figure 5). This suggests a small but significant difference between conditions, whereby DBT post-treatment anger scores were lower than those of the comparator groups.

One experimental medication study was not included in this analysis as participants in all conditions received DBT. However, they found that when BPD and ADHD were comorbid, combining DBT with methylphenidate (10-80mg) was associated with greater reductions in state anger as measured by the STAXI (Prada et al., 2015).

Figure 2

Forest Plot of Studies Comparing Pre-Post DBT Combined Anger Scores

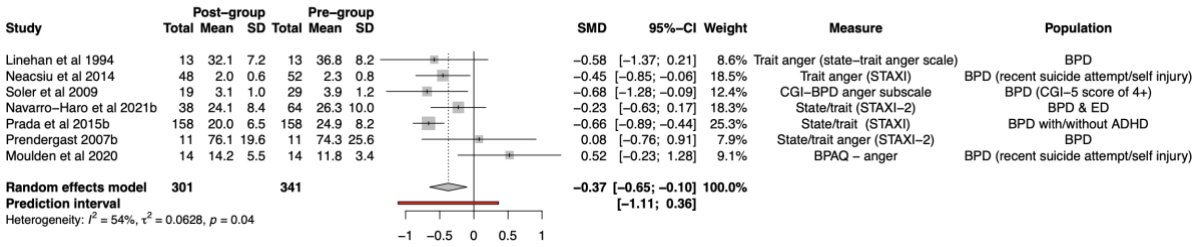


Figure 3

Forest Plot of Studies Comparing Pre-Post DBT Trait Anger Scores

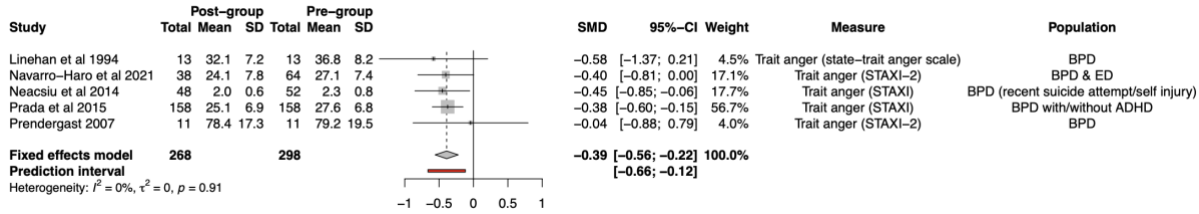


Figure 4

Forest Plot of Studies Comparing Pre-Post DBT State Anger Scores

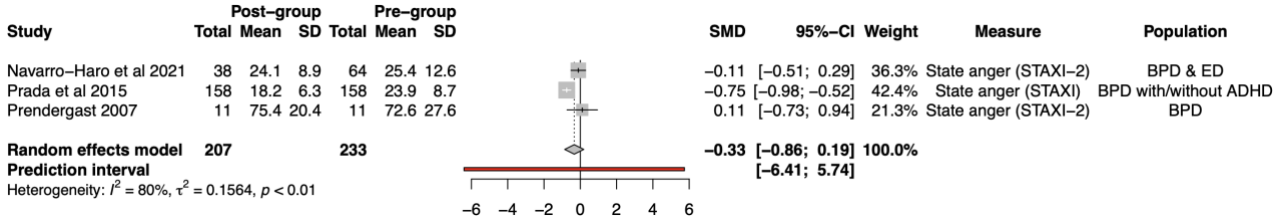
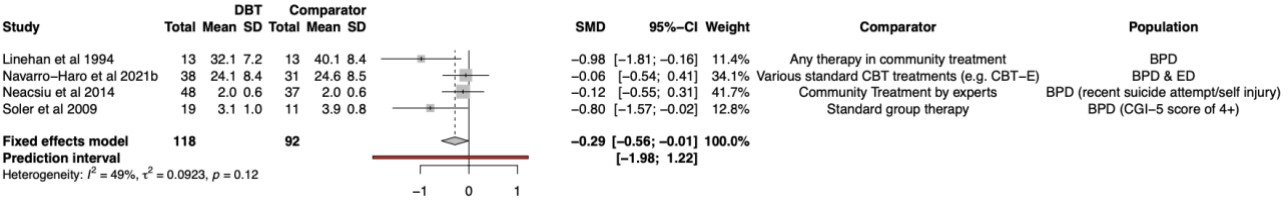


Figure 5

Forest Plot of Trials Comparing the Post-Treatment Scores of DBT against Comparators on Combined Anger Outcomes



DBT and Aggressive Behaviour

The remaining analyses evaluated the effectiveness of DBT in reducing aggressive behaviour. Three studies could not be included in quantitative analysis because they did not

report the necessary data for inclusion (Clarkin et al., 2007; Simpson et al., 2004; Tomlinson & Hoaken, 2017). None found a significant reduction in aggressive behaviour over the period of DBT treatment. Notably, one of these studies administered the post measure before the end of treatment, at week 10 of 12 (Simpson et al., 2004). One further study was also not included, as it reported follow-up data and thus was not suitable for a pre-post analysis (McMain et al., 2012).

We firstly conducted a fixed-effects meta-analysis on the within-group effect of DBT on aggressive behaviour. A significant difference was found for combined outcomes of aggressive behaviour post-treatment for DBT, compared with combined aggression measures before treatment (Hedges' g = -0.45, 95% CI [-0.60, -0.31], n=8, p<.0001), with small between study heterogeneity (I^2=0.0%) (see Figure 6). This suggests DBT has a small effect in reducing aggressive behaviour. These findings also remained significant in a subgroup analysis of studies using the STAXI anger-out subscale (Hedges' g = -0.45, 95% CI [-0.60, -0.30], n=7, I^2=0.0%, p<.0001) (see Figure 7).

To evaluate the effectiveness of DBT compared to other active interventions, another fixed-effects meta-analysis was performed using post-treatment aggressive behaviour scores. This revealed no significant difference between DBT and other active interventions (Hedges' g = -0.04, 95% CI [-0.25, 0.16], n=5, I^2=0.0%, p=.6794,) (see Figure 8).

Two studies assessed whether the effectiveness of DBT on aggressive behaviour would be improved if combined with medication. One study compared DBT with placebo against DBT with 40mg fluoxetine (Simpson et al., 2004) and another compared 3 conditions (BPD, BPD+ADHD untreated, BPD+ADHD with up to 80mg methylphenidate) (Prada et al., 2015). Neither found a significant difference between groups in changes in aggressive behaviour, suggesting that the addition of these medications did not influence the effectiveness of DBT.

Another study compared change during a 2-year follow up between DBT and general psychiatric management (McMain et al., 2012). The within-group effect of DBT was not calculated, though the pooled sample showed further improvements in anger during this period. No difference was found between conditions in the change in scores during follow up (McMain et al., 2012).

Figure 6

Forest Plot of Studies Comparing Pre-Post DBT Combined Aggression Scores

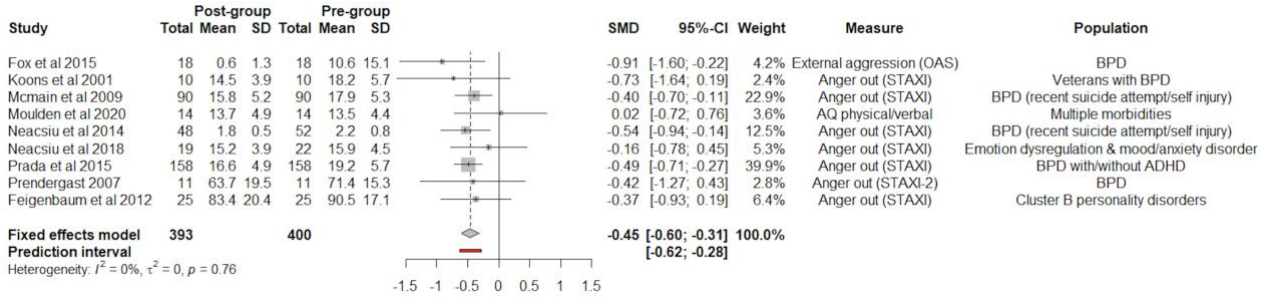


Figure 7

Forest Plot of Studies Comparing Pre-Post DBT STAXI Anger-Out

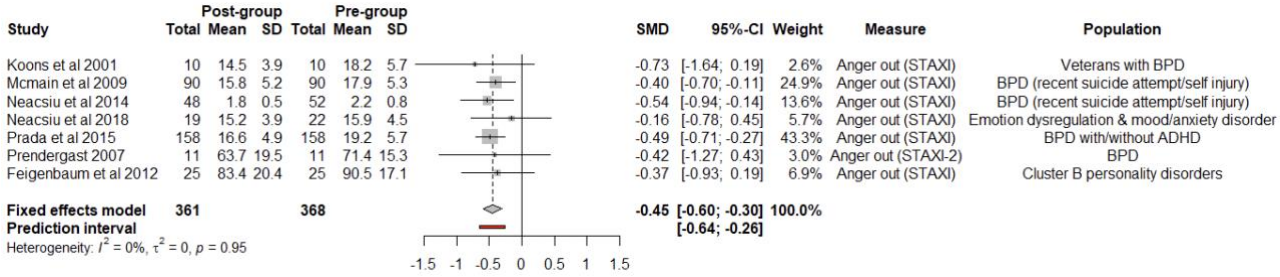


Figure 8

Forest Plot of Trials Comparing the Effect of DBT against Comparators on Combined Aggression Outcomes

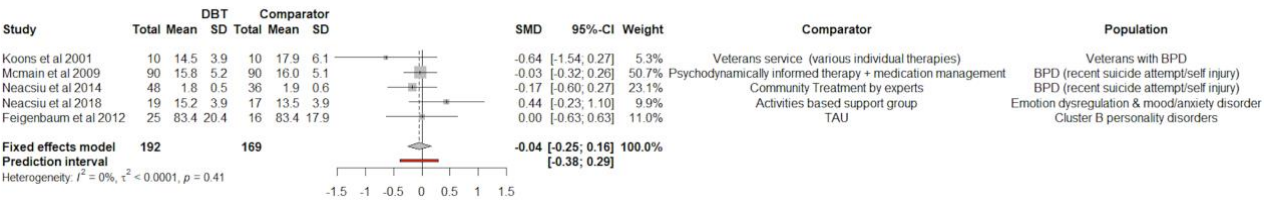


Table 1

Descriptive Details of Included Studies

Study	QR	Country	Design	*N* Post	Setting	Population	Age M (SD)	% female	Ethnicity	DBT components	DBT length (mths)	Comparator	Measures
Clarkin et al. (2007)	0.65	USA	RCT[1]	DBT: 17	Outpatient	BPD (IPDE assessed)	30.9 (7.9)	92%	67.8% Caucasian, 10.0% African American, 8.9% Hispanic, 5.6% Asian, 7.8% Other	SG, IT, BC	12	Comparators present but no data available	AIAQ: anger, verbal assault, direct assault
Feigenbaum et al. (2012)*	0.78	England	RCT	DBT: 25 TAU-PD: 16	Outpatient	Cluster B Personality Disorder (SCID-II assessed)	DBT 35.4 (7.8) TAU-PD 34.6 (7.4)	DBT: 72% TAU-PD: 75%	No data	SG, IT, BC, SC	12	TAU for Personality Disorder (TAU-PD)	STAXI: anger-out OAS: aggression

Fox et al. (2015)*	0.59	England	Pre-post	DBT: 18	Forensic psychiatric (inpatient)	Patients on low secure DBT unit with BPD	29.0 (9.0)	100%	No data	SG, IT, BC, SC	12	-	OAS: weighted sum of verbal aggression, aggression against objects and against people subscales
Koons et al. (2001)*	0.83	USA	RCT	DBT: 10 VS: 10	Outpatient	Veterans with BPD (SCID-II assessed)	35.5 (7.5)	100%	75% Caucasian, 25% African American	SG, IT, BC, SC	6	Veterans Service Usual Care (VS)	STAXI: anger-out
Linehan et al. (1994)*	0.81	USA	RCT	DBT: 13 TIC: 13	Outpatient	BPD (SCID-II assessed. All had ⩾2 instances of parasuicidal behaviour	26.7 (7.8)	100%	No data	SG; IT	12	Therapy in Community (TIC)	STAS: trait anger

						in last 5 years, with ⩾1 in last 8 weeks							
Mcmain et al. (2009)*	0.85	Canada	RCT	DBT: 90 GPM: 90	Outpatient	BPD (IPDE assessed). All had ⩾2 incidents parasuicidal behaviour in last 5 years, with ⩾1 in last 3 months	30.4 (9.9)	86%	No data	SG, IT, BC, SC	12	General Psychiatric Management (GPM)	STAXI: anger-out
Mcmain et al. (2012)	0.88	Canada	RCT (follow up data)	DBT: 90 GPM: 90	Outpatient	BPD (IPDE assessed). All had ⩾2 incidents parasuicidal behaviour in last 5 years, with	30.4 (9.9)	86%	No data	SG, IT, BC, SC	12	General Psychiatric Management (GPM)	STAXI: anger-out

						⩾1 in last 3 months							
Moulden et al. (2020)*	0.59	Canada	Pre-post	DBT: 14	Forensic psychiatric (inpatient & outpatient)	Forensic patients with multiple morbidities	36.4 (12.5)	26%	No data	SG, IT, BC, SC	12	-	BPAQ: physical aggression, verbal aggression, anger
Navarro-Haro et al. (2021)*	0.77	Spain	NRCT	DBT: 64 CBT: 45	Outpatient	Comorbid BPD (SCID-I assessed) & eating disorder (AN, BN, EDNOS)	27.4 (8.8)	100%	No data	SG, IT, BC, SC	6	CBT for Eating Disorders, with additional strategies for personality pathology	STAXI-2 (Spanish): trait anger
Neacsiu et al. (2014)*	0.88	USA	RCT	DBT: 52 CTBE: 49	Outpatient	BPD (IPDE & SCID-II assessed). All had ⩾2 instances of	29.3 (7.5)	100%	88% Caucasian	SG, IT, BC, SC	12	Community Treatment by Experts (CTBE)	STAXI: trait anger, anger-out

						parasuicidal behaviour in last 5 years, with ⩾1 in last 8 weeks							
Neacsiu et al. (2018)*	0.92	USA	RCT	DBT: 22 ASG: 22	Outpatient	Emotion dysregulation (as assessed by a score of ⩾97 on DERS) & a primary diagnosis of mood or anxiety disorder	35.5 (12.4)	66%	93% Caucasian	SG	4	Activities Based Support Group (ASG)	STAXI: anger-out
Prada et al. (2015)*	0.67	Switzerland	NRCT	BPD: 76,	Outpatient	BPD (SCID-II assessed) with and without	BPD: 2.9 (10.6)	92%	No data	SG, IT, TC	1	DBT with/without methylphenidate (MPH)	STAXI: trait anger, state

				BPD+ADHD+MPH: 24 BPD+ADHD: 23		comorbid ADHD	BPD+ADHD: 30.2 (9.3) BPD+ADHD+MPH: 29.1 (7.1)					when ADHD comorbid	anger, anger-out
Prendergast and McCausland (2007)*	0.64	Australia	Pre-post	DBT: 11	Outpatient	BPD	36.7 (7.4)	100%	No data	SG, IT, BC, SC	6	-	STAXI-2: state anger, trait anger, anger-out
Simpson et al. (2004)	0.86	USA	RCT	DBT + placebo: 11 DBT + fluoxetine = 9	Outpatient	BPD (SCID-II), met criteria for $\geqslant 1$ affective instability symptoms and $\geqslant 1$	35.3 (10.1)	100%	72% White, 20% African American, 7% Native American	SG, IT, BC, SC	3	DBT + placebo vs DBT + 40mg fluoxetine	OAS-M: combined verbal and physical aggression subscales

						impulsivity symptom							STAXI: anger-out
Soler et al. (2009)*	0.81	Spain	RCT	DBT: 19 SGT: 11	Outpatient	18-45, BPD (SCID-II & DIB-R) & CGI-S score ≥ 4	DBT-ST: 28.5 (6.6) SGT: 30.0 (5.6)	DBT: 79% SGT: 26%	No data	SG	13 weeks	Standard Group Therapy (SGT)	CGI-BPD anger subscale
Tomlinson and Hoaken (2017)	0.75	Canada	RCT (crossover design)	15	Forensic psychiatric (inpatient)	Forensic patients with emotion dysregulation (clinician opinion)	42.7 (12.1)	0%	80% Caucasian; 7% Aboriginal; 7% Asian/Pacific Islander; 7% East Indian	SG, BC, SC	6	Ward Standard Care	BPAQ-SF: physical aggression, verbal aggression, anger IPAS: impulsive and premeditated aggression subscales

| | | |

Discussion

This systematic review and meta-analysis aimed to evaluate the effectiveness of DBT in reducing anger and aggressive behaviour. It looked at interventions that followed the treatment manuals (Linehan, 1993, 2014b) conducted with adults in all settings without significant adaptations. The findings suggested that DBT has a small but significant effect in reducing anger and aggressive behaviour pre-post intervention. DBT had a small superior effect when compared to other active interventions in post-treatment measures of anger, but no difference was found between groups for aggressive behaviour. This is interesting when compared to meta-analyses of CBT in this context, which found medium effect sizes for reductions in anger and aggressive behaviour when compared to other conditions (Hofmann et al., 2012).

Three studies were not included in meta-analyses due to incomplete data reporting (Clarkin et al., 2007; Simpson et al., 2004; Tomlinson & Hoaken, 2017). These studies found no significant effect of DBT in reducing anger and aggressive behaviour over time. The studies were not adequately powered to find a small effect so may be biased results; however, they are still acknowledged.

The finding that DBT has a small but significant effect in reducing anger scores suggests that the treatment is effective in its aim to improve emotion regulation (Linehan, 1993, 2014b; Linehan & Wilks, 2015). This also builds on a previous systematic review that concluded there was promising evidence for the effectiveness of DBT in treating anger (Frazier & Vela, 2014). Anger regulation difficulties are a diagnostic marker of BPD (American Psychiatric Association, 2013), so this may also be seen as further evidence in support of using DBT with this population. Notably, none of the studies that found a reduction in anger symptoms employed the full DBT model (all treatment components for 12 months). They included a skills group only

study (Soler et al., 2009), a one-month intensive intervention (Prada et al., 2015), and several interventions with all treatment components but shorter duration (Navarro-Haro et al., 2021; Neacsiu et al., 2014; Prendergast & McCausland, 2007). This suggests that the full model may not be necessary for significant reductions in anger, which has meaningful implications for services low on resource.

Interestingly, subgroup analyses suggested that DBT is effective at reducing self-reported trait, but not state anger. These results suggest that DBT may lead to a reduction in the frequency and intensity of anger over time, rather than a change to anger that is specific to certain situations (Deffenbacher et al., 1996; Spielberger et al., 1983, 1995). This is in line with the teaching of DBT skills to be applied across contexts (Linehan, 2014b).

DBT was also found to lead to a reduction in combined aggression outcomes with a small effect, suggesting it is an effective intervention for reducing aggressive behaviour. However, no difference was found between DBT and other active interventions in these outcomes at post-treatment. As this comparator group was so varied, it is not possible to conclude whether this is because the treatment effect is due to non-specific factors in therapy, or because the other conditions are also effective interventions. Future research would benefit from defining comparator conditions further, by looking at DBT compared to waitlist or other specific psychological interventions. We also note that there was a small number of studies in the between-group analysis, and some were underpowered to find an effect. Finally, a follow-up study that was not included in the meta-analysis suggested that improvements in aggressive behaviour may continue after treatment ends, so this will be important for future studies to explore (McMain et al., 2012).

A previous systematic review concluded that there is inconclusive evidence for the effectiveness of DBT in reducing aggressive behaviour (Gillions et al., 2019). By conducting a

meta-analysis, we have been able to quantitatively synthesise the available data to better understand the effect of DBT. From our findings, we echo the calls of this previous review that exploring modifications to improve the effect of DBT on aggressive behaviour may be beneficial. Exploring adaptations was beyond the scope of our review; however, one study has reported moderate to large effects in the reduction of aggressive behaviour with an adapted DBT intervention for irritability and aggression. This intervention focused on irritability and aggression in behavioural targets, and highlighted skills in teaching that were thought to be particularly helpful for these difficulties (Linehan et al., 2008). Future studies may explore whether this adapted version of DBT is more effective than standard DBT to reduce aggressive behaviour. Standardised adaptations to the DBT protocol are available to treat other specific presentations, including DBT for PTSD (Steil et al., 2011) and DBT for binge eating (Safer & Jo, 2010), and it may be that DBT for aggressive behaviour becomes another example of this if it leads to improved treatment of this outcome.

Two studies assessed whether the effect of DBT is improved when in combination with medication. No difference in aggressive behaviour was found between medicated and unmedicated participants in either study (Prada et al., 2015; Simpson et al., 2004). However, Prada et al. (2015) found the addition of methylphenidate was associated with greater reductions in state anger for participants with ADHD. This suggests that treating ADHD may improve the effectiveness of DBT in reducing state anger, although does not appear to influence changes in aggressive behaviour.

Limitations

This review has several limitations. Firstly, the samples are largely white and female participants with BPD, which limits generalizability of findings. We particularly note that all participants included in the anger meta-analyses had a personality disorder diagnosis, so it will

be important to explore whether these findings hold when applied to other groups. Secondly, most outcomes were subjective self-report measures. However, risk of bias is not necessarily mitigated when measures are delivered by clinicians or researchers, which risk confirmation and observer bias. Some studies employed both self-report and observational measures, which should be encouraged (Simpson et al., 2004; Tomlinson & Hoaken, 2017).

Three studies that found no significant effect of DBT on anger and aggressive behaviour were not possible to include in meta-analyses, due to incomplete data reporting (Clarkin et al., 2007; Simpson et al., 2004; Tomlinson & Hoaken, 2017). The authors were contacted but did not respond. Whilst their findings have been reported as part of the systematic review, the data were not possible to include in the aggregated effect sizes. These may have therefore over-estimated the impact of the DBT intervention. Notably, these studies were low powered to find an effect. As with all other reviews, the meta-analyses may also be influenced by publication bias.

There are also several reasons that the treatment effect may be underestimated in these analyses. Firstly, we included studies with shorter durations of treatment as this is acknowledged in the manual as necessary in some settings. However, shorter interventions offer a reduced selection of skills and/or less time for implementation and consolidation of learning. Thus, including these interventions may have limited the observed DBT treatment effect. Two studies also reported post-treatment scores before treatment had ended, and so may have missed some symptom improvement. Finally, most studies were not adequately powered and thus may have missed the small effect sizes observed in other papers.

Implications and Future Directions

Future research will be essential to improve our understanding of the effect of DBT on anger and aggressive behaviour. Most studies in this review include small sample sizes and

participants with a diagnosis of BPD, so it is essential that future research explores changes in anger and aggressive behaviour with larger and more diverse samples. It would also be beneficial to examine whether DBT is superior to waitlist conditions in reducing aggressive behaviour, and to explore whether reductions in this outcome may be larger with the adaptation reported by Linehan et al. (2008). It would be interesting for future reviews to assess whether change in anger and aggressive behaviour are maintained during follow-up, and to also assess whether DBT is associated with an increase in individuals' use of anger control strategies. It would also be helpful for future research to explore moderators of the relationship between DBT and these outcomes, to increase our understanding of mechanisms of change.

There is little evidence for further improvement with medication at this time, though treating comorbid ADHD may lead to further reductions in anger. This review also suggests that the full DBT model is not necessary for change in these outcomes, which has important clinical implications for services. We echo previous calls for the development of guidelines for the treatment of anger and aggressive behaviour as a priority, given the crucial importance of effective intervention in this area (Saini, 2009). In addition to other evidence-based interventions, this review provides evidence for DBT as an effective treatment to include. The comparators in this review included a wide range of active but non-specific interventions, and it would be useful for future studies to compare DBT to other specific psychological interventions. This would provide clinically meaningful comparisons to inform clinician treatment decisions and patient choice.

Conclusions

The studies included in this meta-analysis suggest that DBT is an effective treatment for the reduction of anger, specifically trait anger, and aggressive behaviour. It appears to be more

effective than other active interventions for anger, but not for aggressive behaviour. We acknowledge that some studies that reported no effect were not possible to include in this quantitative synthesis. Future research is important to build on these findings by exploring the effect of DBT with more diverse samples, comparing DBT to other specific psychological interventions, and exploring mechanisms of change.

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Service Improvement Project (SIP)

Title: Understanding and Improving the Experience of Young People and Families in The Oxfordshire CAMHS Crisis Service

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Journal Rationale: This is an international peer-reviewed journal with a five-year impact factor of 1.784. It has a multidisciplinary readership and publishes a wide range of articles covering clinical and treatment issues that are relevant to children and adolescents. It has previously published projects that have been conducted within a single NHS service.

Abstract

Background: The Oxfordshire CAMHS Crisis service provides support for children and young people (CYP) experiencing acute mental health crisis. Since 2013 there has been no comprehensive evaluation of the service, nor any consultation with service users about their experience. This mixed-methods project aimed to understand service users' experience of the service and priorities for crisis care, service performance against available standards for care, and how care could be improved.

Method: Survey data were received from 34 parents and eight CYP who accessed the service within a 13-month period. Semi-structured interviews were also conducted with nine parents and three CYP. Quantitative data were analysed using descriptive statistics and qualitative responses were thematically analysed.

Results: Service users particularly valued 24/7 access to support and most participants reported that staff were warm in interactions. There was some discrepancy between CYP and parents' reports of what was received. Six themes were highlighted from qualitative data: staff warmth and understanding, parents need support, service access, need for improved liaison, clearer service information, and the importance of a long-term approach.

Conclusions: Several recommendations are made for how care could be improved. Further research is needed into crisis care for CYP to inform evidence-based practice. Limitations and future directions are discussed.

Keywords: crisis intervention; self-harm; suicide; adolescents; parents

Introduction

The importance of access to high-quality mental health care for children and young people (CYP) is clear. Research suggests that 75% of mental health problems in adulthood start before the age of 18 (NHS, 2015) and the demand for support is rising. A recent NHS England survey identified 16.0% of 5- to 16-year-olds as having a probable mental disorder, up from 10.8% in 2017 (NHS, 2020). Research also suggests that CYP are more vulnerable than other age groups to mental health deterioration following the COVID-19 pandemic (Varma, Junge, Meaklim, & Jackson, 2021). Available support at times of crisis is essential to support CYP, prevent suicide, and avoid unnecessary inpatient admissions (Lybbert, Ryland, & Bean, 2019; NHS, 2015; Vusio, Thompson, Birchwood, & Clarke, 2019).

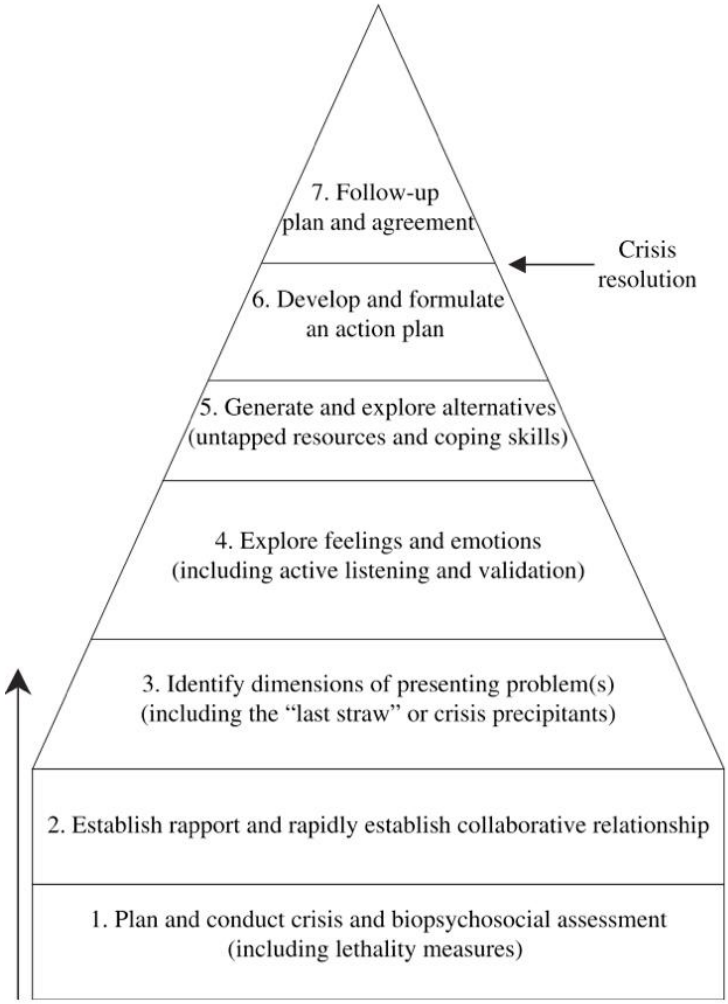
Crisis resolution teams are multidisciplinary, specialist mental health services that offer short-term intervention for people experiencing a mental health crisis and aim to avoid unnecessary hospital admissions (Lloyd-Evans et al., 2018; Wheeler et al., 2015). Crisis care provision varies widely between teams (Lloyd-Evans et al., 2018). Roberts and Ottens (2005) proposed a seven-stage crisis intervention model (R-SSCIM) to guide assessment and intervention with this population. This involves seven stages to guide individuals through, with the aim to achieve 'crisis resolution'. The model was developed for use across settings and focuses on rapid assessment of the problem, goal identification and attainment, developing an alliance, exploring coping strategies, and building on strengths (Roberts & Ottens, 2005) (see Figure 1).

Research with adults suggests that community crisis care can reduce hospital admissions and patient satisfaction is higher than inpatient care (Johnson et al., 2005; Lloyd-Evans et al., 2018; Murphy, Irving, Adams, & Waqar, 2015; Winness, Borg, & Kim, 2010). A

Cochrane review of adult crisis care suggested that it is less expensive than standard care, leads to greater improvement in patient wellbeing, and places less burden on families (Murphy et al., 2015).

Figure 1

Roberts and Ottens (2005) Seven Stage Crisis Intervention Model



The evidence-base for crisis care with CYP is limited. It is often evaluated with other intensive community treatment models (e.g., home-treatment teams), which limits our ability to assess the effectiveness of crisis care specifically. A Cochrane review found no evidence that intensive community treatment was associated with different outcomes to inpatient care, although only two studies were available to review (Shepperd et al., 2009). A more recent

systematic review of randomised controlled trials found that intensive community treatments were associated with shorter hospitalisations, lower costs, and increased satisfaction from CYP and parents when compared to inpatient care (Kwok, Yuan, & Ougrin, 2016). Thus, the evidence suggests that these interventions may offer valuable support for CYP during a mental health crisis and a favourable alternative to inpatient admission.

Service User Perspectives

Winness et al. (2010) reviewed adult service users' experiences with crisis resolution teams. Unhelpful experiences included short follow-up care, a sense of discontinuity in the service, and a lack of information regarding their illness and medication. Helpful experiences related to three themes: easy access and availability, being understood as 'normal', and dealing with crisis in an everyday life context.

A review of the CYP literature identified six domains for CYP and carer experiences of crisis care: barriers, emotions and emotional reactions, experiences, needs, and perceptions of what appropriate crisis services should be (Vusio et al., 2019). The authors concluded that engagement with crisis services was associated with a complex range of emotional reactions and a high level of carer burden. Priorities for crisis care included integration with other mental health teams, links with hospitals, flexibility, and an emphasis on early intervention and recovery (Vusio et al., 2019). Whilst this review provides valuable insights, the definition of CYP varied between studies and the carer literature was not CYP specific. Thus, there is a need for research into the experiences of, and priorities for, mental health crisis care in the United Kingdom for both CYP and parents.

National Guidelines

The Five Year Forward View (NHS, 2014) stated that anyone experiencing a mental health crisis should have access to community-based mental health care 24 hours, 7 days a

week. The Future in Mind document (NHS, 2015) recognised the need for crisis services for CYP specifically and committed to improve the provision of crisis care for CYP in England.

A set of standards were developed for crisis resolution and home-treatment teams as part of the Crisis team Optimisation and Relapse prevention (CORE) project (Lloyd-Evans et al., 2016).

The Oxfordshire CAMHS Crisis Service

Since 2011, the Oxfordshire CAMHS Crisis Service has provided countywide support for CYP experiencing a mental health crisis. The service provides emergency assessments, intensive short-term interventions, and crisis telephone support to both CYP and parents[1]. The aims of the service include reducing CYP's vulnerability to mental health crisis, avoiding unnecessary inpatient admissions, and offering advice to the systems around CYP. Staff are trained in Dialectical Behaviour Therapy (DBT), which is effective in reducing self-harm and suicidal behaviour in adolescents (Kothgassner et al., 2021). DBT is not delivered in the crisis service; however, the skills are often shared with CYP as part of crisis interventions to reduce emotional distress.

The service was audited in 2012/13 to review service user feedback. Although there have been several polices published with key recommendations since this time (NHS, 2014, 2015), there has been no further consultation with service users. Understanding the service user experience is an essential part of service improvement (Brookes & Baker, 2017) and has been described as a 'critical driver for reform' (Department of Health, 2009). The service was keen to understand the recent experiences of young people and parents in the service, and to use this feedback to inform service developments.

[1] The term 'parents' is used in this report to reference parents and guardians of CYP.

This project explored the experiences of service users to inform a set of recommendations for how care could be improved. The recommendations also drew on pre-existing literature and clinical guidance related to crisis care for CYP. The following questions were addressed:

1. How did CYP and parents experience their care from the service?
    a) What was helpful and unhelpful?
    b) How did they experience their interactions with crisis staff?
2. What are CYPs and parents' priorities for crisis care?
3. According to service user reports, is the crisis team meeting standards for care?
4. How could the care given to CYP and parents be improved?

Method

This mixed-methods project collected data from families who had received care from the service between 4th August 2019 and 25th September 2020. Surveys collected data regarding service user experiences of, and priorities for, crisis care and compared this to available standards. Interviews were also conducted to gain a richer understanding of individual experiences and views.

The project was approved by the Oxford Health Quality & Audit team (Appendix E). Eating disorder as the primary reason for referral was an exclusion criterion because these referrals are managed in a different pathway.

Stakeholder Consultation

The project aims were developed through consultation with staff about priorities for service development and the challenges facing the service. Consultation with the service continued throughout the project. The service manager gave feedback on project materials.

The CAMHS participation group also provided feedback on the project design and piloted the survey.

Surveys

Materials

Separate surveys were developed for parents and CYP (Appendices F-G). The surveys asked participants about the interventions that they received, and which they would prioritise. The survey also asked about their overall service experience (NHS, 2019) and experiences of discharge and staff interactions. The options were informed by available standards for crisis care (Lloyd-Evans et al., 2016; NHS, 2014, 2015) and service priorities for data collection.

The survey used a range of question formats, including single- and multiple-choice answers, Likert scales and qualitative questions. It was delivered online using Joint Information Systems Committee (JISC) survey software. Questions were optional to complete. Each survey ended with an invitation to provide contact details for interview.

Procedure

Eligible individuals were identified and invited to take part by the service. Parents were contacted by email where possible, and telephone if not. They were also asked to consider sharing the information with their child. 168 families were invited. Survey responses were collected between 2nd October and 13th December 2020.

Participants

34 parents completed the survey (20% response rate) and eight CYP (response rate cannot be calculated, invitation was at parents' discretion) (see Table 1). All participated until the end.

Interviews

Materials

Interviews followed a semi-structured interview schedule (Appendix H).

Procedure

All participants who expressed interest to interview in the survey were contacted by the primary researcher (HG). All individuals read an information sheet and provided informed consent prior to participation. Interviews were held online using Microsoft Teams or by telephone due to Covid-19 restrictions. All interviews were completed by HG, who had no previous relationships with any participants. A debrief was held with each participant following the interview.

Participants

16 parents and three CYP expressed interest in an interview. Some individuals were unable to be contacted using details provided. The final interview sample included nine parents and three CYP (see Table 2).

Table 1

Demographic Information for Survey Participants

Variable	Parents (*n*=34)	CYP (*n*=8)
Age	31-40: 5 (14.7%) 41-50: 14 (41.2%) 51-60: 13 (38.2%) 61-70 2 (5.9%)	*M*=15.63 (*SD*=1.60)
Gender		
Male	0	2 (25.0%)
Female	34 (100%)	5 (62.5%)
Non-binary	0	1 (12.5%)
Ethnicity		
Asian / Asian British	0	0
Black / Black British	0	0
White	33 (97.1%)	5 (62.5%)
Mixed ethnicity	0	2 (25.0%)
Other	1 (2.9%)	0
Reason(s) for referral		
Self-harm	18 (52.9%)	6 (75.0%)
Suicidal thoughts	26 (76.5%)	7 (87.5%)
Suicide attempt(s)	17 (50.0%)	6 (75.0%)
Violence/aggression	6 (17.6%)	1 (12.5%)
Eating disorder (secondary)	3 (8.8%)	1 (12.5%)

Other	3 (8.8%)	1 (12.5%)
Length of crisis care		
1-3 days	4 (11.8%)	0
4-6 days	7 (20.6%)	1 (12.5%)
1-2 weeks	8 (23.5%)	1 (12.5%)
More than 2 weeks	9 (26.5%)	4 (50.0%)
I don’t know	6 (17.6%)	2 (25.0%)
Previous times in crisis		
This was the first time	18 (52.9%)	2 (25.0%)
Once before this time	7 (20.6%)	2 (25.0%)
Twice before this time	4 (11.8%)	0
3+ times before this time	3 (8.8%)	2 (25.0%)
I don’t know	2 (5.9%)	2 (25.0%)

Note. Data are presented as n (%) unless otherwise indicated.

Table 2

Demographic Information for Interview Participants

Variable	Parents (*n*=9)	CYP (*n*=3)
Age	31-40: 1 (11.1%) 41-50: 4 (44.4%) 51-60: 4 (44.4%) 61-70: 0	*M*=16.33 (*SD*=2.08)
Gender		
Male	0	1 (33.3%)
Female	9 (100%)	2 (66.7%)
Non-binary	0	0
Ethnicity		
Asian / Asian British	0	0
Black / Black British	0	0
White	9 (100%)	3 (100%)
Mixed ethnicity	0	0
Other	0	0

Note. Data are presented as n (%).

Data Analysis

One researcher (HG) conducted all analysis. Qualitative analysis was conducted before interpretation of quantitative data, to reduce risk of confirmation bias. Quantitative data were analysed descriptively and presented as frequency data.

Interviews were audio-recorded and transcribed verbatim. Interview transcripts and qualitative survey responses were imported into NVivo v12 and thematically analysed (Braun & Clarke, 2006). CYP and parent data were analysed separately before considering how codes could be merged into one thematic structure. HG conducted the analysis and kept a reflective diary. Data familiarity was established by conducting and transcribing interviews and reading survey responses. Relevant extracts were identified and coded within Nvivo. After coding was complete, the first four transcripts were revisited to ensure the data fit the most recent nodes. All uncoded extracts were also revisited to ensure all relevant data had been captured. The nodes were then grouped into themes. CA and LC reviewed extracts for all themes to assess face validity and inform discussions about thematic structure. Themes were restructured to ensure the most comprehensive presentation of the data. Three interview transcripts were also read and coded by a second coder (PT), who developed themes from this sample of transcripts. HG and PT then met to discuss their themes and identify discrepancies, which were minimal, suggesting evidence of inter-rater reliability. A final set of themes were agreed by all involved.

Dissemination

The findings of this project were shared and discussed with the service manager. Following this, HG co-facilitated an away-day with staff team to present findings and develop an implementation plan for recommendations. A lay summary was shared with participants (Appendix I).

Results

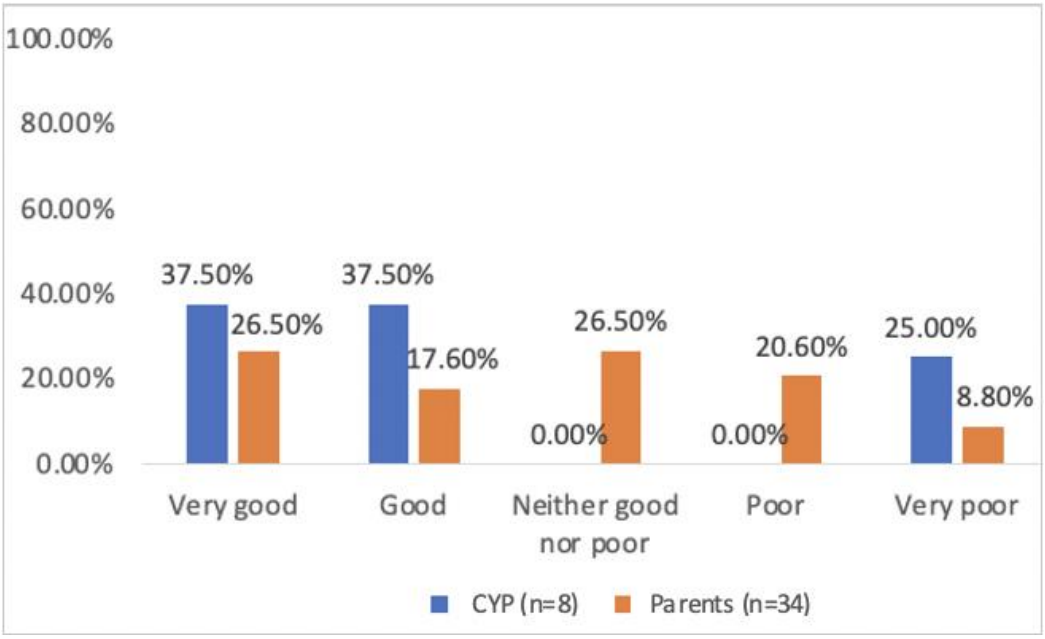
Quantitative Results (Surveys)

Overall Experience

Most CYP (*n*=6; 75.0%) said that their overall experience with the crisis service was very good or good. Less than half (*n*=15; 44.1%) of parents said their overall experience was very good or good (Figure 2).

Figure 2

Parents and CYP Overall Experience of Service



Performance Against Standards of Care

Service user reports were compared to standards for crisis care to assess performance. These standards included the service Standard Operating Procedure (SOP), CORE (Lloyd-Evans et al., 2016), and Five Year Forward View (NHS, 2014).

Performance against standards for intervention are presented in Table 3. Only seven CYP (87.5%) and 24 parents (75.0%) were aware of access to 24/7 support. No CYP reported options for face-to-face support. A number of discrepancies were evident between CYP and

parents reported experience. For example, 75.0% (*n*=6) of CYP reported having a space to discuss risks and safety, but only 26.5% (*n*=9) of parents reported receiving the same.

Experiences of staff interactions are presented in Figure 3. Six CYP (75.0%) and 25 parents (73.5%) agreed that staff were warm in interactions. Less than half of CYP (*n*=3; 37.5%) and parents (*n*=12; 35.3%) felt their experience was normalised.

Performance against standards for discharge are presented in Table 4. Half of CYP (*n*=4) said they were given notice before discharge and developed a relapse prevention plan. Only two CYP (25.0%) and six parents (17.6%) reported an invite to a discharge meeting. For further quantitative results, see Appendix J.

Table 3

Performance Against Standards for Crisis Intervention

Standard	Reported receiving this:	
	CYP	Parents
24/7 access to support (SOP, CORE, Five Year Forward View)		
24/7 emergency support	7 (87.5%)	24 (75.0%)
Allocation of a named worker (CORE)		
A named crisis worker	3 (37.5%)	10 (29.4%)
Individualised care (SOP, CORE)		
Care tailored to your needs	5 (71.4%)	12 (35.3%)
Working closely with families and wider social networks (CORE)		
Involving people close to me in my care	6 (75.0%)	-
Invited to meetings about the young person's care	-	22 (64.7%)

Carer support and assessment of needs (CORE)		
Separate meeting to discuss needs	-	5 (14.7%)
Carer support service information	-	4 (11.7%)
Written carer support plan	-	6 (17.6%)
Frequent visits to service users (CORE)		
Home visits	0 (0%)	-
Face to face support outside of home	0 (0%)	-
Offer choice of appointment location (CORE)		
Choice of appointment location	0 (0%)	-
Written care plan (CORE)		
Written care plan	4 (50.0%)	-
Help plan service user responses to future crisis (CORE)		
A plan to cope with future difficulties	5 (62.5%)	-
Other (requested by service)		
Space to discuss risk/safety	6 (75.0%)	9 (26.5%)
Information to understand the mental health difficulty	5 (62.5%)	10 (29.4%)
Telephone appointments	7 (87.5%)	-
Video appointments	2 (25.0%)	-
Learning skills to manage emotions	5 (62.5%)	-

Note. Data are presented as n (%). CYP *n*=8. Parents *n*=34. Where no data is presented for a group, question was not asked.

Figure 3

Performance against Standards for Staff Interactions

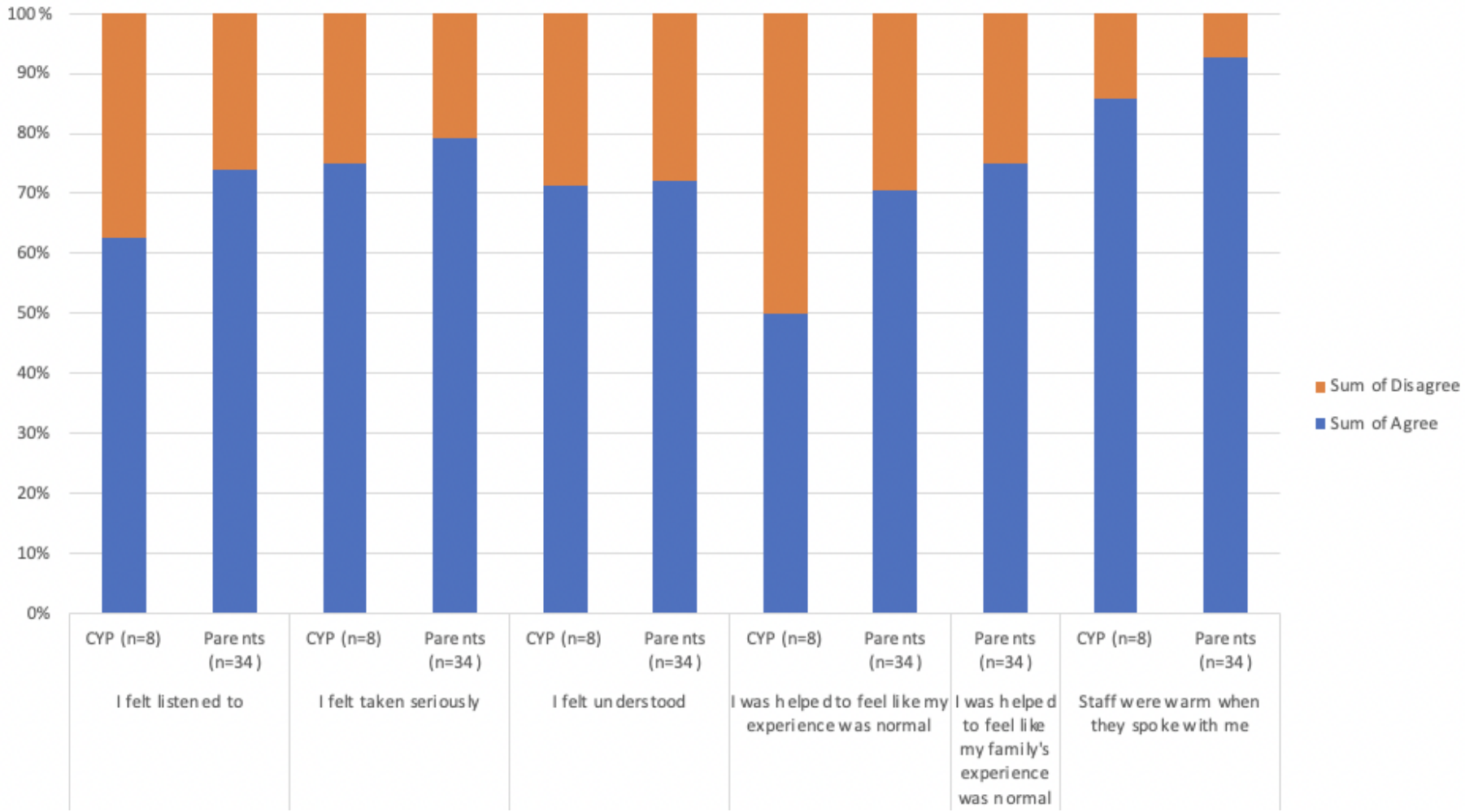


Table 4

Performance Against Standards for Discharge - CORE (Lloyd-Evans et al., 2016)

	Reported receiving this:	
	CYP	Parents
A discharge meeting is arranged, service users and involved family attend (CORE)		
A discharge meeting	2 (25.0%)	6 (17.6%)
At least 48 hours' notice before discharge (CORE)		
Giving notice before discharge	4 (50.0%)	13 (38.2%)
Tapered care prior to discharge (CORE)		
Less frequent sessions before discharge	5 (62.5%)	-
Routinely develop relapse prevention plans (CORE)		
Making a plan for future difficulties	4 (50.0%)	-
Shared plan to cope with future difficulties	-	9 (26.5%)

Note. Data are presented as n (%). CYP *n*=8. Parents *n*=34. Where no data is presented for a group, question was not asked.

Qualitative Results (Surveys and Interviews)

Six main themes emerged from qualitative data collected through the surveys and interviews with CYP and parents. A description of each theme is provided below. For further illustrative quotes, see Appendix K.

1. Staff Warmth and Understanding

CYP described mixed experiences of staff warmth. Some positive interactions with staff were described, and it was particularly valued when staff provided support to CYP even when

not distressed, referenced parts of their care plan, and showed genuine warmth. However, all interviewees highlighted a need for improved validation from crisis staff. Several explained that strategies provided when they called in distress were unhelpful, felt impersonal, and led to them feeling not taken seriously (‘*they always throw the same things at you … it feels like talking to a brick wall’ (Interview09, child)).* One also suggested crisis staff assume people are familiar with mindfulness and other DBT strategies, which is not always the case. Some CYP said that they did not feel they received any support from the service and the only function was to assess their risk *(‘they just wanted to know that I was still alive and then the call would pretty much end’ (Survey37, child)).* Suggestions for improvement included: listening before suggesting strategies, ask follow-up questions, explore pre-existing coping strategies, and provide opportunities for feedback after phone calls.

Many parents also discussed the importance of feeling cared for and understood by the crisis staff. Several staff qualities were valued, including kindness, compassion, forgiveness, warmth, and non-judgement. Many stated that validation was important. Some parents felt validated by staff, but others felt that staff had become desensitised. Many parents felt the staff had shown warmth and care to their child, although some felt this could be improved through more personalised recommendations and by holding ‘*curiosity’* rather than taking responses at face value *(Interview07, parent)*. Several parents suggested that staff knowing the family allows for more helpful advice and for them to feel understood.

Parents also discussed the importance of setting and keeping to clear timeframes. They explained this is important to show care and support families in distress. Several parents discussed experiences of unreliability, including poor adherence to agreed plans, although others did find the service to be *‘dependable’ (Interview01, parent)*.

2. Parents Need Support

Some CYP suggested that attending more to the system around them might be a more effective approach (‘*it's more of like a social issue … you kind of need all the pieces of the puzzle to work together’ (Interview10, child)).* This was echoed by parents emphasising the need for *emotional support*. They discussed the impact of CYP crisis on the wellbeing of parents and the wider family *(‘this self-perpetuating cycle of brokenness’ (Interview08, parent))*. Suggestions for parent support included access to crisis telephone support, having separate meetings with staff, and peer support groups. Parents emphasised that support would need to be tailored to the individual family.

Additionally, many parents said they did not know how to care for a young person in crisis *(‘you feel helpless’ (Survey23, parent)).* Several described *practical support* as a key priority. Helpful experiences of this included: guidance for removing access to means of harm, facilitating negotiations for keeping safe at home *(e.g. ‘leaving the doors open’, Interview03, parent)*, and strategies to manage child distress *(‘ice dives … breathing techniques’ (Interview11, parent))*. Such support helped parents manage their own anxiety and build confidence to manage independently. Nevertheless, some parents felt that more practical support could have been offered. Particular gaps included: difficulty accessing crisis after the initial 24-hours; support for parents to implement boundaries with children; and confidentiality limiting information sharing with parents. Several parents also suggested developing a resource list, including helplines and resources to understand particular mental health conditions.

3. Service Access

Some CYP strongly valued the 24-hour telephone support. They explained it felt validating to have this access and it provided a sense of safety. Several parents also described the fast access to the service as ‘*life saving’ (Interview06, Interview08, parents),* including the

referral process and telephone support. Parents praised the crisis staff for ability to de-escalate risk situations and knowing how to engage CYP. However, some barriers to this 24-hour access were also described by parents, including crisis staff being unavailable; mistakenly been told they are '*not on the list'* (*Interview03 & Interview11, parents)*; and the telephone line going to voicemail. Some parents were able to access their own support from crisis but others were not. Some also described a sense that their role was to '*push'* for appropriate support for their child *(Survey28, parent).* Nevertheless, parents acknowledged barriers to service provision that were outside of the crisis team's control, including lack of funding and Covid-19.

Some CYP described low motivation to engage whilst in crisis but said it is important for staff to *'follow up'* regardless of this *(Interview09, child).* Suggestions for improved engagement included having a mobile member of staff available to visit CYP in distress, and being understanding if a child does not answer a planned call *('with depressed people you have to take into consideration there are days they don't want to get out of bed' (Interview09, child)).* Similarly, parents also discussed the importance of being proactive with CYP, who may find it difficult to engage due to their mental state. Suggestions included flexibility with communication formats (e.g. email, phone, visits), although one parent highlighted that choice can facilitate avoidance (*'she was just in that avoidant kind of cycle really' (Interview07, parent)).* Parents also highlighted the need for staff to speak to the child directly rather than through the parent.

Some parents discussed the importance of parental involvement in CYP crisis care, to offer additional information and to help CYP '*represent themselves' (Interview01, parent)*. Several parents described positive experiences of this, though some felt it could be improved. Suggestions included routine separate conversations with the parent and child at assessment and inviting the parent to the final session.

4. Need for Improved Liaison

CYP described connections between teams as '*confusing'* and '*disjointed' (Interview09 & Interview10, child),* and said they felt passed around between different professionals. One said it felt like she was repeating the same story to different people with no perceived outcome ('*you say that so many times and then kind of nothing comes from it*' *(Interview10, child))*.

Several parents also found the different services confusing. One explained that the distinctions within CAMHS services can be unhelpful as they are '*all representative of the same service to someone on the receiving end'* (*Interview01, parent).* Many parents suggested that communication could be improved between crisis, CAMHS, and other agencies. This included schools, police, hospital staff, the GP, and substance misuse services. One said '*at every point you felt you were going back to the beginning … it was the same conversation again' (Interview04, parent).* Suggestions for improvement included CAMHS attendance at crisis discharge, crisis attendance at CAMHS assessments, and identifying individual staff members to links with different services.

5. Clearer Service Information

CYP shared concerns about crisis involvement, including confidentiality and whether crisis care would delay CAMHS input. Several parents also said they still did not fully understand the role of crisis. They described a lack of clarity around service pathways and who to contact. Parents suggested that service information could be more clearly shared using service leaflets, email summaries, and sharing written care plans. They also said that being explicit about the short-term nature of crisis intervention would be helpful, whilst acknowledging the longer-term journey of recovery.

6. Long-Term Approach Important (Parents Only)

There was a sense from parents that the crisis intervention felt '*standalone'* and '*if it fed into longer term planning it would be more effective' (interview04, parent).* Several parents called for earlier intervention to prevent problems from becoming '*more chronic' (Interview08, parent)*. Some explained that it felt like they were discharged after having '*a good week' (Interview11, parent)* and they felt '*back to square one again'* after discharge from crisis support (*Interview01, parent*). Suggestions included longer intervention, thorough assessment of needs prior to discharge, tapering sessions, and follow-up sessions.

Service Recommendations

Service improvement recommendations related to seven domains: responding to distress, goals, engaging CYP, supporting and involving parents, written information, discharge, and service issues (Table 5). When presented to the service, each section began with recognition of positive practice before discussing recommendations for improvement (see Appendix L).

Roberts and Ottens (2005)'s seven stage crisis intervention model (R-SSCIM) was recommended to structure interactions with CYP in distress. This encapsulated several of the highlighted areas for improvement, including validating experiences, building an alliance as a priority, and exploring existing resources before offering advice. The model could be used by crisis staff when speaking to CYP in distress and given as a visual reference for ease of access.

The responses from both the service-lead and wider team were positive. Minimal concerns about feasibility were shared and recommendations were adjusted accordingly. The service had already made progress on several recommendations by the time of writing, including the goals-based outcome, written service information, parent peer-support group, and crisis care plans (see Table 5).

Table 5

Service Improvement Recommendations

Responding to CYP Distress • Roberts and Ottens (2005)'s seven stage crisis intervention model could be used to structure interactions with CYP in distress • Individual crisis care plans could be used for each family and referred to when a CYP calls, so that interactions and advice feel more individualised • Be careful not to assume familiarity with DBT techniques and mindfulness • Consider staff stress and potential burnout, explore support options as necessary (e.g. reflective practice, mindfulness, recognition initiatives)
Parents: Support and Involve • Ensure a consistent understanding across the team of what support is and is not available for parents and ensure this is clearly explained to families. • Consider facilitating a parent support group • Offering an assessment of parents' needs and a carer support plan would be valuable • Facilitate parental involvement at assessment and discharge where possible and appropriate
Identify Goals • Identifying goals and needs with service users from the outset could help to evaluate progress and make interactions feel more individualised
Engaging CYP • Explore and address any CYP concerns that may impact engagement, e.g. clear explanation of confidentiality

- Offer flexibility of appointment format to CYP (including digital and visits), with some understanding of motivation issues
- If there is continued non-engagement, consider a more proactive approach with visits (and explain this from the outset)

Written Information

- Develop an easily accessible leaflet to introduce the crisis service that can be shared with all families. Consider coproducing with service users.
- Develop a resource list with contact details for support services and resources to understand particular mental health difficulties
- Offering a written care plan consistently to CYP and their families would be valuable

Discharge

- Routinely hold discharge meetings
- Give notice before discharge and consider tapering sessions before ending
- Develop a plan for CYP to cope with future difficulties, share if appropriate

Service Issues

- Opportunities for additional staff to ensure maximum availability would be valuable
- Consider rephrasing the language of families being 'not on the list', and why some report being mistakenly told this
- Consider ways to improve liaison with other CAMHS teams and agencies (e.g. particular staff members with additional training and links to specialist teams, attending and/or organising multi-agency meetings)

- Consider ways to offer consistency in staff interactions with CYP and parents (e.g. having 1-2 named workers)
- Allow opportunities for service users to provide feedback after contact with staff (e.g. I Want Great Care (NHS, 2019)), review and act on feedback

A summary of service implementation of recommendations

- Routine use of a goal-based measure, with an identified team champion to ensure consistent implementation
- Routine use of crisis care plans to individualise treatment, with ongoing training for new starters on how to use these effectively
- Routinely developing written relapse prevention plans as part of the discharge process and sharing with parents where appropriate
- Coproduced a 'CAMHS life river' which explains the differences in CAMHS services and teams
- In the process of redrafting service written information, and developing an 'assessment pack' to take to all initial contacts
- Setting up a six-week rolling peer-support group for parents, due to begin in September 2022

Discussion

This mixed-methods project aimed to understand the service user experience of the Oxfordshire CAMHS Crisis service and how it could be improved. Some areas of good practice were highlighted including staff warmth, practical support for parents, and access to 24-hour support. Areas for improvement were highlighted, both from service user suggestions and comparing the findings to standards of care. The service response to these findings and

recommendations was positive, and several recommendations have already been implemented.

The findings that the service was not consistently meeting service standards echo previous literature (Lloyd-Evans et al., 2018). However, the CORE standards were developed for crisis resolution and home-treatment services (Lloyd-Evans et al., 2016). The service was not operating to a home-treatment model at the time of evaluation and so was not expected to have a high level of fidelity to the standards. Notably, the standards often aligned with service user priorities for crisis care (see Appendix J).

The themes identified from the qualitative data are largely consistent with Vusio et al. (2019), in which CYP and carers also prioritised a flexible and integrated model of crisis care, a focus on early prevention, the need for parental support, and the importance of staff listening and understanding. The need to clarify service information and service access often related to local issues; however, parents have previously reported a role of 'battling' through services and needing to be assertive (Vusio et al., 2019), and the importance of easy access to support and information has also been highlighted for crisis care (Winness et al., 2010).

Limitations

The sample included in this project was self-selected and therefore at risk of sampling bias. Participation may have been more likely if individuals held strong views, either positive or negative. The data is also based on retrospective self-reports. CYP reports of their care may also be affected by the complex attachment difficulties often experienced in the crisis population (Green, Berry, Danquah, & Pratt, 2020). However, this project aimed to understand the service user experience, and this design has allowed differing views to be voiced.

The sample included a range of reasons for referral and past experiences of crisis. The ethnicity and gender of parents was largely homogenous and may not represent experiences of other groups. The CYP survey sample was more diverse, despite the smaller sample size.

The mixed-methods design of this project allowed for breadth and depth in understanding of the service user experience. However, some discrepancies were found between survey and interview results. This may reflect the complexity of crisis care and the challenge that staff face in meeting individual needs. The aim of qualitative research is not generalisability, and both the survey and interviews provide valuable information about the service user experience.

Not all experiences were captured in this project due to the small sample size, particularly with CYP. Recruitment was significantly impacted by the Covid-19 pandemic, with several CYP describing deterioration in mental health and difficulty interacting remotely. This was in addition to the anticipated difficulty of recruiting individuals following a mental health crisis. Though coding slowed towards the end of analysis, data saturation was not reached. It is of note that the usefulness of data saturation as a concept has been questioned in the literature (Braun & Clarke, 2021), and the qualitative data collected in this project was rich in detail and explored a range of experiences.

Covid-19 is likely to have affected the findings of this report, as some of the participants had received their intervention during the pandemic and this impacted service provision. Thus, it is important to interpret the results within this context.

Future Implications

This project offered an in-depth review of the service user experience of the Oxfordshire CAMHS Crisis Service and involved a set of recommendations for how care could be improved. This was specific to this service and should not be expected to generalise; further research is

needed into crisis care for CYP to inform evidence-based practice. It is hoped that these findings will lead to meaningful change within this local context. The recommendations have been shared with the staff team and implementation has already started. Future directions may include a re-evaluation of performance against the key standards of care 12 months after this review.

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Declaration of Conflicting Interest

The authors declare that there is no conflict of interest.

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Theory Driven Research Project (TDRP)

Title: Tell Me Something New: The Contribution of Self-Compassion to our Current Understanding of Hearing Voices

Short Title: Self-Compassion and Hearing Voices

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The data that support the findings of this study are available from the corresponding author, HG, upon reasonable request.

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Journal Structure: British Journal of Clinical Psychology

Journal Rationale: This journal publishes research relevant to theory and practice in Clinical Psychology. It has an impact factor of 4.125 and is 33rd out of 131 journals related to clinical psychology. It has previously published studies exploring self-compassion interventions for various mental health presentations.

Keywords: hearing voices; auditory verbal hallucinations; psychosis; self-compassion; cognitive behavioural therapy

Abstract

Objectives: This study aimed to test key predictions of the compassion model of voice hearing. It also aimed to assess whether self-compassion offers any additional understanding of voice-related distress and voice content than mood and negative self-schema, which are central parts of established cognitive-models.

Design: A within-group observational design.

Methods: Fifty-six adults who currently hear voices completed an online survey. The survey included measures of self-compassion, negative self-schema, mood, voice-related distress, and soothing/critical voice content. Twenty-five of these participants also completed a follow-up measure of voice content. Correlation, hierarchical regression, and mediation analyses assessed relationships between variables.

Results: Higher self-compassion was associated with lower voice-related distress and critical voice content, with a large effect size. It was also the only variable significantly associated with soothing voice content. Critical voice content was found to mediate the effect between self-compassion and voice-related distress. Self-compassion remained associated with voice-related distress and soothing voice content, even when mood and negative self-schema were controlled for; however, this was not significant when predicting voice content at follow-up.

Conclusions: These findings suggest that self-compassion offers an additional understanding of the variance in voice-related distress and soothing voice content than is already offered by mood and negative self-schema. Increasing self-compassion in therapy may lead to significant clinical benefits, including reduced voice-related distress and a switch from critical to soothing voice content. Further research is needed to assess directions of causality.

Practitioner Points

- Compassion-focused interventions for voice hearing aim to regulate overactive threat-monitoring by increasing access to a 'soothing system'. This includes techniques to increase self-compassion, with the aim to reduce voice-related distress and switch from critical to soothing voice content
- In this study, higher self-compassion was associated with lower voice-related distress and critical voice content, and higher levels of soothing voice content.
- Critical voice content was found to mediate the relationship between self-compassion and voice-related distress.
- Self-compassion remained significantly associated with voice-related distress and soothing voice content when mood and negative self-schema were controlled for. This suggests that the compassion model of voice hearing offers additional explanation of the variance in these outcomes than is already known from mood and negative self-schema.

Introduction

Hearing voices is an experience shared by individuals in the general population as well as those under the care of mental health services (Baumeister et al., 2017). Prevalence estimates have varied greatly, from 0.6 to 84% of the general population (Beavan at al., 2011). Hearing voices refers to hearing a voice or voices that others cannot hear. User-led groups have preferred this term over the medicalised language of 'psychosis' or 'auditory verbal hallucinations' (Corstens et al., 2014). Therefore, 'hearing voices' will be used hereafter where possible and will refer to hearing a single voice or multiple voices.

There has been a conceptual shift in the field's understanding of hearing voices and other psychotic experiences, from categorical to continuum models (Baumeister et al., 2017; van Os & Reininghaus, 2016) . The continuum approach suggests that abnormal sensory experiences range from those of 'healthy individuals' to those more commonly associated with psychiatric diagnosis (Baumeister et al., 2017). This is supported by the observation that many voice hearers exist in the general population without seeking help from services (Collins et al., 2020). Identified distinctions between help-seeking and non-help-seeking voice hearers include voice-related distress, voice content, and behavioural responses (Baumeister et al., 2017; Daalman et al., 2010; Johns et al., 2014).

Cognitive Models of Voice Hearing

The most established models of psychosis are cognitive models, which highlight the importance of the appraisal of perceptual experiences (e.g. hearing voices) (Garety et al., 2001; Morrison & Renton, 2001). Appraisals are influenced by a range of factors, including mood and the beliefs that the individual holds about themselves and others, which are formed as a result of early experiences (Garety et al., 2001). Beliefs about the self as vulnerable, or others as dangerous, are understood to increase the likelihood of maladaptive attributions. These beliefs

are sometimes labelled ‘schemas’ and are also understood to play a role in maintaining symptoms. Smith et al. (2006) found that negative self-schema was associated with voice content and voice-related distress; however, no associations were found for negative beliefs about others. In further support of the model, negative self-schema is associated with negative voice content (Scott et al., 2020) and difficulties with mood predict an increase in frequency of voice hearing (So et al., 2021).

These models inform Cognitive Behavioural Therapy for Psychosis (CBTp). CBTp addresses problematic appraisals and schematic beliefs about the self and others, and aims to reduce distress, psychotic symptoms, and risk of relapse (Garety et al., 2001). It is currently the first line recommended psychological treatment for hearing voices (NICE, 2014). Research evaluating CBTp has typically grouped voice hearing into ‘positive symptoms of psychosis’, which includes delusional beliefs and all forms of hallucinations (Garety et al., 2001). This research shows that CBTp is associated with significant reductions in positive symptoms during treatment, with effects maintained at follow-up (Bighelli et al., 2018; Lincoln & Pedersen, 2019). However, effect sizes for symptom reduction are small to moderate, and this reduces when compared to an active treatment or controlling for bias (Bighelli et al., 2018; Jauhar et al., 2014; Lincoln & Pedersen, 2019). There is also little evidence for reductions in voice-related distress with CBTp (Fielding-Smith et al., 2015). Thus, there is rationale to explore other treatment approaches to hearing voices. One emerging alternative approach is the compassion model.

The Compassion Model of Voice Hearing

Compassion has been defined as “a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it” (Gilbert & Choden, 2013, p.94). Gilbert (2009) proposed that compassion can be understood as part of an evolved system in mammals, which

motivates caring behaviour and regulates negative affect ('soothing system'). There are three proposed flows of compassion: compassion to the self, to others, and from others (Gilbert, 2014). There is also a proposed system that monitors and responds to potential threats ('threat system') (Gilbert, 2009). The soothing and threat systems are ideally balanced and regulate one another; however, problems can arise when this is not the case. For example, individuals with more threatening experiences during development may have an over-attuned threat system, and an under-developed soothing system (Gilbert, 2009). Therefore, many aspects of their experience (e.g. attention, cognitions, behaviours) are directed towards potential threats, and they may have difficulty feeling soothed or reassured (Gilbert, 2009).

The compassion model informs compassion focused therapy (CFT), which aims to increase skills in compassion towards the self and others (Gilbert, 2009). The model predicts that an increase in compassion will increase access to the soothing system, which will naturally regulate the overactive threat system (Gilbert, 2009; Mayhew & Gilbert, 2008). Self-compassion has been strongly negatively associated with symptoms of psychopathology across presentations (MacBeth & Gumley, 2012) and CFT appears to be effective in reducing a range of mental health symptoms (Craig et al., 2020).

The compassion model has since been applied to voice hearing (Braehler et al., 2012; Heriot-Maitland et al., 2019). This suggests that critical voice hearing may too be understood as an overactive threat system, whereby thoughts about potential threats are dissociated and experienced from 'another' as an external voice (Heriot-Maitland et al., 2019). Indeed, this is supported by established associations between voice hearing and childhood trauma (Kelleher et al., 2013) and dissociation (Pilton et al., 2015). The dominant system is proposed to influence the voice content; specifically, that people with an overactive threat system will experience more negative voice content and subsequently more voice-related distress, and those with a

more active soothing system would experience more soothing voice content and therefore a lower level of voice-related distress (Heriot-Maitland et al., 2019).

In support of the compassion model of voice hearing, there is an established negative association between self-compassion and voice-related distress (Dudley et al., 2018; Norman et al., 2020). People with psychotic experiences also describe self-compassion as an important facilitator of recovery in qualitative research (Waite et al., 2015). Emerging evidence into compassion-focused interventions suggests that self-compassion can be cultivated in the voice hearing population, and that this may be associated with reduced depression, anxiety, fear of relapse, negative beliefs about psychosis, and psychotic symptoms (Braehler et al., 2013; Mayhew & Gilbert, 2008). A case series also found that voices reduced in malevolent content and increased in soothing content during a compassion-focused intervention (Mayhew & Gilbert, 2008). Therefore, there is emerging evidence to support the compassion model of hearing voices.

Whilst there is a known association between self-compassion and voice-related distress, several of the predictions of Heriot-Maitland et al. (2019)'s model have not been tested. These include the relationship between self-compassion and voice content, and voice content as a mediator of the relationship between self-compassion and voice-related distress. It is also not known whether self-compassion offers any additional understanding of voice-related distress than established cognitive models.

This Study

This study aimed to test the predictions of the compassion model of distressing voices proposed by Heriot-Maitland et al. (2019). We also aimed to understand whether this approach offers any additional understanding of voice hearing beyond what is already known from mood and negative self-schema, which are central parts of the cognitive models (Garety et al., 2001;

Morrison & Renton, 2001). Whilst all three flows of compassion are important to the compassion model of voice hearing (Heriot-Maitland et al., 2019), this study focuses on the role of self-compassion. This is both to understand whether it offers any additional understanding of voice hearing than the self-relating variable in the cognitive model (negative self-schema), and to build on previous research findings on the relationship between self-compassion and voice hearing (e.g., Dudley et al., 2018; Norman et al., 2020). The following hypotheses were set:

Primary hypothesis:

1. Voice-hearers with higher levels of self-compassion will experience lower levels of voice-related distress. This relationship will hold when mood and negative self-schema are controlled for.

Secondary hypotheses:

2. Voice-hearers with higher levels of self-compassion will experience a lower level of critical voice content, when controlling for mood and negative self-schema.
3. Voice-hearers with higher levels of self-compassion will experience a higher level of soothing voice content, when controlling for mood and negative self-schema.

Exploratory analyses also repeated the tests of hypotheses two and three with follow-up voice content data, to examine whether the voice content could be predicted longitudinally. We also set the following exploratory hypotheses for mediating effects:

4. Critical voice content will mediate the relationship between self-compassion and voice-related distress
5. Soothing voice content will mediate the relationship between self-compassion and voice-related distress

Design

This online survey study employed a within-group observational design. Data were collected at two timepoints; baseline (T1) and follow-up (T2). It was reviewed by the research committee of the Oxford Doctorate in Clinical Psychology. The materials were also reviewed by two people with lived experience of voice hearing. Sponsorship was provided by Oxford Health NHS Foundation Trust (Appendix N) and ethics approval was obtained from the Health Research Authority (Appendix O).

Methods

Participants

An a priori power calculation using G*power (Faul et al., 2009) was conducted to establish the minimum sample size required to test the primary and secondary hypotheses. For a hierarchical regression model with three included predictors and one tested predictor, 55 participants would be required at T1 to achieve 80% power to find a medium F^2 effect size of 0.15 (Cohen, 1988) at an alpha level of 0.05.

A total of 56 participants completed the T1 measures relevant to the primary hypothesis. Of these, 25 participants also completed T2. To meet eligibility criteria, participants: 1) reported current experience of hearing a voice(s) that others cannot hear, at least once in the last week (as measured by PSYRATS (Haddock et al., 1999) frequency item); 2) were over the age of 18; and 3) spoke fluent English. Most were white (80.4%) and lived in the United Kingdom (73.2%). Only 5.4% had heard voices for less than one year. See Table 1 and Appendix P for further details.

Procedure

Participants were identified through Early Intervention in Psychosis Services, Community Mental Health Teams, Hearing Voices Groups, and social media. This allowed for

recruitment of help-seeking and non-help-seeking voice hearers. The researcher attended team meetings and hearing voices groups to share the research. The research poster was shared on social media platforms, and clinicians shared it with potentially eligible individuals on their caseload.

The surveys were delivered on Qualtrics. The research poster (Appendix Q) included a hyperlink to directly access the information sheet (Appendix R) and consent form (Appendix S). Informed consent was required to take part and participants set up a unique ID to link data between timepoints. They were then asked two screening questions relating to the inclusion criteria (Appendix T). Eligible participants continued with the T1 survey, whilst those who did not meet criteria were directed to a screen-out message. An email invitation to complete T2 was sent four weeks later, followed by one reminder email. T2 surveys were completed an average of 40 days after T1 (SD = 9.53). Each survey ended with debrief information (Appendix U). One participant completed the surveys by phone with a researcher. A summary of results was sent to participants who opted to receive this.

Measures

The self-report questionnaires included in the surveys are summarised below (see also Appendix V).

T1 Questionnaires

Psychotic Symptom Rating Scales for Auditory Hallucinations (PSYRATS-AH) (Haddock et al., 1999). The frequency item of this measure was used for eligibility screening. Participants were eligible if they heard voice(s) at least once a week.

Demographics. A set of questions developed by the research team asked about key demographics such as age, gender, ethnicity, and history of hearing voices.

Hamilton Program for Schizophrenia Voices Questionnaire (HPSVQ) (Van Lieshout & Goldberg, 2007). This was used to measure dimensions of the voices, including voice-related distress ("How distressing are the voices that you hear?"). The nine items are rated on a 0-4 Likert scale, from least to most severe. The measure has demonstrated good test-retest reliability and internal consistency, and concurrent validity with clinician-administered measures of voices (Kim et al., 2010; Van Lieshout & Goldberg, 2007).

Self-Compassion Scale-Short Form (SCS-SF) (Raes et al., 2011). This scale includes 12 items that measure trait self-compassion (Neff et al., 2021). For example, 'I try to see my failings as part of the human condition'. Items are scored from 1 (almost never) to 5 (almost always). The scale has demonstrated good internal consistency and the total score has shown near perfect correlation with the original Self Compassion Scale (Neff, 2003; Raes et al., 2011). Good internal consistency was also observed in this sample (α=0.79). The total score was used for analysis after reverse scoring. Higher scores indicate higher levels of self-compassion.

Brief Core Schema Scales (BCSS) (Fowler et al., 2006). The six-item negative self-schema subscale from this measure was included. Respondents rate six statements on how strongly they believe them, from 0 (no) to 4 (yes, believe it totally). For example, 'I am vulnerable'. This subscale has demonstrated excellent internal consistency, test-retest reliability, and convergent validity with a self-esteem measure (Fowler et al., 2006). It is valid and acceptable for use in psychosis populations (Addington & Tran, 2009; Fowler et al., 2006). Excellent internal consistency was observed in this sample (α=0.83). Responses were summed to obtain a total score.

Depression Anxiety Stress Scales (21-item short-form) (DASS-21) (P. F. Lovibond & Lovibond, 1995). The seven-item depression subscale of this measure was included to assess mood. Respondents rate symptoms on how often it has applied to them, from 0 (never) to 3

(almost always). For example, 'I felt down hearted and blue'. This subscale has demonstrated excellent internal consistency and concurrent validity (Antony et al., 1998). It has been validated in clinical and non-clinical samples, and across several countries (Antony et al., 1998; Crawford et al., 2011; Henry & Crawford, 2005; Scholten et al., 2017). Excellent internal consistency was also observed in this sample (α=0.87). Scores are summed and multiplied by two, to ensure comparability with the longer-form measure (S. H. Lovibond & Lovibond, 1995).

T1 and T2 Questionnaire

Soothing and Critical Voice Content. This was measured using an adapted version of the measure employed in a previous case series (Mayhew & Gilbert, 2008). A description of critical and soothing voices was added to introduce the measure, and qualitative questions were excluded. Respondents are asked about dimensions of their critical and soothing voices; for example, 'How often did you have critical voices?'. Responses were summed to provide a total score for critical voice content for soothing voice content respectively. Excellent internal consistency was observed in this sample (α=0.93 for both subscales).

Analytic Strategy

Data analyses were conducted using SPSS v27 (IBM Corp, 2020). All statistical analysis was checked and approved by the departmental statistician. No missing values were present within primary hypothesis variables; however, one participant closed the survey before completing the soothing voice content measure and some demographic questions.

Demographic variables and outcome measures were summarised with descriptive statistics. Distribution of responses and inter-variable relationships were visually inspected with histograms and scatterplots. Correlational analyses assessed associations between tested variables and assessed for multicollinearity. Hypotheses 1-3 were tested using hierarchical multiple regression. For these analyses, negative self-schema and mood were predictors in

model one, and self-compassion was introduced in model two to determine the unique contribution to the variance explanation (R^2 change). In exploratory analyses, the analyses from hypotheses two and three were repeated with voice content data from T2. Mediation analyses for hypotheses four and five were based on 5000 bootstrapped samples (Preacher & Hayes, 2008) using the PROCESS macro (v4.0) for SPSS (Hayes, 2013).

Results were statistically significant if $p<.05$ (two-tailed). In mediation analyses, the indirect effect was considered significant if the 95% confidence intervals did not include zero. Effect sizes for correlations were defined as small ($r<0.3$), moderate ($r<0.5$), large ($r\geq0.5$) (Cohen, 1988). Cohens F^2 was calculated to determine the local effect size for the contribution of self-compassion to the model (Selya et al., 2012). This was defined as small ($f^2 \geq 0.02$), moderate ($f^2 \geq 0.15$), large ($f^2 \geq 0.35$) (Cohen, 1988). Standardised regression coefficients are reported for individual predictors.

Table 1

Demographic Information for T1 Participants (N=56)

	***n* (%)**
Age	
18-24	10 (17.9)
25-34	24 (42.9)
35-44	12 (21.4)
45-54	9 (16.1)
55-64	1 (1.8)
65+	0 (0.0)
Gender	

Male	16 (28.6)
Female	33 (58.9)
Non-binary	6 (10.7)
Prefer not to say	1 (1.8)
Ethnicity	
Asian / Asian British	3 (5.4)
Black / African / Caribbean / Black British	5 (8.9)
White	45 (80.4)
Mixed ethnicity	1 (1.8)
Prefer not to say	1 (1.8)
Other	1 (1.8)
Country	
United Kingdom	41 (73.2)
Europe (other)	1 (1.8)
North America	7 (12.5)
South America	2 (3.6)
Australia/Oceania	1 (1.8)
Asia	2 (3.6)
Africa	0 (0.0)
Other	2 (3.6)
How often do you hear voices?	
At least once a week	11 (19.6)
At least once a day	28 (50.0)

At least once an hour	7 (12.5)
Continuously or almost continuously	10 (17.9)
How long have you been hearing voices for?	
Less than 1 year	3 (5.4)
1-2 years	12 (21.4)
3-4 years	13 (23.2)
5-10 years	13 (23.2)
11 years or more	15 (26.8)

Results

Descriptive data and between variable associations can be found in Table 2. Pearson correlations were calculated for all variables except soothing voice content. Soothing voice content data were positively skewed despite transformation attempts; Spearman's Rho analysis was therefore used for these associations to account for non-normality. There were significant associations between all variables (p<.01) except soothing voice content, which was only associated with self-compassion (r=.453, p=.001). Voice-related distress was strongly negatively associated with self-compassion (r=-.528, p<.001) and moderately positively associated with negative self-schema (r=.446, p=.001) (Cohen 1988).

H1: Voice-hearers with higher levels of self-compassion will experience lower levels of voice-related distress. This relationship will hold when mood and negative self-schema are controlled for (n=55)

All assumptions were met for this hierarchical regression equation. One outlier was identified and removed for this analysis. See Table W1 for a full model summary.

The final model with all predictors significantly explained the variance in voice-related distress (R^2=.437, adjusted R^2=.404, F(3,51) =12.187, p<.001). The addition of self-compassion significantly improved the explanation of voice-related distress (R^2 change =.071, F change (1,51) =6.463, p=.014). Difficulties with mood were associated with an increase in voice-related distress (β=.329, p=.024). Negative self-schema was not a significant predictor (β=.074, p=.618). Consistent with the primary hypothesis, self-compassion remained associated with lower voice-related distress in the final model, with a small but significant effect size (β=-.355, p=.014, F^2=0.128).

Table 2

Descriptive and Correlational Data for all Tested Variables

	Measure	M	SD	1	2	3	4	5	6
1	Self-compassion	32.71	7.89	-	-	-	-	-	-
2	Negative self-schema	10.55	5.69	-.622***	-	-	-	-	-
3	Mood	22.21	10.18	-.585***	.636***	-	-	-	-
4	Voice distress	2.25	1.10	-.528***	.446**	.531***	-	-	-
5	Critical voice content	34.89	13.03	-.533***	.650***	.624***	.650***	-	-
6	Soothing voice content (*n*=55)	20.35	12.50	*.450***	*-.116*	*-.080*	*-.169*	*.031*	-

*Note***.** Results of two-tailed correlation analyses. Italics = Spearman's Rho, non-italics = Pearson's *r*. *N*=56 unless otherwise indicated. Significance levels indicated as follows: *=*p*<.05; **=*p*<.01; ***=*p*<.001.

H2: Voice-hearers with higher levels of self-compassion will experience a lower level of critical voice content, when controlling for mood and negative self-schema (*n*=56)

All assumptions were met for this hierarchical regression. Critical voice content data were transformed to account for a moderate negative skew. See Table W2 for a full model summary.

The final model significantly explained the variance in critical voice content (R^2=.460, adjusted R^2=.404, $F(3,52)$ =14.750, p<.001); however, the addition of self-compassion

did not lead to significant change in explained variance (R^2 change =.036, *F* change (1,52) =3.488, *p*=.067). Difficulties with mood were negatively associated with critical voice content (*β*=-.474, *p*=.001). Negative self-schema was not a significant predictor (*β*=-.029, *p*=.841). Self-compassion was not significantly associated with critical voice content when controlling for mood and negative self-schema (*β*=.256, *p*=.067, F^2=0.067); therefore, the null hypothesis could not be rejected.

H3: Voice-hearers with higher levels of self-compassion will experience a higher level of soothing voice content, when controlling for mood and negative self-schema (*n*=55)

All assumptions were met for this hierarchical regression. See Table W3 for a full model summary.

The final regression model significantly explained the variance in soothing voice content (R^2=.251, adjusted R^2=.207, *F*(3,51) =5.692, *p*=.002). The addition of self-compassion significantly improved the explanatory power (R^2 change =.236, *F* change (1,51) =16.041, *p*<.001). Neither negative self-schema nor mood were significant predictors of soothing voice content (*β*=.163, *p*=.325; *β*=.145, *p*=.368; respectively). Self-compassion was the only significant predictor, with a moderate effect size (*β*=.628, *p*<.001, F^2=0.315). This supports the hypothesis and suggests that self-compassion offers a unique explanation of the variance in soothing voice content.

Exploratory Analyses

Longitudinal Replication of H2

The analysis of hypothesis two was repeated to predict critical voice content at T2 (*n*=25) (see Table W4). All assumptions were met. All predictor variables (mood, negative self-schema, self-compassion) were measured at T1.

The final regression model did not significantly explain the variance in critical voice content at T2 (R^2=.202, adjusted R^2=.088, F(3,21) =1.773, p=.183) and there were no significant predictors. The addition of self-compassion did not improve the model's explanatory power (R^2 change =.073, F change (3,21) =1.909, p=.182).

Longitudinal Replication of H3

The analysis of hypothesis three was repeated to predict soothing voice content at T2 (n=25) (see Table W5). All predictor variables (mood, negative self-schema, self-compassion) were measured at T1. All assumptions were met.

The full regression model did not significantly predict the variance in soothing voice content at T2 (R^2=.259, adjusted R^2=.153, F(3,21) =2.444, p=.092) and there were no significant individual predictors. The addition of self-compassion did not improve the model's explanatory power (R^2 change =.032, F change (3,21) =.892, p=.356).

H4: Critical voice content will mediate the relationship between self-compassion and voice-related distress (n=56)

Assumptions were met for all regression analyses run as part of this model. Higher self-compassion was associated with lower critical voice content (β=.551, p<.001) and lower critical voice content was associated with lower voice-related distress (β=-.511, p<.001) (see Figure 1). A 95% percentile bootstrap confidence interval for the indirect effect (β=-.282) did not include zero (-.431, -.138). This supports the hypothesis that critical voice content mediates the relationship between self-compassion and voice-related distress.

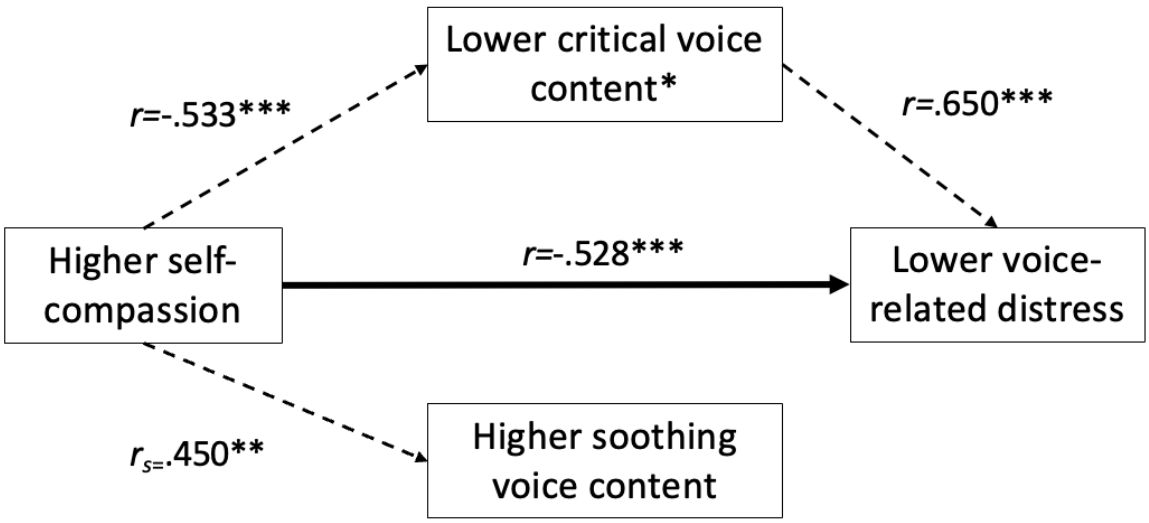
H5: Soothing voice content will mediate the relationship between self-compassion and voice-related distress (n=55)

Assumptions were met for all regression analyses run as part of this model. Higher self-compassion was associated with higher soothing voice content (β=.453, p<.001); however,

soothing voice content was not associated with voice-related distress (*β*=.005, *p*=.685) (see Figure 1). A 95% percentile bootstrap confidence interval for the indirect effect (*β*=.025) did include zero (-.091, .134). Therefore, the null hypothesis could not be rejected.

Figure 1

Self-Compassion and Voice-Related Distress: Mediation Findings



Note: r = Pearson's correlation, r_s = Spearman's Rho. Significance levels indicated as follows: *=*p*<.05; **=*p*<.01; ***=*p*<.001. Connected variables indicate significant correlational relationships.

Discussion

This study aimed to test key predictions of the compassion model of voice hearing (Heriot-Maitland et al., 2019) and examine whether self-compassion can offer any additional understanding of voice content and distress than mood and negative self-schema, which are central to cognitive models (Garety et al., 2001; Morrison & Renton, 2001).

Self-Compassion and Voice-Related Distress

In line with previous literature (Dudley et al., 2018; Maisey et al., 2022; Norman et al., 2020), a cross-sectional association was found between self-compassion and voice-related

distress. The large effect size supports previous research, which has shown moderate to large effects (Dudley et al., 2018; Maisey et al., 2022; Norman et al., 2020). This is consistent with the proposal that self-compassion is part of a soothing system that regulates feelings of threat (Gilbert, 2009; Heriot-Maitland et al., 2019).

The results of this study also extend current knowledge on the role of self-compassion, as the association between self-compassion and voice-related distress remained significant, even whilst mood and negative self-schema were controlled for. Self-compassion therefore appears to offer a unique explanation of the variance in voice-related distress, over and above what is already understood through mood and negative self-schema (Garety et al., 2001; Morrison & Renton, 2001). These findings offer strong rationale for further research into compassion-focused approaches with this population. It may be that interventions that increase self-compassion lead to further reductions in voice-related distress than CBTp alone. This would be particularly important given the little evidence for change in distress following CBTp (Fielding-Smith et al., 2015). Indeed, research has already demonstrated that self-compassion can be cultivated in this population (Braehler et al., 2013) and studies have shown that this is associated with reduced voice-related distress (Braehler et al., 2013; Mayhew & Gilbert, 2008). Future research should now build on this with larger sample sizes and control conditions.

Self-Compassion and Voice Content

A key prediction of the compassion model for voice hearing is that individuals with an overactive threat system will experience more critical voices, and that those with a more active soothing system will experience soothing voices (Heriot-Maitland et al., 2019). In support of this, our findings showed that higher self-compassion was associated with higher soothing and lower critical voice content. Together, this provides initial evidence that the activation of

motivational systems may indeed influence voice content, as proposed by Heriot-Maitland et al. (2019). This also supports the findings of a case series, which showed that a compassion-focused intervention led to voices becoming less malevolent and critical, and more soothing in content (Mayhew & Gilbert, 2008). This has important therapeutic implications, as negative voice-content is the strongest sole predictor of distress and presentation to clinical services (Larøi et al., 2019).

When controlling for the effects of mood and negative self-schema, self-compassion remained significantly associated with soothing, but not critical voice content. This suggests that self-compassion offers a unique relationship with soothing voice content, but does not offer any new understanding of the variance in critical voice content than mood or cognitive models. Interestingly, self-compassion was the only variable associated with soothing voice content even when variables were uncontrolled, which offers further evidence that soothing voice content is uniquely associated with self-compassion. This suggests that mood and negative self-schema may be unable to account for the presence of soothing voice content, and that this may be something better explained through the self-compassion framework. The association between self-compassion and soothing voice content did not hold longitudinally, which may suggest that the association is not predictive over time; however, it could be due to the limitations of the voice content measure.

There was no evidence of soothing voice content mediating the relationship between self-compassion and voice-related distress. This analysis was powered to find a mediating effect where associations between variables were large, or large and medium effects; therefore, smaller effects may have been missed (Fritz & MacKinnon, 2007). However, soothing voice content was not associated with voice-related distress and this could therefore be a true absence of mediating effect. Interestingly, our findings did reveal a mediating effect of critical

voice content on the relationship between self-compassion and voice-related distress. One explanation for this may be through the evolutionary theory in the compassion model. As mammals, we are primed to respond to threat-focused information (Gilbert, 2009; Heriot-Maitland et al., 2019) and this may therefore have a more salient impact on distress. Indeed, the relationship between negative voice content and voice-related distress is well established (Larøi et al., 2019). Whilst self-compassion was associated with increased soothing voice content, the impact on voice-related distress may be better explained by its proposed regulation of the threat system and associated reduced critical voice content.

There have been several advances in the literature into the role of mindfulness in supporting those with distressing psychosis symptoms, and mindfulness-based interventions that have been explored with this population include Acceptance and Commitment Based Therapy (Shawyer et al., 2017) and Person-Based Cognitive Therapy (Chadwick, 2006). Mindfulness skills also form an important part of compassion-focused therapy approaches to voice hearing (Heriot-Maitland et al. 2019). It would therefore be interesting for future research to consider mindfulness of voices as a potential mediator of the relationship between self-compassion and voice-related distress. Indeed, mindfulness of voices and self-compassion are strongly associated in voice hearers and have already been found to mediate each other's relationship with voice severity (Dudley et al., 2018).

Limitations

As data were largely gathered at one measurement point and no constructs were manipulated, no conclusions can be drawn about the direction of causality in the findings.

The regression analyses were powered to find a medium effect size, which may mean smaller effects were missed. Similarly, the exploratory mediation analyses had limited statistical

power to find small to medium effects. The sample was also largely biased to Caucasian people in the United Kingdom with access to the internet, which limits generalizability.

As no self-report measures of voice-related distress exist, this was measured with a single item, which introduces potential bias. Unfortunately the HPSVQ voice-distress subscale (Berry et al., 2021) also includes our other tested variables voice content and negative self-beliefs. Whilst the item we used has been employed in similar research, we echo calls for development of a robust voice-distress scale (Dudley et al., 2018). Furthermore, the only available measure that distinguished between soothing and threat-based voice content was from a case series (Mayhew & Gilbert, 2008). This has not been psychometrically tested and thus cannot be assumed to be valid or reliable. Whilst there was evidence of internal reliability in this sample, future research must develop and psychometrically assess measures of soothing and critical voice content.

Conclusions

The findings of this study suggest that self-compassion is relevant to the voice hearing experience and offer support for many predictions in the compassion model of voice hearing (Heriot-Maitland et al., 2019). Importantly, self-compassion demonstrated a unique association with voice-related distress and soothing voice content that was not otherwise explained by mood and negative self-schema, which are central parts of the well-established cognitive models (Garety et al., 2001; Morrison & Renton, 2001). Whilst research is needed to determine the direction of causality in these relationships, this is important preliminary evidence for the role of compassion-focused interventions with this population. These findings suggest that increases in self-compassion may lead to reductions in voice-related distress, and a switch from critical to soothing voice content. Future research should assess directions of causality, by examining whether self-compassion interventions lead to reliable changes in these outcomes.

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Executive Summary

Word count: 754

Introduction to the study

Hearing a voice or voices is an experience shared by people in the general population as well as people under the care of mental health services. Whilst hearing voices is not distressing for everybody, many people come to mental health services to seek help to manage this experience. The therapy that is most widely offered for hearing voices is based on the *cognitive model of voice hearing*. This suggests that the voice hearing experience can be understood through several factors, including negative self-beliefs and mood. This model informs the first-line recommended treatment for voice-hearing (Cognitive Behavioural Therapy (CBTp)). However, the reductions in symptoms after treatment are often small to moderate. There is also little evidence that CBTp leads to reductions in voice-related distress. Therefore, it is important to consider other approaches to voice hearing.

There is a growing interest in the *compassion model of voice hearing*, which offers an alternative approach to understanding and treating voice hearing. This model suggests that we each have a 'soothing system' that regulates distress, and self-compassion forms a part of this. Therefore, the authors propose that people with higher self-compassion would have lower voice-related distress. They also propose that people higher with self-compassion would have higher levels of soothing voice content, and lower levels of critical voice content.

Previous research has shown that self-compassion is associated with lower voice-related distress, however the relationship between self-compassion and voice content had not been tested before this research. We also did not know whether self-compassion offered any additional understanding of hearing voices than the cognitive model, which was already well-established. This research aimed to test key predictions from the compassion model of voice

hearing, and to examine whether self-compassion offers any additional understanding of voice-related distress and voice content than key parts of the cognitive model (negative self-beliefs and mood).

How the Study was Carried Out

Participants were recruited from social media, Early Intervention for Psychosis services, Community Mental Health Teams, and hearing voices groups. Taking part involved completing an online survey. The survey included measures of voice-related distress, voice content, self-compassion, and key parts of the cognitive model (negative self-beliefs and mood).

Fifty-six adults who were currently hearing voices completed the first survey. Twenty-five of these participants also completed a follow-up survey that repeated the measure of voice content.

What we Found

People who reported having higher self-compassion also reported lower voice-related distress. They also reported less critical voice content, and more soothing voice content. Interestingly, there was not a relationship between soothing voice content and measures of mood or negative self-beliefs. The relationship between self-compassion and voice-related distress could be explained through critical voice content. However, it could not be explained through soothing voice content.

When controlling for mood and negative self-beliefs, self-compassion was still associated with voice-related distress and soothing voice content. However, this was not the case when predicting voice content at a follow-up time-point.

Limitations

Most of the data included in this study was collected at one time-point. This means that we cannot draw any conclusions about what variable leads to changes in another (for example,

if higher self-compassion leads to lower voice-related distress, or the other way around). To be able to understand this, future research should explore these relationships over periods of time and examine changes during interventions that increase self-compassion.

The sample in this study mostly included Caucasian people in the United Kingdom with access to the internet, which means the results may not apply to people from other groups. Finally, there were not widely used measures available for voice content and voice-related distress. This means that we cannot trust that the measures we used were measuring what we think they were measuring, because there is a risk of bias.

Conclusions

The results of this study add to our understanding of the role of self-compassion in hearing voices. They suggest that self-compassion is related to voice-related distress and voice content, which is evidence that supports the compassion model of voice hearing. This could mean that increasing self-compassion in therapy would lead to meaningful changes, such as reduced voice-related distress and a switch from critical to soothing voice content.

The findings also suggest that self-compassion offers an additional understanding of voice-related distress and soothing voice content than we already know through key parts of the cognitive model (mood and negative self-schema). It is therefore important to continue to research self-compassion, so that we can improve the available treatment approaches for people who hear voices and seek help to manage them.

Connecting/Reflective Narrative

Word count: 950

This section contains reflections about the process of completing these research projects, including challenges and what I have learned along the way. The connecting theme across my projects has been research that aims to improve the care provided in secondary or specialist care teams. This is very important to me and has developed from my experience working in prisons, Community Mental Health Teams (CMHTs), and a community outreach service.

Critical Review of the Literature (CRL)

My interest in the topic for my CRL was driven by my experiences working with women in prison. During this time, I observed that DBT was regularly offered to individuals with difficulties with anger and aggression. Given this observation, I was really surprised to learn of the limited evidence base for DBT in treating these outcomes. This gap between the literature and clinical practice felt important to address. I have since been fortunate to be able to share the findings when working in a DBT placement and was encouraged by the enthusiasm from the team for this review.

Despite my interest in the topic, I found this process of this project the most challenging. Developing a research question was difficult, as so many of my initial ideas had already been registered or had too few studies. I had also not conducted a systematic review before, so making sense of the process I needed to follow was often challenging. When it came to the meta-analysis, my supervisors and the research team were honest about their lack of experience with this technique. I found this interesting, as meta-analyses are so relied upon in the field. Indeed, this process has shown me how valuable they are - the process of trying to

understand the data before and after the meta-analysis was striking. I am grateful to now have some skills in this technique for both conducting and digesting future research.

Service Improvement Project (SIP)

After working as an Assistant Psychologist in newly established services, I have developed a strong interest in service development. I really enjoyed the process of service-level research in the SIP, as working directly with the team made it easier for me to see how my work would make a difference. I was particularly fortunate that this was conducted during a time of service transition, so management were open to changes and had the opportunity to implement them.

A particular challenge in this project was recruitment of young people. The service was keen to hear from them, but they were often either still acutely unwell or did not wish to recall the time when they were. Covid-19 also had a very significant impact on the recruitment for this project. Parents were noticeably more responsive and available to speak, which is reflected in the study sample. However, these conversations were often challenging; parents were recalling a highly distressing time in their lives, which often involved lots of unprocessed emotions. Many were also angry at 'the system', and I often found it difficult to know where I stood in that, as I was speaking to them as a researcher but with the title of a trainee psychologist. Research supervision was invaluable to reflect on these experiences.

I learned a lot from the findings of this research that I will carry throughout my career. For example, the importance of exploring strengths before offering solutions, individualising recommendations, and not to expect any information to sink in during a crisis period. Our systemic teaching has also been helpful to make sense of the impact that the young person's distress had on their parents, and has taught me to always consider the wider system in assessment, formulations and interventions.

Theory Driven Research Project (TDRP)

I enjoy working within a compassion-focused approach but am often frustrated by the slow progress in the evidence-base, so conducting some research within this area was something I knew I wanted to do. The idea for this project came from a case that I worked with in a CMHT. I had used a compassion-focused approach with a person who heard voices, as this fit more with their goals than CBTp. They responded well to the approach, and by the end of therapy their distress had reduced so much that they no longer felt they needed to be under the care of the team. After this experience, I knew I wanted to conduct some research to further understand the role of self-compassion in voice hearing.

The recruitment for this project was delayed by difficulties obtaining ethics, which took 12 months due to Covid-19 delays and a new sponsorship process. This was a frustrating experience, as there was little that could be done whilst waiting for this approval. However, when recruitment was able to begin, I was really encouraged by the response to the study from the hearing voices community. It was sad to hear that they often felt left out of research attention, but it was clear that improving the psychological interventions in services was important to them. I was pleased to be able to share this project, I and am so thankful for those that took the time to take part.

Conclusion

As I prepare to embark on my next chapter as a qualified Clinical Psychologist, I have been reflecting on the type of psychologist I would like to be. Whilst I imagine that a full-time clinical role will make it difficult to find the time to continue involvement in research, I am hopeful that I will be involved in more service-level projects in future. I will also continue to read and apply research relevant to the populations and settings that I am working in, and continue to share new developments in the field with my colleagues.

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Appendices
Appendix A (CRL)

Comparator Conditions

Feigenbaum et al. (2012)	*TAU for Personality Disorder (TAU-PD)* Individualised treatment package for Cluster B personality disorder. May include outpatient psychiatric review, care coordination, inpatient admissions, counselling, substance misuse treatment, crisis management. May also include psychoanalytic therapy for personality disorders at a centre of excellence (The Tavistock), or evidence-based treatment with a Clinical Psychologist (e.g. cognitive behavioural therapy or schema focused therapy).
Koons et al. (2001)	*Veteran Service Usual Care (VS)* Treatment within veterans service, at or above usual standard of care. 60 mins of weekly individual therapy and offered access to supportive or psychoeducational groups. Therapists described approach as primarily: cognitive-behavioural (4), psychodynamic (2), eclectic (2).
Linehan et al. (1994)	*Therapy in the Community (TIC)* Any therapy treatment in community, uncontrolled by researchers. Therapists described approach as: behavioural/cognitive behavioural (2), cognitive (3), client centred/supportive (5), psychodynamic (1), eclectic (2).
Mcmain et al. (2009, 2012)	*General Psychiatric Management (GPM)*

	Psychodynamically informed therapy and medication management. Included weekly individual sessions, adherence ratings and staff weekly supervision to match DBT condition.
Navarro-Haro et al. (2021)	*CBT for Eating Disorders, with additional strategies* Includes components of CBT for treatment of bulimia nervosa and anorexia nervosa, and CBT strategies to treat personality related difficulties. 1 hour of individual therapy per week, two-hour group per week, to match DBT.
Neacsiu et al. (2014)	*Community Treatment by Experts (CTBE)* Intervention content was uncontrolled by research team, however characteristics of therapists were controlled by election of therapists and supervisory arrangements. This controlled for the following non-specific factors: expertise, treatment allegiance, availability of a clinical supervision group, prestige, general factors, assistance in finding a therapist, availability of affordable and sufficient treatment hours, therapist gender, training, and clinical experience. Therapists who self-identified as primarily cognitive or behavioural in orientation were excluded.
Neacsiu et al. (2018)	*Activities Based Support Group (ASG)* Group intervention. Designed to exclude active ingredients of DBT (e.g. homework review, skills teaching and coaching) but preserve elements of supportive therapy and CBT (e.g. psychoeducation, facilitating support

	building, behavioural activation) and common factors in therapies (e.g. structure, empathy, therapeutic alliance).
Soler et al. (2009)	*Standard Group Therapy (SGT)* Group intervention led by two experienced psychodynamic oriented therapists. Aimed to provide a relational intervention, allowing group members to share difficulties with peers. 13 weeks, 120 minutes each (to match DBT condition).
Tomlinson and Hoaken (2017)	*Ward Standard Care*[1] Weekly sessions with psychiatrist and 24-hour nursing supervision. No individual therapy, nor any other group therapy.

Table A1. Summary of comparator conditions included in review. [1]Does not meet criteria for 'active intervention'; however, this study was not included in meta-analyses.

Appendix B (CRL)

Outcome Measures Included in Review

Measure	Subscales	Reference	Assessment method
Anger, Irritability and Assault Questionnaire (AIAQ)	Anger	(Coccaro et al., 1991)	Self-report
Buss-Perry Aggression Questionnaire (BPAQ)	Anger	(Buss & Perry, 1992)	Self-report
The Short-Form Buss-Perry Aggression Questionnaire (BPAQ-SF)	Anger	(Bryant & Smith, 2001)	Self-report
The Clinical Global Impression Scale for Borderline Personality Disorder Patients (CGI-BPD)	Anger	(Perez et al., 2007)	Clinical interview
State-Trait Anger Scale (STAS)	Trait anger	(Spielberger et al., 1983)	Self-report
State-Trait Anger expression Inventory (STAXI)	State anger Trait anger	(Spielberger, 1991)	Self-report

State-Trait Anger expression Inventory 2 (STAXI-2)	State anger Trait anger	(Spielberger, 1999)	Self-report

Table B1. Measures of anger included in this review.

Measure	Subscales	Reference	Assessment method
Anger, Irritability and Assault Questionnaire (AIAQ)	Verbal assault Direct assault	(Coccaro et al., 1991)	Self-report
Buss-Perry Aggression Questionnaire (BPAQ)	Physical aggression Verbal aggression	(Buss & Perry, 1992)	Self-report
The Short-Form Buss-Perry Aggression Questionnaire (BPAQ-SF)	Physical aggression Verbal aggression	(Bryant & Smith, 2001)	Self-report
The Impulsive/Premeditated Aggression Scale (IPAS)	Impulsive aggression Premeditated aggression	(Stanford et al., 2003)	Self-report
Modified Overt Aggression Scale (MOAS)	Verbal aggression Physical aggression Aggression against objects	(Kay et al., 1988)	Staff/clinician rated
Overt Aggression Scale (OAS)	Verbal aggression Aggression against objects Aggression against people	(Yudofsky et al., 1986)	Staff/clinician rated
The Overt Aggression Scale Modified (OAS-M)	Verbal aggression Physical aggression	(Coccaro et al., 1991)	Staff/clinician rated

State-Trait Anger expression Inventory (STAXI)	Anger-out	(Spielberger, 1991)	Self-report
State-Trait Anger expression Inventory 2 (STAXI-2)	Anger-out	(Spielberger, 1999)	Self-report

Table B2. Measures of aggressive behaviour included in this review.

Appendix C (CRL)

Quality Assessment Scores

	Objecti ve	Desig n	Meth od	Subjec ts	Randomi se	Blindi ng 1	Blindi ng 2	Outcom es	Samp le size	Analys is	Varian ce	Confoun ds	Resul ts	Conclusio ns	Summa ry score
Clarkin et al. (2007)	1	1	1	2	1	2	-	2	1	1	0	2	1	2	0.65
Feigenba um et al. (2012)*	2	2	2	1	2	2	-	1	1	2	2	2	1	1	0.78
Fox et al. (2015)*	1	1	2	1	-	-	-	2	1	1	1	0	1	2	0.59
Koons et al. (2001)*	2	2	2	2	1	-	-	2	1	2	1	2	1	2	0.83

Linehan et al. (1994)*	2	2	1	1	2	2	-	2	1	1	1	2	2	2	0.81
Mcmain et al. (2009)*	2	2	2	1	2	2	-	2	2	1	1	2	1	2	0.85
Mcmain et al. (2012)	2	2	2	1	2	2	-	2	2	1	2	2	1	2	0.88
Moulden et al. (2020)*	2	1	1	1	-	-	-	2	0	2	1	0	2	1	0.59
Navarro-Haro et	2	2	2	1	-	-	-	2	1	1	1	2	1	2	0.77

al. (2021)*															
Neacsiu et al. (2014)*	2	2	1	2	2	2	-	2	1	2	2	2	1	2	0.88
Neacsiu et al. (2018)*	2	2	2	2	1	2	-	2	2	2	2	2	1	2	0.92
Prada et al. (2015)*	1	1	2	1	-	-	0	2	2	2	1	1	2	1	0.67
Prenderg ast and McCausla	2	1	2	1	-	-	-	2	1	1	1	0	2	1	0.64

nd (2007)*															
Simpson et al. (2004)	2	2	2	2	2	2	2	1	0	2	1	2	2	2	0.86
Soler et al. (2009)*	1	2	1	1	2	2	-	2	1	2	1	2	2	2	0.81
Tomlinson and Hoaken (2017)	2	1	1	2	1	-	-	2	1	2	1	2	1	2	0.75
Mean score	1.75	1.63	1.63	1.38	1.64	2.00	1.00	1.88	1.13	1.56	1.19	1.56	1.38	1.75	0.77

Table C1. Results of quality assessment for all papers included in review. Calculated using QualSyst assessment tool for quantitative studies (Kmet et al., 2004). * = Studies included in meta-analysis. Blinding 1 = blinding of investigators; Blinding 2 = blinding of participants.

Appendix D (CRL)

Journal Guidelines

Clinical Psychology: Science and Practice follows publication policies and ethical principles of the American Psychological Association (APA). Authors are assumed to be familiar with and are responsible for adherence to such policies. Among the tenets, the policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications or from publishing any manuscript that has already been published in whole or substantial part elsewhere. Authors are obligated to consult journal editors concerning prior publication of any material upon which their article depends.

Although the vast majority of papers will be review and discussion articles, occasionally papers representing programs of research or papers drawing on such research will be published. Compliance with APA ethical standards in the treatment and protection of the sample is expected by the journal.

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Original Publication

Submission of a manuscript will be understood to mean that the manuscript contains original unpublished work and is not being submitted for publication elsewhere at the same time. The author must supply a full statement upon submission of the work about any and all submissions and previous reports that might be regarded as duplicate publication of the same or very similar work.

Invited Commentaries

Upon acceptance of manuscript, the editor-in-chief will invite 2-3 individuals to submit brief commentaries that target 2-3 important and high-level issues related to the review (see recent issues of the journal for examples). These commentaries are also peer-reviewed. The original paper and the commentaries are published simultaneously. These commentaries are by invitation only.

Conflicts of Interest

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If reporting on empirical data involving human participants, these individuals have a right to privacy that should not be infringed without informed consent. No identifying information should be included in written descriptions, photographs and pedigrees unless the information is essential for scientific purposes and the individual (or parent or guardian) gives written informed consent for publication. Identifying details must be omitted if they are not essential but essential empirical data should never be altered or falsified in an attempt to attain anonymity. Complete anonymity is difficult to achieve and informed consent should be obtained if there is any doubt. Empirical manuscripts must be accompanied by a statement that the research was undertaken with the understanding and written consent of each participant (or the participant's representative, if they lack capacity).

Articles that draw upon previously-published empirical literature (meta-analyses) do not need to have undergone review by the responsible committee on human experimentation (institutional or regional). In these instances, authors are expected to include a complete listing of all empirical studies that were included in the analyses, including citation, relevant details of the methodology, and a brief synopsis of the findings that are included in the review. In cases where space constraints are of concern, this information may be included as an on-line supplemental appendix.

Clinical trials should be reported using APA's Journal Article Reporting Standards-Quantitative (see American Psychologist (January 2018). These guidelines are available at **www.apastyle.org/jars/quant-table-2c.pdf**).

CPSP encourages authors submitting manuscripts that report results of a clinical trial to register the trials in any of the following free, public clinical trials registries: **www.clinicaltrials.gov**, **www.isrctn.org**. The clinical trial registration number and name of the trial register will then be published with the paper.

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As a member of the Committee on Publication Ethics (COPE), adherence to these submission criteria is considered essential for publication in *CPSP*; mandatory fields are included in the online submission process to ensure this. If, at a later stage in the submission process or even after publication, a manuscript or authors are found to have disregarded these criteria, it is the duty of the Editor-in-Chief to report this to COPE. COPE may recommend that action be taken, including but not exclusive to, informing the authors' professional regulatory oversight body and/or institution of such a dereliction.

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After the accepted manuscript is published online, any requests to add, delete, or rearrange author names in an article published in an online issue will follow the same policies as noted above and result in a corrigendum.

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The Journal has recently instituted a policy of including Public Health Significance statements for each article (not the commentaries). These are designed to increase dissemination and usage by larger and diverse audiences, such as other health professionals and the lay public. These 2-3 sentence statements should be user-friendly and geared to be informative and useful for all types of readers. They would include a basic message regarding the importance of the paper's topic and the essential findings with regard to public health issues. These statements would be boxed on the first page of the article for immediate recognition. Authors should include such statements on the abstract page below the key words.

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**Beginning Monday, November 23, 2020, Clinical Psychology: Science and Practice will begin using the Editorial Manager (EM) manuscript submission platform. All new submissions from November 23 forward must use EM, located here:

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Appendix E (SIP)

Audit Approval Email

From: Rhodes Katie (RNU) Oxford Health [redacted]
Sent: 24 July 2020 15:32
To: Goodison Hannah (RNU) Oxford Health [redacted]
Subject: FW: Audit Registration CAMHS Crisis

Hi Hannah,

Your audit proposal has now been approved.

Please see attached copy of an Audit Report Template in which will need to be completed and returned once the project is complete.

Kind Regards,

Katie Rhodes
Senior Team Administrator
Oxford Health NHS Foundation Trust
The Whiteleaf Centre
Bierton Road
Aylesbury
HP20 1EG

Appendix F (SIP)

CYP Survey

PAGE ONE: THE STUDY

This survey is for the young people who have accessed the crisis team. If you are a parent/guardian, please complete this survey instead.

This survey is part of an evaluation of the Oxfordshire CAMHS Crisis Service. You have been invited to take part because you have been under the care of this service in the last 12 months.

The research is being carried out separately to the service as part of doctoral research at the University of Oxford. Nobody from the service will know who has taken part.

This survey will ask:

- What support you received from the service
- What your journey into and out of the service was like
- How you think the service could be improved

This is an opportunity for you to discuss your experiences and offer your opinions about the crisis service. Your feedback is important and will be used to make recommendations about how the service's care for young people and their families can be improved.

The survey will take around 20 minutes to complete.

PAGE TWO: INFORMATION AND CONSENT

Who can take part?

- We are sending this survey to all young people and their families that have had a period of care with the Oxfordshire CAMHS Crisis Service which ended in the last 12 months.
- You can take part even if somebody else in your family has already completed the survey. We would like to hear from as many people as possible.
- This survey is for the young person that was under the care of the team - there is another survey for parents/guardians in the email that you received.

What does it involve?

- If you agree to take part, you will start the survey on the next page.
- You can close the survey at any time, but you will not be able to come back to it later.
- The survey will take around 20 minutes.

Will my responses be confidential?

- All responses will be kept fully confidential.
- Nobody in the crisis service will have access to your individual answers, or any data that could identify who you are.
- At the beginning of the survey you will be asked for your name and contact details if you would like to be contacted for an interview. This will not be seen by anybody from the crisis service. You do not have to give any personal details if you would prefer not to.

If you want to give feedback (positive or negative) about your care directly to the service, please contact the team manager (phone: 01865 902 936,

email: OxonOSCA.Admin@oxfordhealth.nhs.uk) or Patient Advice & Liason (PALS) on 0800 328 7971.

What are the possible risks and benefits?

- The feedback from this survey will be used to make recommendations about how to improve the Oxfordshire CAMHS Crisis Service.
- We do not expect that this survey will be upsetting for you to complete, but if thinking about the time that you had crisis support might be difficult for you, you might not want to take part. If you do find the survey difficult to complete, there are contact numbers for services below and at the end of the survey.

Who can I contact if I need support?

- If you are open to CAMHS, you can call your care coordinator (in office hours)
- Your GP (in office hours)
- NHS 111
- If you need immediate urgent support, you can call 999 or visit your local A&E department

Would you like to take part in this survey?

- Yes, I understand the above and want to take part (*continues to survey*)
- No, I don't want to take part *(-> screen out message*)

PAGE THREE: DEMOGRAPHICS

The below questions help us to understand some information about who is completing this survey.

How old are you?

- 10 or younger *(-> screen out message)*
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20 or older *(-> screen out message)*

What is your gender?

- Male
- Female
- Non-binary
- Prefer not to say

What is your ethnic group?

- Asian / Asian British

- Black / African / Caribbean / Black British
- White
- Mixed / multiple ethnic groups
- Other ethnic group
- Prefer not to say

PAGE FOUR: YOU AND THE CRISIS SERVICE

If you have been under the care of the crisis service more than once, please complete this survey about the last time that you were under their care.

Who referred you to the crisis service?

- Care coordinator from a mental health team (CAMHS)
- Inpatient unit (hospital)
- A&E
- I don't know
- Other (please give details): FREE TEXT BOX

Why were you referred to the crisis team? (You can choose more than one option)

- Self-harm
- Suicidal thoughts
- Suicide attempt(s)
- Violence / aggression
- Eating Disorder
- Other (please give details)
    - FREE TEXT BOX

How long were you under the care of the crisis service for?

- 1-3 days
- 4-6 days
- 1-2 weeks
- More than 2 weeks
- I don't know

How many times have you been under the care of a crisis team?

- This was my first time
- Once before this time
- Twice before this time
- Three or more times before this time
- I don't know

We would like to hold some interviews to understand more about your experience of the crisis service. They would be 30-60 minutes long and could be either face to face or online. If you would be happy for us to contact you about an interview, please write your name and contact details in the box:

- FREE TEXT BOX

PAGE FIVE: INTERVENTIONS

Thinking about your most recent time with the crisis service…

Below are some things that crisis teams can offer. What did you receive, and how important do you think these things are?

	Did you receive this?	**How important do you think this is for crisis care?**
A named crisis worker	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
24/7 availability if needed for emergency support	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
Home visits	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
Other face to face support (not at home)	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
I could choose where I wanted to meet for appointments	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
Telephone appointments	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
Video appointments	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know

A written care plan	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
Information to help me understand my mental health difficulty	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
Teaching of skills to manage emotions	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
Support to use the skills to manage emotions	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
A place to talk about the safety of myself or others (e.g. from violence or self-harm)	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
I could involve people close to me in my care (e.g. family/friends)	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
A plan to help me respond to future difficulties (e.g. 'safety plan' or 'relapse prevention')	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know

Is there any other support that you received from the service that is not included above? If so, how important are those things to you?

- FREE TEXT BOX

Do you have any ideas about what other support would have been helpful, or how the things that you received could have been better?

- FREE TEXT BOX

Do you feel that the care you received was tailored to match your personal goals and needs at the time?

- Yes
- No
- I don't know

Can you tell us any more about that?

- FREE TEXT BOX

PAGE SIX: STAFF INTERACTIONS

Thinking about your most recent time with the crisis service…

How much do you agree with these statements?

I felt understood	Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
I felt taken seriously	Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
I felt listened to	Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree

I was helped to feel like my experience was normal	Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
Staff were warm when they spoke with me	Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree

Can you tell us any more about that?

- FREE TEXT BOX

PAGE EIGHT: YOUR JOURNEY OUT OF THE CRISIS SERVICE

Thinking about your most recent time with the crisis service…

Where did you receive your care after discharge from the crisis service?

- Under the care of a care coordinator from a mental health team (CAMHS)
- Psychiatric hospital
- I don't know
- Other (please give details): FREE TEXT BOX

Below are some things that could be offered to somebody at the end of their care. What did you receive, and how important do you think these things are?

	Did you receive this?	**How important do you think this is for crisis care?**
A discharge meeting	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know

We made a plan for how I will cope	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
Less frequent sessions towards the end to help me prepare	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
I was given some notice about when my care would end	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know

How much notice were you given before your care ended?

- No notice at all
- 1 day
- 2 days
- 3-6 days
- 1 week
- 2 weeks
- Other (please specify): FREE TEXT BOX

Is there any other support that you received from the service that is not included above? If so, how important are those things to you?

- FREE TEXT BOX

Do you have any ideas about what other support would have been helpful at the end of your care, or how the things that you received could have been better?

- FREE TEXT BOX

PAGE NINE: FINAL QUESTIONS

Thinking about your most recent time with the crisis service…

Overall, how was your experience of the service?

- Very good
- Good
- Neither good nor bad
- Bad
- Very bad
- Don't know

If you were in charge of the service, what would you do to improve it?

- FREE TEXT BOX

Is there anything else that you'd like us to know?

- FREE TEXT BOX

PAGE TEN: FINAL PAGE

If you did not leave your contact details but you would be happy to be contacted about a confidential interview to discuss your experience and feedback, please contact the researcher (hannah.goodison@hmc.ox.ac.uk).

If you need any support after accessing this survey, these are some people you can call:

- If you are open to CAMHS, you can call your care coordinator (in office hours)
- Your GP (in office hours)
- NHS 111
- If you need immediate urgent support, you can call 999 or visit your local A&E department

If you have recently been discharged and need advice or a re-referral, you can call the mental health helpline (0800 783 0121) or the Oxford CAMHS team (01865 902515).

Appendix G (SIP)

Parent Survey

PAGE ONE: THE STUDY

This survey is for the parents/guardians. If you are the young person who was under the care of the crisis service, please complete **this survey instead**.

This survey is part of an evaluation of the Oxfordshire CAMHS Crisis Service. You have been invited to take part because somebody that you care for has been discharged from this service in the last 12 months.

The research is being carried out separately to the service as part of doctoral research at the University of Oxford. Nobody from the service will know who has taken part.

This survey will ask:

- What support you received from the service
- What your journey into and out of the service was like
- How you think the service could be improved

This is an opportunity for you to discuss your experiences and offer your opinions about the crisis service. Your feedback is important and will be used to make recommendations about how the service's care for young people and their families can be improved.

The survey will take around 20 minutes to complete.

PAGE TWO: INFORMATION AND CONSENT

Who can take part?

- We are sending this survey to all young people and their families that have had a period of care with the Oxfordshire CAMHS Crisis Service which ended within the last 12 months.
- You can take part even if somebody else in the family has already completed the survey. We would like to hear from as many people as possible.
- You can take part if you are the young person that was under the care of the service, or if you are their parent / guardian.
- This survey is for parents/guardians - there is another survey for the young person in the email that you received.

What does it involve?

- If you agree to take part, you will be redirected to an online survey.
- You can close the survey at any time, but you will not be able to come back to it later.
- The survey will take around 20 minutes to complete.

Will my responses be kept confidential?

- All responses will be kept fully confidential.
- Nobody in the crisis service will have access to individual survey responses or any data that could identify you.
- At the beginning of the survey you will be asked for your email address if you would like to be contacted for an interview. If you choose to give your email address, this will not be seen by anybody from the crisis service. If you would rather, you can keep all of your responses anonymous.

If you want to give feedback (positive or negative) directly to the service about your care in particular, please do so by contacting the team manager (phone: 01865 902 936, email: OxonOSCA.Admin@oxfordhealth.nhs.uk) or Patient Advice & Liason (PALS) on 0800 328 7971.

What are the possible risks and benefits?

- The feedback from this survey will be used to make recommendations about how to improve the Oxfordshire CAMHS Crisis Service.
- We do not expect that this survey will be upsetting to complete, but if thinking about the time that you had crisis support might be difficult for you, you might not want to complete this survey. If you do find the survey difficult to complete, there are contact numbers for services below.

Who can I contact if I need support?

- Your GP (in office hours)
- NHS 111
- If you need immediate urgent support, you can call 999 or visit your local A&E department

Would you like to take part in this survey?

- Yes, I understand the above and want to take part (continues to survey)
- No, I don't want to take part (-> screen out message)

PAGE THREE: DEMOGRAPHICS

The below questions help us to understand some information about who is completing this survey.

How old are you?

- 16-20
- 21-30
- 31-40
- 41-50
- 51-60
- 61-70
- 71-80
- 81 or above

What is your gender?

- Male
- Female
- Non-binary
- Prefer not to say

What is your ethnicity?

- Asian / Asian British
- Black / African / Caribbean / Black British
- White
- Mixed / multiple ethnic groups

- Other ethnic group
- Prefer not to say

PAGE FOUR: YOU AND THE CRISIS SERVICE

If you have been under the care of the crisis service more than once, please complete this survey about the last time that you were under their care.

Who referred the young person you care for to the crisis service?

- Care coordinator from a mental health team (CAMHS)
- Inpatient unit (hospital)
- A&E
- I don't know
- Other (please give details): FREE TEXT BOX

Why was the young person in your care referred to the crisis team? (You can choose more than one option)

- Self-harm
- Suicidal thoughts
- Suicide attempt(s)
- Violence / aggression
- Eating Disorder
- Other (please give details)
    - FREE TEXT BOX

How long were they under the care of the crisis service for?

- 1-3 days
- 4-6 days

- 1-2 weeks
- More than 2 weeks
- I don't know

How many times have they been under the care of a crisis team?

- This was the first time
- Once before this time
- Twice before this time
- Three or more times before this time
- I don't know

We would like to hold some interviews to understand more about your experience of the crisis service. They would be 30-60 minutes long and could be either face to face or online. If you would be happy for us to contact you about an interview, please write your name and contact details in the box:

- FREE TEXT BOX

PAGE FIVE: INTERVENTIONS

Thinking about your most recent time with the crisis service…

Below are some things that crisis teams can offer. What did you receive, and how important do you think these things are?

	Did you receive this?	**How important do you think this is for crisis care?**
A named crisis worker	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know

24/7 availability if needed for emergency support	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
I was invited to meetings about the young person's care	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
A separate meeting to discuss my needs (without the young person)	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
Information about carer support services	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
A written carer's support plan	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
Information to help me understand the young person's mental health difficulty	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
Space to talk about the safety of myself and others (e.g. from violence or self-harm)	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know

Is there any other support that you received from the service that is not included above? If so, how important are those things to you?

- FREE TEXT BOX

Do you have any ideas about what other support would have been helpful, or how the things that you received could have been better?

- FREE TEXT BOX

Do you feel that the care you received was tailored to match the goals and needs of your family at the time?

- Yes
- No
- I don't know

Can you tell us any more about that?

- FREE TEXT BOX

PAGE SIX: STAFF INTERACTIONS

Thinking about your most recent time with the crisis service…

How much do you agree with these statements?

I felt understood	Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
I felt taken seriously	Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
I felt listened to	Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree

I was helped to feel like my experience was normal	Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
I was helped to feel like my family's experience was normal	Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree
Staff were warm when they spoke with me	Strongly agree / agree / neither agree nor disagree / disagree / strongly disagree

Can you tell us any more about that?

- FREE TEXT BOX

PAGE EIGHT: YOUR JOURNEY OUT OF THE CRISIS SERVICE

Thinking about your most recent time with the crisis service…

Where did the young person receive their care after discharge from the crisis service?

- Under the care of a care coordinator from a mental health team (CAMHS)
- Psychiatric hospital
- I don't know
- Other (please give details): FREE TEXT BOX

Below are some things that could be offered to somebody at the end of their care. What did you receive, and how important do you think these things are?

	Did you receive this?	**How important do you think this is for crisis care?**
A discharge meeting	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know

We had a shared plan for how the young person can cope with future difficulties	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know
I was given some notice about when the care would end	Drop down: yes/no/don't know	Absolutely essential / Very important / Slightly important / Not important / don't know

How much notice were you given before the care ended?

- No notice at all
- 1 day
- 2 days
- 3-6 days
- 1 week
- 2 weeks
- Other (please specify): FREE TEXT BOX

Is there any other support that you received from the service that is not included above? If so, how important are those things to you?

- FREE TEXT BOX

Do you have any ideas about what other support would have been helpful at the end of your care, or how the things that you received could have been better?

- FREE TEXT BOX

PAGE NINE: FINAL QUESTIONS

Thinking about your most recent time with the crisis service…

Overall, how was your experience of the service?

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Don't know

If you were in charge of the service, what would you do to improve it?

- FREE TEXT BOX

Is there anything else that you'd like us to know?

- FREE TEXT BOX

PAGE TEN: FINAL PAGE

If you did not leave your contact details but you would be happy to be contacted about a confidential interview to discuss your experience and feedback, please contact the researcher (hannah.goodison@hmc.ox.ac.uk).

If you need any support after accessing this survey, these are some people you can call:

- Your GP (in office hours)
- NHS 111
- If you need immediate urgent support, you can call 999 or visit your local A&E department

If the young person you care for has recently been discharged and you would like advice or a re-referral, you can call the mental health helpline (0800 783 0121) or the Oxford CAMHS team (01865 902515).

Appendix H (SIP)

Interview Guide

PREAMBLE

Thank you so much for agreeing to this interview.

In this interview, we hope to find out more about your experience of the Oxford Crisis Service for children and young people. We would like to understand what you think is important about crisis care, and what was helpful/unhelpful in your experience. I will ask you about this in 3 sections:

1. Your journey in to the crisis team
2. Your experience with the crisis team
3. Your thoughts now looking back on this time.

Some people have been under the care of a crisis team more than once. If that applies to [you / the young person you care for], we would like to hear about the most recent time. I don't work for the crisis team, so they won't know who gave this feedback. All feedback is anonymous.

Do you have any questions for me?

1. JOURNEY IN TO SERVICE

For this part of the interview, we'd like to you to try and remember what things were like when the crisis team first got involved. You don't need to share all the difficult things that were happening then. We'd just like to get a general sense of what was going on and how it came about that you started seeing them.

- So, what led to [you / the young person] being involved with the crisis team?

    - How did you feel at that time?
    - Who got them involved?
    - What did you think about that?
- What were your expectations about the service?
    - How was it explained to you?
    - Was there anything you were hoping for? Or afraid of?

2. TIME IN SERVICE

For this part we'd like you to try and remember your experience of the crisis team. Take a minute to try and remember that time – who you met with, what it felt like.

- What did you like about the service?
    - Why is that?
    - What was helpful? Why?
- What did you not like about the service?
    - Why is that?
    - What was unhelpful? Why?
    - Was there anything you would have liked them to do differently?
    - Is there anything they didn't do that would have been helpful?

3. AFTER BEING IN THE SERVICE

This is the last part of the interview. For this part we'd like to hear what your thoughts are now, looking back on your time with the crisis service.

- What do you think about the crisis service as you look back on your time with them?
    - If you were in charge of the service, what changes would you make?

    - Do you have any (other) ideas about how the service could be improved?
    - What would you want people to know about the service?
- What do you think is the most important thing when professionals are caring for young people in a mental health crisis?
- Is there anything else that you think is important or would like to tell me?

Appendix I (SIP)

Lay Summary of Results

Word Count: 674

You recently took part in a service improvement project for the Oxfordshire CAMHS Crisis Service. You said that you would like to be sent a summary of the findings and recommendations when the project was completed. These can be found below.

Project Background

This project aimed to explore people's experience of the Oxfordshire CAMHS Crisis service and to understand how it could be improved. This was achieved through a survey and a smaller number of interviews. Everybody who accessed the crisis service between 4th August 2019 and 25th September 2020 was invited to participate.

The project aimed to answer the following questions:

1. How did young people and parents[2] experience their care from the service?
    - What was helpful and unhelpful?
    - How did they experience their interactions with crisis staff?
2. What are young people's and parents' priorities for crisis care?
3. Is the service meeting standards for care?
4. How could the care given to young people and parents be improved?

[2]The term 'parents' is used in this report to reference parents and guardians of children and young people.

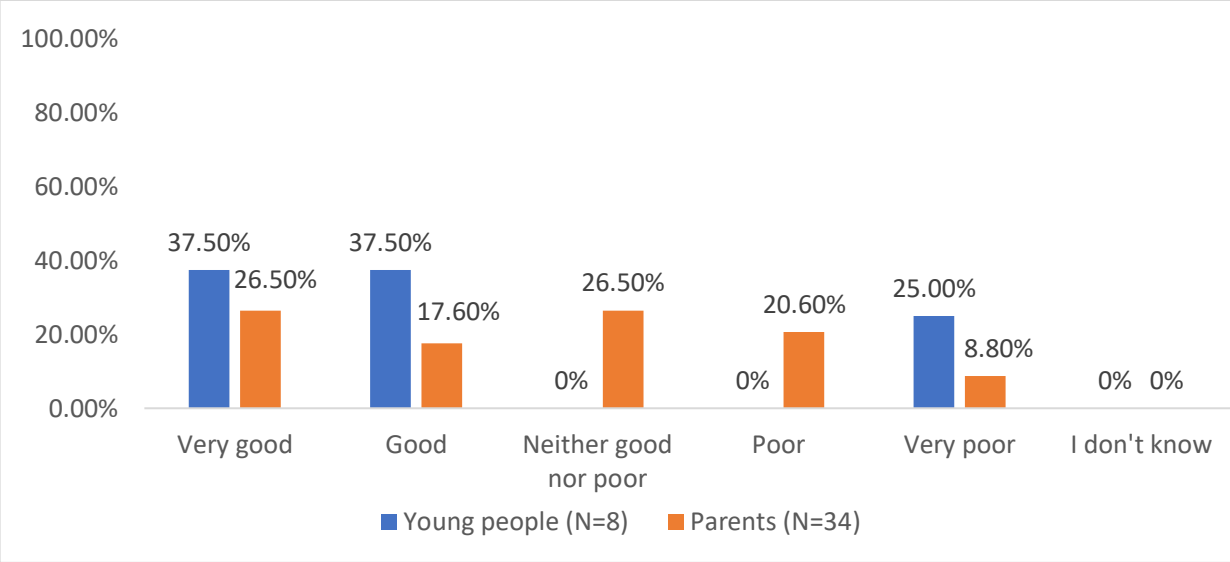
Project Findings

The online survey was completed by 34 parents and eight young people. Interviews were also held with nine parents and three young people.

Overall Experience of the Service

Most young people (75.0%) said that their overall experience with the crisis service was very good or good. Conversely, less than half (44.1%) of parents said their overall experience was very good or good.

Parents and CYP Overall Experience of Service



Staff Interactions

Most young people and parents agreed that staff were warm in interactions; however, half of the parents did not feel listened to or understood. Less than half of CYP (37.5%) and parents (35.3%) felt their experience was normalised.

Meeting Standards

The service was found to have some areas of good practice (e.g. 24/7 support) but some areas to improve (e.g. offering face-to-face appointments, parent support, discharge meetings). There were some discrepancies between young people's and parents' reports of what was

received by the service (young people tended to report receiving more than parents). Some of the people who took part in this evaluation received care during the Covid-19 pandemic, so this may have affected what the service was able to offer.

Six themes were also found from the interviews and the open-ended questions in the survey:

1. Staff warmth and understanding
2. Parents need support
3. Service access issues
4. Need for improved liaison
5. Clearer service information
6. A long-term approach is important

Service Recommendations

Several recommendations were developed from these findings for how care for CYP and their parents could be improved. These were presented in seven themes. An overview is provided below:

1. **Responding to distress** (validate distress, listen before giving advice, tailor advice to the individual, be careful not to assume familiarity with DBT techniques)
2. **Identify goals** (identify each person's goals so that care can be tailored to these)
3. **Engaging young people** (clearly explain confidentiality, offer choice and flexibility with appointments, make visits if the young person repeatedly does not engage)
4. **Support and involve parents** (offer a parent support group, clearly explain what support is and is not available for parents, involve parents at assessment and discharge where possible)

5. **Written information** (develop service information to share with families from the beginning, develop a resource list, share a written care plan where possible)
6. **Discharge** (hold a discharge meeting and make a plan to cope with future difficulties, give notice before discharge, offer a gentle end with fewer sessions)
7. **Service issues** (improve links with CAMHS teams and other agencies, increase consistency in staff members that families interact with, allow opportunities for feedback)

A full version of these recommendations has been shared with the service.

Thank you again for your participation. If you have any questions about these findings, please email the primary researcher (Hannah.goodison@hmc.ox.ac.uk).

Appendix J (SIP)

Additional Quantitative Results

Priorities for Crisis Care

Most CYP (87.5%) said 24/7 emergency support was essential, followed by 75.0% reporting that learning skills to manage emotions and having a space to discuss risk were essential. Most parents (79.4%) rated 24/7 emergency support as essential, followed by information to understand the mental health difficulty (55.9%) and a space to discuss risk (60.0%). See Table C1 for further details.

In terms of discharge, most CYP (62.5%) felt it was essential to have notice before discharge, less frequent sessions before discharge, and a plan for future difficulties. Most parents felt it was essential to have a plan for future difficulties (61.8%), a discharge meeting (58.8%) and notice before discharge (55.9%). However, 37.5% of CYP and 32.4% of parents reported having no notice prior to discharge. See Tables C2 and C3 for further details.

	Absolutely essential	Very important	Slightly important	Not important	I don't know	No response
24/7 emergency support	CYP: 7 (87.5%) Parents: 27 (79.4%)	CYP: 1 (12.5%) Parents: 5 (14.7%)	CYP: 0 (0%) Parents: 0 (0%)	CYP: 0 (0%) Parents: 0 (0%)	CYP: 0 (0%) Parents: 0 (0%)	CYP: 0 (0%) Parents: 2 (5.9%)
A named crisis worker	CYP: 1 (12.5%) Parents: 12 (35.3%)	CYP: 4 (50.0%) Parents: 11 (32.4%)	CYP: 2 (25.0%) Parents: 5 (14.7%)	CYP: 0 (0%) Parents: 1 (2.9%)	CYP: 0 (0%) Parents: 1 (2.9%)	CYP: 1 (12.5%) Parents: 4 (11.8%)
Involving people close to me in my care	CYP: 3 (37.5%)	CYP: 1 (12.5%)	CYP: 4 (50.0%)	CYP: 0 (0%)	CYP: 0 (0%)	CYP: 0 (0%)
Invited to meetings to about the young person's care	Parents: 13 (38.2%)	Parents: 14 (41.2%)	Parents: 2 (5.9%)	Parents: 0 (0%)	Parents: 1 (2.9%)	Parents: 4 (11.8%)
Separate meeting to discuss needs	Parents: 10 (29.4%)	Parents: 14 (41.2%)	Parents: 2 (5.9%)	Parents: 4 (11.8%)	Parents: 0 (0%)	Parents: 4 (11.8%)
Carer support service information	Parents: 10 (29.4%)	Parents: 12 (35.3%)	Parents: 7 (20.6%)	Parents: 0 (0%)	Parents: 0 (0%)	Parents: 5 (14.7%)

Written carer support plan	Parents: 14 (41.2%)	Parents: 8 (23.5%)	Parents: 7 (20.6%)	Parents: 1 (2.9%)	Parents: 0 (0%)	Parents: 4 (11.8%)
Home visits	CYP: 0 (0%)	CYP: 0 (0%)	CYP: 4 (50.0%)	CYP: 2 (25.0%)	CYP: 1 (12.5%)	CYP: 1 (12.5%)
Face to face support outside of home	CYP: 1 (12.5%)	CYP: 2 (25.0%)	CYP: 4 (50.0%)	CYP: 0 (0%)	CYP: 0 (0%)	CYP: 1 (12.5%)
Choice of appointment location	CYP: 1 (12.5%)	CYP: 3 (37.5%)	CYP: 1 (12.5%)	CYP: 1 (12.5%)	CYP: 2 (25.0%)	CYP: 0 (0%)
Written care plan	CYP: 5 (62.5%)	CYP: 0 (0%)	CYP: 2 (25.0%)	CYP: 0 (0%)	CYP: 0 (0%)	CYP: 1 (12.5%)
A plan to cope with future difficulties	CYP: 6 (75.0%)	CYP: 1 (12.5%)	CYP: 1 (12.5%)	CYP: 0 (0%)	CYP: 0 (0%)	CYP: 0 (0%)
Space to discuss risk/safety	CYP: 6 (75.0%) Parents: 18 (52.9%)	CYP: 2 (25.0%) Parents: 3 (8.8%)	CYP: 0 (0%) Parents: 6 (17.6%)	CYP: 0 (0%) Parents: 3 (8.8%)	CYP: 0 (0%) Parents: 0 (0%)	CYP: 0 (0%) Parents: 4 (11.8%)
Information to understand the mental health difficulty	CYP: 4 (50.0%) Parents: 19 (55.9%)	CYP: 3 (37.5%) Parents: 9 (26.5%)	CYP: 1 (12.5%) Parents: 1 (2.9%)	CYP: 0 (0%) Parents: 0 (0%)	CYP: 0 (0%) Parents: 0 (0%)	CYP: 0 (0%) Parents: 5 (14.7%)

Telephone appointments	CYP: 3 (37.5%)	CYP: 3 (37.5%)	CYP: 2 (25.0%)	CYP: 0 (0%)	CYP: 0 (0%)	CYP: 0 (0%)
Video appointments	CYP: 2 (25.0%)	CYP: 0 (0%)	CYP: 3 (37.5%)	CYP: 1 (12.5%)	CYP: 1 (12.5%)	CYP: 1 (12.5%)
Learning skills to manage emotions	CYP: 6 (75.0%)	CYP: 2 (25.0%)	CYP: 0 (0%)	CYP: 0 (0%)	CYP: 0 (0%)	CYP: 0 (0%)

Table J1. CYP and Parent Priorities for Crisis Interventions.

Note. Data are presented as n (%). CYP *n*=8. Parents *n*=34. Where no data is presented for a group, question was not asked.

	Absolutely essential	Very important	Slightly important	Not important	I don't know	No response
A discharge meeting	CYP: 3 (37.5%) Parents: 20 (58.9%)	CYP: 2 (25.0%) Parents: 4 (11.8%)	CYP: 1 (12.5%) Parents: 2 (5.9%)	CYP: 0 (0%) Parents: 1 (2.9%)	CYP: 1 (12.5%) Parents: 3 (8.8%)	CYP: 1 (12.5%) Parents: 4 (11.8%)
Giving notice before discharge	CYP: 5 (62.5%) Parents: 19 (55.9%)	CYP: 3 (37.5%) Parents: 9 (26.5%)	CYP: 0 (0%) Parents: 1 (2.9%)	CYP: 0 (0%) Parents: 0 (0%)	CYP: 0 (0%) Parents: 0 (0%)	CYP: 0 (0%) Parents: 6 (17.6%)
Less frequent sessions before discharge	CYP: 5 (62.5%)	CYP: 2 (25.0%)	CYP: 1 (12.5%)	CYP: 0 (0%)	CYP: 0 (0%)	CYP: 0 (0%)
Making a plan for future difficulties	CYP: 5 (62.5%)	CYP: 1 (12.5%)	CYP: 2 (25.0%)	CYP: 0 (0%)	CYP: 0 (0%)	CYP: 0 (0%)
Shared plan to cope with future difficulties	Parents: 21 (61.8%)	Parents: 7 (20.6%)	Parents: 0 (0%)	Parents: 0 (0%)	Parents: 1 (2.9%)	Parents: 5 (14.7%)

Table J2. CYP and Parent Priorities for Discharge.

Note. Data are presented as n (%). CYP *n*=8. Parents *n*=34. Where no data is presented for a group, question was not asked

	CYP	Parents
No notice at all	3 (37.5%)	11 (32.4%)
1 day	2 (25.0%)	5 (14.7%)
2 days	0 (0%)	2 (5.9%)
3-6 days	2 (25.0%)	2 (5.9%)
1 week	0 (0%)	3 (8.8%)
2 weeks	1 (12.5%)	5 (14.7%)
I don’t know	0 (0%)	5 (14.7%)
No response	0 (0%)	1 (2.9%)

Table J3. Notice Given Before Discharge.

Note. Data are presented as n (%). CYP *n*=8. Parents *n*=34.

Appendix K (SIP)

Illustrative Quotes

Staff warmth and understanding	'I know it's probably difficult for them because they see so many people in that situation, but sometimes it can kind of come off as like, they are just doing their job and there's not that much um … it can sometimes come across as a bit like, cold … just someone being friendly is all you kind of need in those situations' (Interview10, child)
	'For example, one night I said, 'I'm gonna do it, I'm gonna do it, I'm gonna kill myself'. And they were just like 'well, why don't you download a mindfulness app, and if you get a hot drink, put some sugar in it and then call me back in an hour if still want to kill yourself'. And I was just there crying, having a panic attack. And my mum was just holding me like 'don't do anything' to stop me from doing anything. And they were just like, 'well, why don't you just have a nice hot chocolate or something and it'll all be OK' and I was like 'hot chocolate doesn't stop suicidal thoughts mate'' (Interview12, child)
	'if I was at the end of the Crisis line I'd conversate with the person until I knew, let's say they had an interest in art, then instead of suggesting exercise for someone who doesn't go out because they get too anxious to exercise in public, I would say, "Oh well instead maybe you could try

painting something" … I think talking before you just suggest something' (Interview09, child)

'They were very warm and welcoming people. Everyone I've spoken to has been really helpful. And I feel like they really do want to make a change and to help you and help your child' (Interview11, parent)

'Just some recognition that actually you're going through a horrible horrible time and it's really really hard. So- because sometimes that's all you need' (Interview02, parent)

'One person was very unsympathetic on the phone and in fact told me that if I couldn't pull together and 'cope' social services would have to intervene. This seemed very threatening to me.' (Survey04, parent)

'I would ring and it might somebody who I didn't know, didn't know the situation. And at that point you find that the advice is quite generic, you know, which obviously it's bound to be because they haven't really got the background and you know they don't really know the ins and outs of the case as such' (Interview08, parent)

'My child found having to deal with different people calling every day, rather than a designated person, difficult. This created a sense of no one

	knowing/understanding her … I would try to reduce the number of staff making contact with the client, ideally having a dedicated worker' (Survey33, parent)
Parents need support	'I feel like it's more of like a social issue rather than, like strictly crisis team issues … I think that a lot of times, young people feel this type of way, because of issues that stem from family and from friendships and stresses outside of themselves. So it's kind of like, you kind of need all the pieces of the puzzle to work together kind of thing' (Interview10, child) 'I felt, just felt I was out of my depth, and that if I couldn't find some grounding that he would end up an inpatient because I couldn't find, I just couldn't find the resources to keep him at home' (Interview05, parent) 'You're kind of in the dark, and you can't be in the dark and care properly for someone if you don't know what they need.' (Interview01, parent) 'I didn't understand what I needed to do, what I was doing wrong. But the crisis team talked me through different ways of dealing with it and different ways of coping. Like doing ice dives, and holding ice in her

	hands and breathing techniques and stuff. So they were really good'. (Interview11, parent)
	'It would be nice to have maybe even like a group that you could go to and say, you know, 'this happened today and I wasn't really too sure how to deal with it'. And to have more reassurance if that makes sense' (Interview11, parent)
	'as a single parent … it would be better to be able to access organisations without long trauling searches on the internet - there is simply not enough time in the day to take the whole burden' (Survey11, parent)
Service access	'Having 24/7 communication via telephone made me feel a lot safer at home and outside' (Survey38, child)
	'The fact that they can kick in so quickly, I think is absolutely vital … I think the fact that it kicks in within 24 hours is just- A) it's brilliant, that it can be done, that that can be managed that way. And B) it's just absolutely crucial so the parents don't just come apart at the seams' (Interview08, parent)
	'me and [child] both agree that actually having been told, "This is what you're going to have, we are going to come and knock on your door

	every day and we are going to come and see you", you know, probably would have been more helpful … a more structured approach … because she, umm, it's in her nature just to, to avoid things' (Interview07, parent)
	'Sometimes I get frustrated by having to ring crisis and them saying 'oh, well, we can't take your call at the moment but we'll ring you back in half an hour'. And you think oh, well, the crisis might have escalated in half an hour, it might be over in half an hour. You know sometimes it's there in that moment that you need them. … I did get through it. But what if I hadn't though? What if I hadn't have got through it and she did run away and did something silly?' (Interview11, parent)
Need for improved liaison	'I was kind of passed around between different places, like CAMHS and social workers and stuff like that and it felt very kind of like disjointed, maybe. So it was kind of like, I didn't know if I was coming or going or who was going to be there' (Interview10, child)
	'There's the crisis team, there's getting more help, and some other teams. I mean, from my perspective as a parent, I don't care what team she's with. It's like when you go into a shop, and they say 'well, oh, I'm sorry but I didn't serve you, that's nothing to do with me. We need to find whoever it was that served you'. You're all representative of the same service to someone on the receiving end' (Interview01, parent)

	'I think the frustration because we had police involved, school involved, GP involved ... I mean it was just all, so many elements and nothing really working and nothing joined up. You know, the police weren't joining up with CAMHS, weren't joining up with school, um there was a safeguarding issue at that time as well and that wasn't- all those parallel services were sort of involved, but not really.' (Interview04, parent)
Clearer service information	'I was kind of worried that they'd go after like two months 'Okay, well you've been under CAMHS crisis, we think you're getting better' or something like that, or 'we don't think you need to talk to us anymore', something like that, I don't know. I just didn't want CAMHS crisis to get in the way … I wanted to receive support from them but I still wanted to make sure that I saw CAMHS' (Interview12, child)
	'At that point I wasn't taking on board you know, how it was all supposed to work and who was who, I couldn't remember people's names … I didn't know when I needed to call them really, or I didn't know that they would be people to help, because there was a couple of occasions when I was really worried … the GP rang me back and said you know, we were in the hands of the Crisis team and they would deal with applications like that, it wasn't a GP's job. … I think at that point I realised that I didn't actually know what Crisis do' (Interview06, parent)

	'What they didn't seem to do was have any sort of a card or anything. I remember writing the number down on a scrappy bit of paper and then losing it, you know because I was in a bit of a state' (Interview08, parent)
Long-term approach important	'If it fed into the longer term planning it would be more effective I think … think I thought they would be um deeper, and more in depth, I thought they fed into something, I just wasn't so aware of them as sort of you know stand-alone … You know you were just getting 'okay keep yourself safe, put the knives away, put the alcohol away, call us if she goes missing'. But then that didn't seem to feed into anything, and even if people said it did, there was never any hint that that has actually been, you know, used in terms of her care planning moving forward, those crisis discussions. So just my feeling as a parent was that they didn't impact on her long term care planning. But maybe they did, but it didn't feel like that' (Interview04, parent)
	'Frighteningly CAMHS is only interested in offering proper support when the young person is not coping, surely by working with them earlier the crisis points would not occur and the risk would be significantly reduced' (Survey13, parent)
	'Earlier intervention, maybe prolong the treatment, but then also equally important to make sure that if the wheels come off again, there

is some way of helping yourself or some way of contacting someone you've previously seen, accessing some help. Rather than 'oh, you've now been discharged, sorry you have to go back to square one again and phone the GP, wait eight months' … It would feel less desperate. Less hopeless. And just like *'oh yeah. I remember this bad place. I'm in a bad place again. But don't worry, I know what to do this time. You know, I can easily reach out'*. I don't know how we would ever afford that level of care but I think that's what's needed' (Interview01, parent)

Appendix L (SIP)

Full Service Recommendations

Responding to Distress

Most survey participants described that staff were warm in their interactions. This was a real strength that was highlighted in the surveys.

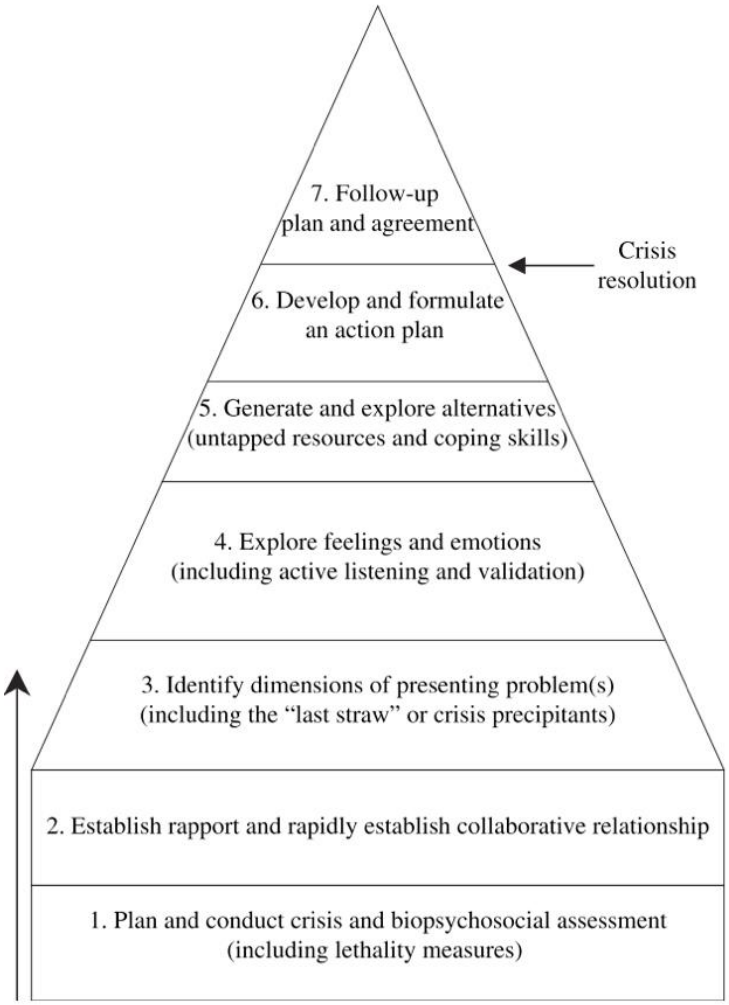
However, some areas for improvement have been highlighted when responding to distress. Many of these suggestions came from interviews with young people and parents:

- Some participants suggested that **validation** could be improved in the service. Suggestions included spending time listening to the individual before giving advice, and asking follow-up questions (e.g. when children and young people (CYP) phone in distress).
- Several CYP also said that advice sometimes felt generic and suggested that care could be more **individualised**. Suggestions included exploring their interests and pre-existing coping strategies, and tailoring advice to the individual.
- The above information could be captured in individual **crisis care plans**, so that staff can easily refer to it when a young person calls. This would still be important to use in conjunction with exploratory questions. Care plans could include:
    - The individual's needs and goals
    - Style of interaction/communication tips
    - Interests and coping strategies
    - What they find helpful/unhelpful
- It may also be helpful to follow the **Seven-Stage Crisis Intervention Model** (Roberts & Ottens, 2005) (see below). This could be a way for staff to structure responses in crisis

conversations, including CYP calls to the telephone line. This model could be introduced in a team meeting and included in the briefing document for crisis staff.

- When speaking with a CYP in distress, be careful **not to assume familiarity** with mindfulness and other DBT techniques.
- One possibility is that busy shifts, repeated exposure to CYP distress and/or ongoing burnout might lead to some desensitisation and lower levels of compassion. This should be explored with all staff and supported offered as necessary (e.g. reflective practice groups, mindfulness practice, recognition initiatives).

Roberts and Ottens (2005) Seven Stage Crisis Intervention Model



Identify Goals

71.4% of CYP and 35.3% of parents in the survey felt their care was matched to their needs.

- Some parents and CYP felt the care they received was not tailored to match their needs and goals. This may be improved by identifying goals and needs with service users from the outset.

Engaging CYP

Many parents felt that the support for their child was excellent. The engagement of CYP may be further improved with the below suggestions.

- Explore and address any CYP concerns that may impact engagement, including clear explanation of confidentiality to all clients from the outset.
- Offer flexibility to CYP in format of appointments (e.g. phone, visit) with some understanding of motivation issues.
- If there is continued non-engagement, consider a more proactive approach with visits (and explain this from outset). *It is of note that the number of visits to this sample will have been affected by the pandemic.*

Parents: Support and Involve

Parents spoke positively about the service's practical support for their needs. Some felt they had also received good emotional support; however, others felt this could be improved.

- It is important to offer support for parents in addition to CYP.
    - Ensure a consistent understanding across the team of what support is and is not available for parents (e.g. separate calls, access to 24-hour telephone line) and ensure this is clearly explained to families as part of initial contacts.

    - Consider facilitating a parent support group.
    - Offering an assessment of parents' needs and a carer support plan would be valuable (at present, few parents report receiving this).
- Parental involvement at assessment (separate meetings with parent and child) and discharge (consider inviting parent) is important where possible.

Written Information

- Develop easily accessible information to introduce the crisis service, that can be given to all families both on paper and by email. This will help to clarify the service role. Share this with families from the outset and consider co-producing with service users (CYP and parents). Include:
    a. The service number
    b. The service aims
    c. The distinctions between CAMHS teams
    d. Explanation of what to expect from crisis care
    e. Explanation of the short-term nature of the service within context of a longer-term journey
    f. What crisis can and cannot be contacted for, and who to contact when crisis is not appropriate (e.g. violence, urgent care)
- Develop a resource list with numbers for charities/support services and resources to understand particular mental health difficulties. Ensure this is easily tailored to each family. Share with families from outset and with CAMHS services.
- Some parents mentioned receiving a written care plan as a positive experience. Offering this consistently to CYP and their families would be valuable.

Discharge

Several parents said that the service was high quality and they found it difficult to lose the support upon discharge. The following discharge support was offered to some participants, but not all. Where possible, it would be helpful to:

- Routinely hold a discharge meeting to agree a plan, share information, and say goodbye
- Give notice before discharge and offer a gentle end by tapering sessions.
- Develop and share (if appropriate) a plan for CYP to cope with future difficulties, as part of the discharge process

Service Issues

Many parents and CYP strongly valued the 24-hour access to crisis support. Suggestions below may further improve service access and address other service issues:

- Any opportunity for additional staff to ensure maximum availability on the telephone line would be valuable.
- Consider the language of telling people they are 'not on the list', and why families have reported they have been mistakenly told this.
- Consider ways to improve liaison with other CAMHS teams and agencies. For example, particular CAMHS workers with additional training and links to specialist teams (e.g. specialist substance misuse worker), establishing regular meetings with other agencies to discuss all shared cases, or organising multi-agency meetings for particular active cases.
- Consider ways to allow for staff consistency in interactions with CYP and parents. For example, having 1-2 named workers.

- Allow opportunities for CYP to provide feedback after contact with the crisis team (e.g. I Want Great Care), review and act on feedback.

Appendix M (SIP)

Journal Guidelines

1. What do we publish?

1.1 Aims & Scope

Before submitting your manuscript to Clinical Child Psychology and Psychiatry, please ensure you have read the Aims & Scope.

> ***Aims and Scope:*** *Clinical Child Psychology and Psychiatry brings together clinically oriented, peer reviewed work of the highest distinction from an international and multidisciplinary perspective, offering comprehensive coverage of clinical and treatment issues across the range of treatment modalities.*
>
> *Clinical Child Psychology and Psychiatry is interested in advancing theory, practice and clinical research in the realm of child and adolescent psychology and psychiatry and related disciplines.*
>
> *The journal directs its attention to matters of clinical practice, including related topics such as the ethics of treatment and the integration of research into practice.*
>
> *Multidisciplinary in approach, the journal includes work by, and is of interest to, child psychologists, psychiatrists and psychotherapists, nurses, social workers and all other professionals in the fields of child and adolescent psychology and psychiatry.*

1.2 Article Types

Clinical Child Psychology and Psychiatry is interested in advancing theory, practice and clinical research in the realm of child and adolescent psychology and psychiatry and related disciplines. Articles should not exceed 6,000 words (including abstract, references, tables and all other elements) and be clearly organized, with a clear hierarchy of headings and subheadings (3 weights maximum). Manuscripts exceeding the word limit cannot be considered for publication by the editor.

1.3 Writing your paper

The SAGE Author Gateway has some general advice and on how to get published, plus links to further resources.

1.3.1 Make your article discoverable

When writing up your paper, think about how you can make it discoverable. The title, keywords and abstract are key to ensuring readers find your article through search engines such as Google. For information and guidance on how best to title your article, write your abstract and

select your keywords, have a look at this page on the Gateway: How to Help Readers Find Your Article Online.

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2. Editorial policies

2.1 Peer review policy

The Editor will screen manuscripts for their overall fit with the aims and scope of the journal, especially in terms of having clear relevance for clinicians. Those that fit will be further reviewed by two or more independent reviewers in terms of merit, readability and interest.

As part of the submission process you will be asked to provide the names of [X no.] peers who could be called upon to review your manuscript. Recommended reviewers should be experts in their fields and should be able to provide an objective assessment of the manuscript. Please be aware of any conflicts of interest when recommending reviewers. Examples of conflicts of interest include (but are not limited to) the below:

- The reviewer should have no prior knowledge of your submission
- The reviewer should not have recently collaborated with any of the authors
- Reviewer nominees from the same institution as any of the authors are not permitted

Please note that the Editors are not obliged to invite/reject any recommended/opposed reviewers to assess your manuscript.

2.2 Authorship

All parties who have made a substantive contribution to the article should be listed as authors. Principal authorship, authorship order, and other publication credits should be based on the relative scientific or professional contributions of the individuals involved, regardless of their status. A student is usually listed as principal author on any multiple-authored publication that substantially derives from the student's dissertation or thesis.

2.3 Acknowledgements

All contributors who do not meet the criteria for authorship should be listed in an Acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, or a department chair who provided only general support.

Any acknowledgements should appear first at the end of your article prior to your Declaration of Conflicting Interests (if applicable), any notes and your References.

2.3.1 Third party submissions

Where an individual who is not listed as an author submits a manuscript on behalf of the author(s), a statement must be included in the Acknowledgements section of the manuscript and in the accompanying cover letter. The statements must:

- Disclose this type of editorial assistance – including the individual's name, company and level of input
- Identify any entities that paid for this assistance
- Confirm that the listed authors have authorized the submission of their manuscript via third party and approved any statements or declarations, e.g. conflicting interests, funding, etc.

Where appropriate, SAGE reserves the right to deny consideration to manuscripts submitted by a third party rather than by the authors themselves.

2.4 Funding

It is the policy of Clinical Child Psychology and Psychiatry to require a declaration of conflicting interests from all authors enabling a statement to be carried within the paginated pages of all published articles.

Please ensure that a 'Declaration of Conflicting Interests' statement is included at the end of your manuscript, after any acknowledgements and prior to the references. If no conflict exists, please state that 'The Author(s) declare(s) that there is no conflict of interest'. For guidance on conflict of interest statements, please see the ICMJE recommendations here.

2.5 Declaration of conflicting interests

Clinical Child Psychology and Psychiatry encourages authors to include a declaration of any conflicting interests and recommends you review the good practice guidelines on the *SAGE Journal Author Gateway.*

It is the policy of Clinical Child Psychology and Psychiatry to require a declaration of conflicting interests from all authors enabling a statement to be carried within the paginated pages of all published articles.

Please ensure that a 'Declaration of Conflicting Interests' statement is included at the end of your manuscript, after any acknowledgements and prior to the references. If no conflict exists, please state that 'The Author(s) declare(s) that there is no conflict of interest'. For guidance on conflict of interest statements, please see the ICMJE recommendations here

2.6 Research ethics and patient consent

Medical research involving human subjects must be conducted according to the World Medical Association Declaration of Helsinki.

Submitted manuscripts should conform to the ICMJE Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals, and all papers reporting animal and/or human studies must state in the methods section that the relevant Ethics Committee or Institutional Review Board provided (or waived) approval. Please ensure that you have provided the full name and institution of the review committee, in addition to the approval number.

For research articles, authors are also required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal.

Information on informed consent to report individual cases or case series should be included in the manuscript text. A statement is required regarding whether written informed consent for patient information and images to be published was provided by the patient(s) or a legally authorized representative.

Please also refer to the ICMJE Recommendations for the Protection of Research Participants

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3. Publishing Policies

3.1 Publication ethics

Clinical Child Psychology and Psychiatry and SAGE take issues of copyright infringement, plagiarism or other breaches of best practice in publication very seriously. We seek to protect the rights of our authors and we always investigate claims of plagiarism or misuse of published articles. Equally, we seek to protect the reputation of the journal against malpractice. Submitted articles may be checked with duplication-checking software. Where an article, for example, is found to have plagiarised other work or included third-party copyright material without permission or with insufficient acknowledgement, or where the authorship of the article is contested, we reserve the right to take action including, but not limited to: publishing an erratum or corrigendum (correction); retracting the article; taking up the matter with the head of department or dean of the author's institution and/or relevant academic bodies or societies; or taking appropriate legal action.

3.1.1 Plagiarism

If material has been previously published it is not generally acceptable for publication in a SAGE journal. However, there are certain circumstances where previously published material can be considered for publication. Please refer to the guidance on the SAGE Author Gateway or if in doubt, contact the Editor at the address given below.

3.1.2 Prior publication

Before publication, SAGE requires the author as the rights holder to sign a Journal Contributor's Publishing Agreement. SAGE's Journal Contributor's Publishing Agreement is an exclusive licence agreement which means that the author retains copyright in the work but grants SAGE the sole and exclusive right and licence to publish for the full legal term of copyright. Exceptions may exist where an assignment of copyright is required or preferred by a proprietor other than SAGE. In this case copyright in the work will be assigned from the author to the society. For more information please visit the SAGE Author Gateway.

3.2 Contributor's publishing agreement

Clinical Child Psychology and Psychiatry offers optional open access publishing via the SAGE Choice programme. For more information please visit the SAGE Choice website. For information on funding body compliance, and depositing your article in repositories, please visit SAGE Publishing Policies on our Journal Author Gateway.

3.3 Open access and author archiving

The preferred format for your manuscript is Word. LaTeX files are also accepted. Word and (La)Tex templates are available on the Manuscript Submission Guidelines page of our Author Gateway.

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4. Preparing your manuscript for submission

4.1 Formatting

The preferred format for your manuscript is Word. LaTeX files are also accepted. Word and (La)Tex templates are available on the Manuscript Submission Guidelines page of our Author Gateway

4.2 Artwork, figures and other graphics

For guidance on the preparation of illustrations, pictures and graphs in electronic format, please visit SAGE's Manuscript Submission Guidelines.

Figures supplied in colour will appear in colour online regardless of whether or not these illustrations are reproduced in colour in the printed version. For specifically requested colour reproduction in print, you will receive information regarding the costs from SAGE after receipt of your accepted article.

4.3 Supplementary material

This journal is able to host additional materials online (e.g. datasets, podcasts, videos, images etc) alongside the full-text of the article. For more information please refer to our guidelines on submitting supplementary files.

4.4 Reference style

Clinical Child Psychology and Psychiatry adheres to the APA reference style. View the APA guidelines to ensure your manuscript conforms to this reference style.

4.5 English language editing services

Authors seeking assistance with English language editing, translation, or figure and manuscript formatting to fit the journal's specifications should consider using SAGE Language Services. Visit SAGE Language Services on our Journal Author Gateway for further information.

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5. Submitting your manuscript

Clinical Child Psychology and Psychiatry is hosted on SAGE Track, a web based online submission and peer review system powered by ScholarOne™ Manuscripts.
Visit http://mc.manuscriptcentral.com/ccpp to login and submit your article online.

IMPORTANT: Please check whether you already have an account in the system before trying to create a new one. If you have reviewed or authored for the journal in the past year it is likely that you will have had an account created. For further guidance on submitting your manuscript online please visit ScholarOne Online Help.

If you would like to discuss your paper prior to submission, please refer to the contact details below

5.1 ORCID

As part of our commitment to ensuring an ethical, transparent and fair peer review process SAGE is a supporting member of ORCID, the Open Researcher and Contributor ID. ORCID provides a unique and persistent digital identifier that distinguishes researchers from every other researcher, even those who share the same name, and, through integration in key research workflows such as manuscript and grant submission, supports automated linkages between researchers and their professional activities, ensuring that their work is recognized.

The collection of ORCID iDs from corresponding authors is now part of the submission process of this journal. If you already have an ORCID iD you will be asked to associate that to your submission during the online submission process. We also strongly encourage all co-authors to link their ORCID ID to their accounts in our online peer review platforms. It takes seconds to do: click the link when prompted, sign into your ORCID account and our systems are automatically updated. Your ORCID iD will become part of your accepted publication's metadata, making your work attributable to you and only you. Your ORCID iD is published with your article so that fellow researchers reading your work can link to your ORCID profile and from there link to your other publications.

If you do not already have an ORCID iD please follow this link to create one or visit our ORCID homepage to learn more.

5.2 Information required for completing your submission

You will be asked to provide contact details and academic affiliations for all co-authors via the submission system and identify who is to be the corresponding author. These details must match what appears on your manuscript. At this stage please ensure you have included all the required statements and declarations and uploaded any additional supplementary files (including reporting guidelines where relevant).

5.3 Permissions

Please also ensure that you have obtained any necessary permission from copyright holders for reproducing any illustrations, tables, figures or lengthy quotations previously published elsewhere. For further information including guidance on fair dealing for criticism and review, please see the Copyright and Permissions page on the SAGE Author Gateway.

Appendix N (TDRP)

Sponsorship Letter

Professor Andrea Cipriani
Associate Director of Research & Development
Warneford Hospital
Warneford Lane
Oxford
OX3 7JX
Email:research@oxfordhealth.nhs.uk

29/10/2021

Confirmation of Capacity and Capability

Re: Self-Compassion and Hearing Voices
Research and Development Reference: 15389
IRAS Reference: 289071
Research Ethics Committee Reference: 21/LO/0587
NIHR Portfolio Ref: N/A
Sponsor: Oxford Health NHS Foundation Trust

Dear Hannah Goodison,

On behalf of Oxford Health NHS Foundation Trust, I am pleased to confirm Trust Capacity and Capability for the above research as outlined in the application received.

The study is not supported by a Research Delivery Team.

The study team members are as follows: Hannah Goodison, Craig Steel and Nicola Collett.

Approved Documents

Protocol Version 1.1 dated 16/09/2021 is recognised as the most current to date.

The documents approved for use at this Trust are as listed in the following approval documents:
Health Research Authority Letter dated: 15/10/2021
Research Ethics Full Approval Letter dated: 13/10/2021

Any subsequent, relevant amendments are additionally included to date.

Metrics and Recruitment

First participant target date: 08/11/2021
Recruitment target figure: 55
Recruitment target date: 31/03/2022
Anticipated study end date: 31/03/2022

To comply with national research performance requirements the Trust will monitor and publish recruitment for your study:
1.Performance of the recruitment of the first participant.
2.Recruiting planned participants to time and target.

Appendix O (TDRP)

HRA Letter

Professor Craig Steel
Academic Director
Oxford Health NHS Foundation Trust
Oxford Institute of Clinical Psychology Training & Research
Isis Education Centre, Warneford Hospital
OX3 7JXN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

15 October 2021

Dear Professor SteelN/A

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**The Contribution of Self-Compassion to our Current Understanding of Voice Hearing**
IRAS project ID:	**289071**
REC reference:	**21/LO/0587**
Sponsor	**Oxford Health NHS Foundation Trust**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix P (TDRP)

Additional Demographic Data

	n (%)
Are you aware of having any of the following diagnoses: (*n*=56)	
Depression	23 (41.1%)
An anxiety disorder	22 (39.3%)
Obsessive compulsive disorder (OCD)	9 (16.1%)
Schizophrenia	15 (26.8%)
Schizoaffective disorder	3 (5.4%)
Bipolar disorder	6 (10.7%)
Personality disorder	14 (25.0%)
Post traumatic stress disorder (PTSD)	11 (19.6%)
No diagnosis	3 (5.4%)
I don't know / prefer not to say	2 (3.6%)
Other[†]	14 (25.0%)[1]
Currently taking medication to help with voice(s) (*n*=56)	
Yes	37 (66.1%)
No	16 (28.6%)
I don't know / prefer not to say	3 (5.4%)
Experience of therapy (*n*=55)	
Received in the past	36 (65.5%)
Receiving it now	13 (23.6%)
I have never received it	5 (9.1%)
I don't know / prefer not to say	1 (1.8%)

Was (or is) the therapy to help with voices? (*n*=55)	
Yes	36 (65.5%)
No	13 (23.6%)
I don't know	2 (3.6%)
N/a (never received therapy)	4 (7.3%)
What was the type of therapy? (*n*=55)	
Cognitive behavioural therapy (CBT)	20 (36.4%)
Family therapy	4 (7.3%)
Acceptance and commitment therapy (ACT)	5 (9.1%)
Compassion focused therapy (CFT)	6 (10.9%)
Dialectical Behaviour Therapy (DBT)	6 (10.9%)
Psychodynamic Psychotherapy	10 (18.2%)
Cognitive Analytic Therapy (CAT)	9 (16.4%)
I don't know	16 (29.1%)
N/a (never received therapy)	4 (7.3%)
Other[‡]	5 (9.1%)[2]

Note. [†]Free text responses: Dissociative identity disorder (*n*=4); drug induced psychosis (*n*=1); psychosis (*n*=5); acute non organic psychosis (*n*=1); psychosis NOS (*n*=1); schizotypical personality disorder (*n*=1); waiting to see someone for an update (*n*=1). [‡]Free text responses: Care coordinator (*n*=1); EMDR (*n*=3); person-centred (*n*=1).

Appendix Q (TDRP)

Research Poster



Appendix R (TDRP)

Information Sheet

PAGE ONE: INTRODUCTION

'Hearing voices' might involve hearing a voice when other people are not around, or hearing a voice that others cannot hear. Some people might hear more than one voice.

This study also looks at self-compassion. Self-compassion involves being kind and understanding towards yourself.

We are looking to understand whether there is any relationship between self-compassion and voice hearing, and whether this offers any additional understanding to the treatment that is already widely used in the NHS.

Your experience is essential to our understanding of this relationship and we are interested to hear from you.

If you are interested to take part in this survey, please see the next page for more information.

Hannah Goodison, Professor Craig Steel, and Dr Nicola Collett, University of Oxford.

PAGE TWO: Information Sheet

This project is being undertaken to fulfil the requirements for a Doctorate in Clinical Psychology.

Who can take part?

We are surveying people who are over the age of 18 and hear voices. If this includes you, then you are eligible for this survey and we are interested to hear about your experiences.

What does it involve?

- The survey will take about 30 minutes to complete. You can take breaks throughout the survey if you need to but you will need to keep the survey open, because you will not be able to continue if you exit.
- We will also send you a second survey in four weeks. This is a much shorter questionnaire (which will take 5-10 minutes). This helps us to understand more about how things change over time. You do not have to complete this.
- If you would prefer to complete the survey over the telephone, please email the researcher (contact details below) to arrange a suitable time.
- You can exit the survey at any time, without giving a reason. However you will not be able to continue the survey if you exit the window. This would not affect your future care or any of your legal rights. Any data that you have already provided will still be available to the research team and will be included.
- If you would like to withdraw from the study, you can do so by emailing the research team (dclinpsychstudy3@oxfordhealth.nhs.uk) and request for your data to be removed from the study. This will only be possible whilst the survey is open; after this, data will be removed from the survey software and included in analysis.
- If you contact the research team with information that suggests you or somebody else may be at risk of harm, they may need to inform somebody to make sure that you and the people around you are safe.

What will happen to my information?

- All responses will be kept fully confidential.
- You will be asked to provide your name and email address in this survey to show your consent to take part. This will be stored separately to any of your survey responses. You will be asked to

provide a unique, memorable ID code which will be used to link your two survey responses instead of your name.

- This research will be submitted for publication in an academic journal. No identifiable information will be included.
- All data will be kept securely in line with the data protection policies of Oxford Health NHS Foundation Trust.
- You are welcome to contact the researcher for more information about confidentiality or any further questions you may have (contact details below).

  All data collected will be collected in line with the Data Protection Act 2018 and GDPR (General Data Protection Regulations). Data collection will also comply with the Common Law Duty of confidentiality. Oxford Health NHS Foundation Trust is the data controller and is responsible for looking after your information and using it properly.

  Health and care research should serve the public interest, which means that we have to demonstrate that our research serves the interests of society as a whole. We do this by following the UK Policy Framework for Health and Social Care Research. Data protection regulation requires that we state the legal basis for processing information about you. In the case of research, this is 'a task in the public interest.'

  You can find out more about how we use your information

  - at www.hra.nhs.uk/information-about-patients/
  - our Trust website - https://www.oxfordhealth.nhs.uk/privacy/
  - by contacting one of the research team [Hannah.goodison@hmc.ox.ac.uk]

  If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter. If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to

the Information Commissioner's Office (ICO). Oxford Health's Data Protection Officer can be contacted on Mark.Underwood@oxfordhealth.nhs.uk."

We will delete any identifiable information about you immediately after the study has finished. This excludes any research documents with personal information, such as consent forms, which will be held securely at Oxford Health for five years after the end of the study.

Who can I contact if I need support?

The survey includes questions about hearing voices, self-compassion, and mood. It may be that some people find this difficult.

- If you are open to a mental health team, you can call your care coordinator (in office hours) or the out of hours crisis support (out of hours)
- Your GP (in office hours)
- NHS 111
- If you need immediate urgent support, you can call 999 or visit your local A&E department

This project has been reviewed and approved by the Oxford Health NHS Foundation Trust Research Ethics Committee, and is sponsored by Oxford Health NHS Foundation Trust. The research team includes: Hannah Goodison (dclinpsychstudy32oxfordhealth.nhs.uk), Professor Craig Steel and Dr Nicola Collett. If you have any questions or would like more information, please contact Hannah Goodison via email. You can close this window and come back to this survey at another time.

Appendix S (TDRP)

Consent Form

Self-Compassion and Hearing Voices

1. I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, to contact a researcher to ask questions, and have had any questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any consequences to me or my care. ☐
3. I understand that the information I provide as part of this study will be kept confidential and that the only exception would be if the researchers were concerned that I, or someone else, might be at immediate risk of serious harm. ☐
4. I understand that the research team will hold my personal details (e.g. name, contact details) for the duration of the study, in order to contact me for research purposes, and that following completion of the study, this information will be destroyed. ☐
5. I agree to take part in the above study. ☐

Would you like to be sent a summary of the results of this research?

- Yes ☐
- No ☐

Name: ……

As part of Oxford Health NHS requirements, we need participants to provide their name to show consent to take part.

Email address: ……..

We will use your email address to email you a copy of this form and to send you the link to the second survey.

Unique code: ……..

To make your non-identifier code, please use the first three letters of your mother's maiden name and last two numbers of your birth year. We will ask for this code in the survey to link your two survey responses without using your name.

When you press submit, you will be sent to a message with a link to access the survey.

Appendix T (TDRP)

Screening Questions

Self-Compassion and Hearing Voices

How old are you?

- ○ 17 or younger
- ○ 18-24
- ○ 25-34
- ○ 35-44
- ○ 45-54
- ○ 55-64
- ○ 65-74
- ○ 75-84
- ○ 85 or older

Self-Compassion and Hearing Voices

This survey is for people that hear voices.
Please read the statements below and choose the option that best describes how frequently you experience your voices at the moment.

- ○ Voices not present or present less than once a week
- ○ Voices occur for at least once a week
- ○ Voices occur at least once a day
- ○ Voices occur at least once a hour
- ○ Voices occur continuously or almost continuously (i.e. stop for only a few seconds or minutes)

Appendix U (TDRP)

Debrief Sheet

Thank you so much for taking the time to complete this survey.

More Information About This Research

Whilst many people experience voices as a positive part of their lives, some people are distressed by them and seek help. The therapy that is most widely offered for hearing voices is Cognitive Behavioural Therapy (CBT). However, this approach is not helpful for everyone.

There is a growing interest in Compassion Focused Therapy, which is an alternative approach to treatment of hearing voices. This model suggests that increasing somebody's self-compassion can help them to respond differently to their voices and reduce their distress.

This research aims to explore whether there is a relationship between self-compassion and voice hearing, and whether it offers any additional understanding of hearing voices than the CBT approach.

Who You Can Contact for Support

We understand that some people might have found completing this survey difficult.

If you have found it difficult to complete this survey and you need support, these are some people who you can call:

- If you are open to a mental health team, you can call your care coordinator (in office hours)
- Your GP (in office hours)
- NHS 111
- If you need immediate urgent support, you can call 999 or visit your local A&E department.

A Final Thank You

Thank you for taking the time to complete this survey and to help us to understand more about this topic.

If you have any further questions about this research, please email dclinpsychstudy3@oxfordhealth.nhs.uk.

Appendix V (TDRP)

Questionnaires

Demographics Questions

These questions help us to learn more about who is completing this survey.

What is your ethnicity?

- Asian / Asian British
- Black / African / Caribbean / Black British
- White
- Mixed / multiple ethnic groups
- Prefer not to say
- Other:

What is your gender?

- Male
- Female
- Non-binary
- Prefer not to say

How long have you been hearing voices for?

- Less than 1 year
- 1-2 years
- 3-4 years
- 5-10 years
- 11 years or more

Where do you live?

- United Kingdom
- Europe
- North America
- South America
- Australasia
- Asia
- Africa
- Other:

Do you have a current diagnosis? Please tick all that apply.

- Depression
- Anxiety
- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder
- Personality disorder
- PTSD
- No diagnosis
- I don't know
- Other:

Are you currently taking medication to help with your experience of hearing voices?

- Yes
- No

- I don't know

Do you have any experience of psychological therapy?

- I have received it in the past
- I am receiving it now
- I have never received it
- I don't know

Was (or is) the therapy about the voices that you hear?

- Yes
- No
- I don't know
- N/A (I have never received therapy)

Which type of therapy was (or is) it? Please select all that apply.

- Cognitive behavioural therapy (CBT)
- Family therapy
- Acceptance and Commitment Therapy (ACT)
- Compassion focused therapy (CFT)
- Dialectical Behaviour Therapy (DBT)
- Psychodynamic psychotherapy
- Cognitive Analytic Therapy (CAT)
- I don’t know
- N/A (I have never received therapy)
- Other:

Hamilton Program for Schizophrenia Voices Questionnaire (HPSVQ) (Van Lieshout & Goldberg, 2007)

Please choose **ONE** box that best describes your experience of voices **DURING THE PAST WEEK**, including today.

How *frequently* did you hear a voice or voices?

No voices	Less than once a day	Once or twice a day	Several times a day	All the time/Constantly

How *bad* are the things the voices say to you?

No voices saying bad things	Not that bad	Fairly bad	Very bad	Horrible

How *loud* are the voices?

Voices not present	Very quiet (like whispering)	Average (same as my own voice)	Fairly loud	Very loud (yelling or shouting)

How *long* do the voices usually last?

Voices not present	A few seconds to 1 minute	A few minutes	More than 10 minutes but less than an hour	Longer than 1 hour/they just seem to persist

How much do the voices *interfere* with your daily activities?

No interference	A little bit	Moderately	Quite a bit	Extremely interfering

How *distressing* are the voices that you hear?

No voices are distressing me	A little bit	Moderately	Quite a bit	Extremely distressing

How *bad* (worthless/useless) do the voices make you *feel about yourself?*

No voices make me feel bad	A little bit	Fairly bad	Very bad	Extremely bad (as bad as I can feel)

How *clearly* do you hear the voices?

Voices not present	Very mumbled	Fairly mumbled	Fairly clear	Very clear voices

How often do you DO what the voices say?

No voices telling me what to do	Rarely	Sometimes	Often	Always

---

In what *part of the day* do you hear the voices most often?[a]

Right when I wake up	Morning	Afternoon	Evening	Just before bed	The voices are equally as likely at all times of the day

What kind of *social situations* are you in most often when your voices start?

When I am alone	When I am with a few people (like in 'group')	When I am around a lot of people (like in a mall or on a busy street)	No situation in particular/they occur equally in all social situations

Where do the voices come from?[a]

From Inside my head	From Outside my head	From both Inside and Outside

Would you say the last week is like a *typical* week of your hearing voices?[a]

Yes	No (Please explain below)

[a] These items are qualitative in nature and are not included in the calculation of the total score.

Self-Compassion Scale-Short Form (SCS-SF) (Raes et al., 2011)

Please read each statement carefully before answering. Below each item, indicate how often you behave in this way from 1 (almost never) to 5 (almost always).

	1 (almost never)	2	3	4	5 (almost always)
1. When I fail at something important to me I become consumed by feelings of inadequacy.					
2. I try to be understanding and patient towards those aspects of my personality I don't like.					

3.. When something painful happens I try to take a balanced view of the situation.					
4.. When I'm feeling down, I tend to feel like most other people are probably happier than I am.					
5. I try to see my failings as part of the human condition.					
6. When I'm going through a very hard time, I give myself the caring and tenderness I need.					
7. When something upsets me I try to keep my emotions in balance.					
8.. When I fail at something that's important to me, I tend to feel alone in my failure.					
9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.					
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.					
11. I'm disapproving and judgmental about my own flaws and inadequacies.					
12. I'm intolerant and impatient towards those aspects of my personality I don't like.					

Brief Core Schema Scales (BCSS) (Fowler et al., 2006): Negative Self-Schema Subscale

This section lists beliefs that people can hold about themselves. Please indicate whether you hold each belief (and how strongly).

Try to judge the beliefs on how you have generally, over time, viewed yourself. Do not spend too long on each belief. There are no right or wrong answers and the first response to each belief is often the most accurate.

	0 No	1 Yes, believe it slightly	2 Yes, believe it moderately	3 Yes, believe it very much	4 Yes, believe it totally
1. I am unloved					
2. I am worthless					
3. I am weak					
4. I am vulnerable					
5. I am bad					
6. I am a failure					

Depression Anxiety Stress Scales (21-item short-form) (DASS-21) (P. F. Lovibond & Lovibond, 1995): Depression Subscale

Please read each statement and indicate how much the statement applied to you **over the past week.** There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- NEVER: Did not apply to me at all
- SOMETIMES: Applied to me to some degree, or some of the time
- OFTEN: Applied to me to a considerable degree, or a good part of time
- ALMOST ALWAYS: Applied to me very much, or most of the time

	0 Never	1 Sometimes	2 Often	3 Almost always
1. I couldn't seem to experience any positive feeling at all				
2. I found it difficult to work up the initiative to do things				
3.. I felt that I had nothing to look forward to				
4. I felt down hearted and blue				
5. I was unable to become enthusiastic about anything				
6. I felt I wasn't worth much as a person				
7. I felt that life was meaningless				

Voice Content Measure (adapted from Mayhew and Gilbert (2008))

Critical Voices

This section is to understand more about any **critical voices** that you have had in the last week.

This would include any voices that you hear that are negative or critical.

Thinking back over the last week...

How often did you have critical voices?

1 (I had none)	2	3	4	5	6	7	8	9	10 (a lot of the time)

How powerful were your critical voices?

1 (not at all)	2	3	4	5	6	7	8	9	10 (very powerful)

How intrusive were your critical voices?

1 (not at all)	2	3	4	5	6	7	8	9	10 (very intrusive)

How long did your critical voices last?

1 (fleetingly)	2	3	4	5	6	7	8	9	10 (most of the day)

How distressed were you by your critical voices?

1 (not at all)	2	3	4	5	6	7	8	9	10 (very distressed)

How angry/hostile were your critical voices?

1 (not at all)	2	3	4	5	6	7	8	9	10 (very harrassing)

Soothing Voices

This section is to understand more about any **soothing voices** that you have had in the last week. This would include any voices that you hear that are soothing or reassuring.

Thinking back over the last week...

How often did you have soothing voices?

1 (I had none)	2	3	4	5	6	7	8	9	10 (a lot of the time)

How powerful were your soothing voices?

1 (not at all)	2	3	4	5	6	7	8	9	10 (very powerful)

How intrusive were your soothing voices?

1 (not at all)	2	3	4	5	6	7	8	9	10 (very intrusive)

How long did your soothing voices last?

1 (fleetingly)	2	3	4	5	6	7	8	9	10 (most of the day)

How comforting were your soothing voices?

1 (not at all)	2	3	4	5	6	7	8	9	10 (very comforting)

How calming/pleasant were your soothing voices?

1 (not at all)	2	3	4	5	6	7	8	9	10 (very calming/pleasant)

Appendix W (TDRP)

Hierarchical Regression Models

Table W1

Summary of Hierarchical Model for Predictors of Voice-Related Distress (Hypothesis One, T1)

	Outcome: Voice-Related Distress			
	Model 1		Model 2	
Variable	*B*	*β*	*B*	*β*
Mood	.047**	.441	.035*	.329
Negative Self-Schema	.042	.220	.014	.074
Self-compassion			-.049*	-.355
R^2	.365		.437	
F	14.976***		13.187***	
R^2 change			.071	
F change			6.463*	

Note. *N*=55. *B* = unstandardised coefficient; *β* = standardised coefficient; *p<0.05, **p<0.01, ***p<0.001. One outlier data point has been removed for this analysis.

Table W2

Summary of Hierarchical Model for Predictors of Critical Voice Content (Hypothesis Two, T1)

	Outcome: Critical Voice Content			
	Model 1		Model 2	
Variable	*B*	*β*	*B*	*β*
Mood	-.077***	-.555	-.066***	-.474
Negative Self-Schema	-.034	-.137	-.007	-.029
Self-compassion			.046	.256
R^2	.424		.460	
F	19.468***		14.750***	
R^2 change			.036	
F change			3.488	

Note. *N*=56. *B* = unstandardised coefficient; *β* = standardised coefficient; *p<0.05, **p<0.01, ***p<0.001.

Table W3

Summary of Hierarchical Model for Predictors of Soothing Voice Content (Hypothesis Three, T1)

	Outcome: Soothing Voice Content			
	Model 1		Model 2	
Variable	*B*	*β*	*B*	*β*
Mood	-.065	-.051	.183	.145
Negative Self-Schema	-.197	-.086	.375	.163
Self-compassion			1.030***	.628
R^2	.015		.251	
F	.402		5.692**	
R^2 change			.236	
F change			16.041***	

Note. *N*=55. *B* = unstandardised coefficient; *β* = standardised coefficient; *p<0.05, **p<0.01, ***p<0.001.

Table W4

Summary of Hierarchical Model for Predictors of Critical Voice Content (Exploratory Longitudinal Analysis, T1 and T2)

	Outcome: Critical Voice Content (T2)			
	Model 1		Model 2	
Variable	*B*	*β*	*B*	*β*
Mood (T1)	-.325	-.240	-.243	-.180
Negative Self-Schema (T1)	1.400	.536	.438	.168
Self-Compassion (T1)			-.602	-.418
R^2	.130		.202	
F	1.637		1.773	
R^2 change			.073	
F change			1.909	

Note. *N*=25. *B* = unstandardised coefficient; *β* = standardised coefficient; **p*<0.05, ***p*<0.01, ****p*<0.001.

Table W5

Summary of Hierarchical Model for Predictors of Soothing Voice Content (Exploratory Longitudinal Analysis, T1 and T2)

	Outcome: Soothing Voice Content (T2)			
	Model 1		Model 2	
Variable	*B*	*β*	*B*	*β*
Mood (T1)	.565	.388	.507	.348
Negative Self-Schema (T1)	-2.113*	-.751	-1.431	-.508
Self-compassion (T1)			.427	.275
R^2	.227		.259	
F	3.235		2.444	
R^2 change			.032	
F change			.892	

Note. *N*=25. *B* = unstandardised coefficient; *β* = standardised coefficient; *p<0.05, **p<0.01, ***p<0.001.

Appendix X (TDRP)

Journal Guidelines

Guidelines:

4. PREPARING THE SUBMISSION

Free Format Submission

British Journal of Clinical Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-blind peer review policy. Anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

- An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at **https://www.editorialmanager.com/bjcp/default.aspx** and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use **this template** for your title page. The title page should contain**:**

i. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
ii. A short running title of less than 40 characters;
iii. The full names of the authors;
iv. The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
v. Abstract;
vi. Keywords
vii. Data availability statement (see Data Sharing and Data Accessibility Policy);
viii. Acknowledgments.

Authorship

Please refer to the journal's Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the **Project CRediT** website for a list of roles.

Abstract

Please provide a structured abstract under the headings: Objectives, Methods, Results, Conclusions. For Articles, the abstract should not exceed 250 words. For Brief Reports, abstracts should not exceed 120 words.

Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

Keywords

Provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet points, following the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice. (The Practitioner Points should be submitted in a separate file.)

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

i. Title
ii. Main text
iii. References
iv. Tables and figures (each complete with title and footnotes)
v. Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Do not mention the authors' names or affiliations and always refer to any previous work in the third person.
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References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

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Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

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Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

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For guidelines on editorial style, please consult the **APA Publication Manual** published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Wiley Author Resources

Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available **here.** In particular, we encourage authors to consult Wiley's best practice tips on **Writing for Search Engine Optimization**.

Article Preparation Support: **Wiley Editing Services** offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

Also, check out our resources for **Preparing Your Article** for general guidance and the **BPS Publish with Impact infographic** for advice on optimizing your article for search engines.