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**Helpful factors and outcomes in person-centered therapy with clients who experience
psychotic processes: Therapists' perspectives**

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Wendy Traynor is a doctoral research student at the University of Strathclyde who is conducting a mixed method study of person-centered practice with clients who experience psychotic processes. Phase one (detailed here) consisted of practitioner interviews. Phase two (in process) involves an outcome study and systematic case studies.

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Helpful factors and outcomes in person-centered therapy with clients who experience psychotic processes: Therapists' perspectives

Abstract. This qualitative study explores person-centered practitioners' perceptions of what is helpful in their work with clients who experience psychotic processes and the impact that they believe this practice has on their clients. In-depth interviews with twenty British person-centered practitioners focused on how they worked with clients who experienced psychotic process, what they perceived as helpful, and how they believed these practices helped their clients. Analyses used a grounded theory approach. In addition to standard person-centered therapy, practices with this client group often incorporated pre-therapy and other elements acquired through advanced training. Emerging themes in perceived useful practice included "getting beyond labels and illness" and "working with particular care and attention." Results suggest the importance of specific therapeutic conditions, especially unconditional positive regard. The perceived therapeutic change most often described was increased social adjustment. Some clients were also perceived by therapists as showing lessened risk of harm to self or others and improvement in self awareness, mood, resilience and other areas.

Keywords: person-centered therapy, helpful factors, pre-therapy, psychotic processes, qualitative research

Helpful factors and outcomes in person-centered therapy with clients who experience psychotic processes: Therapists' perspectives

Psychotic processes may involve hearing voices, other hallucinations, delusions or paranoia, unusual or disturbed thinking or behavior. Psychotic processes present important challenges for therapies of all orientations. Some clients who experience such processes may not respond well to standard psychotherapy formats and may benefit from flexible, creative and multi-disciplinary packages of care. In person-centered therapy (PCT), psychosis was recognized as an important challenge by Rogers, Gendlin, Kiesler and Truax (1967) when they undertook the Wisconsin Schizophrenia project. Although seen for most of the past forty years as a disappointment (Kirschenbaum, 2007), it is now becoming increasingly obvious that this study was significant in demonstrating some degree of positive outcomes in this client group, particularly when clients were more in 'contact' (Rogers 1967b). In this paper, we examine the accumulated wisdom of a group of experienced PCT therapists who have worked with clients with psychotic processes. The purpose of this study is to develop further understanding and evidence for work with this underserved and critically important population.

A person-centered understanding of psychosis emerged with early writings by Rogers (1951) and was later developed by a range of authors. For instance, Holdstock and Rogers (1977) state:

if experiences are extremely incongruent with the self-concept, the defense system will be inadequate to prevent the experiences from overwhelming the self concept. When this happens the self concept will break down, resulting in disorganization of behavior. This

is conventionally classified as psychosis when the disorganization is considerable. (p. 136).

For Prouty (1990, 1994), clients who experience psychotic processes may have impaired contact with “self”, “world” and “other.”

Warner (2001a, p.183) suggests that a psychotic style of processing is evident in clients “when they have difficulty forming narratives about their experience that make sense within the culture or which offer a predictive validity in relation to their environment.”

Perceptions of helpful and hindering practices

Berghofer (1996) felt that transparency and openness could lead to a deeper relationship with persons diagnosed with schizophrenia, thus enabling them to develop greater trust and saw the establishment and maintenance of a reliable interpersonal relationship as the most important element (p.492).

Berghofer (1996) described how an emphasis on diagnosis hinders the establishment of an authentic relationship, citing Rogers’ (1951) criticism of diagnosis as detrimental and linking it to adoption of an expert role by the therapist. However, Rogers (1957) later modified his position, admitting that diagnosis could sometimes help therapists encounter clients with real empathy and acceptance. More recently, the debate surrounding diagnosis has continued with mixed views. For example, Van Blarikom (2006) views schizophrenia as an illness whilst Read (2004) argued that there is no validity to a diagnosis such as schizophrenia. Sanders (2007)

described diagnosing distress as an illness as potentially damaging. Warner (2001, 2007) took a third position and referred to process diagnosis rather than person diagnosis.

Various views exist in relation to the importance of specific therapeutic conditions. Sommerbeck (2003) discussed how UPR is the primary therapeutic factor in the work with clients seen in psychiatric settings. She attributed this to a more shallow level of experiencing and more external focus of evaluation on the part of the clients typically seen in these setting. She saw a lack of UPR as the primary obstacle in the out of contact client with empathic understanding limited because the therapist can not experience the inner framework of the client. Rogers et al.'s (1967b) Wisconsin project findings also pointed to the critical nature of UPR with clients with a diagnosis of schizophrenia, for whom the real relationship seemed to be more pivotal. Prouty (2001) suggested that people judged and labeled may "suffer many conditions of worth" (p.78), making UPR more important.

Shlien (2003) named therapist congruence as the most important condition with schizophrenia. The importance of congruence is also discussed by Mearns and Thorne (1988), who suggested that when people are psychotic they are by definition at least partly divorced from external reality; thus, a consistent human relationship where the counselor "gives the client a clear picture of her part of that external reality is of paramount importance" (p.94). On the other hand, Warner (2000) discussed the importance of sensitivity in the use of congruence with fragile, dissociated, and difficult process.

Shlien (2003) also discussed the importance of empathy. He wrote:

“I would like especially to note that in dealing with the schizophrenic the therapist at his best, empathizes with the client’s world as it is at that moment and the meanings it has for the client at that moment whether it is wildly bizarre delusion, a moment of essentially rational self-control or a chaotic disorganisation.” (p. 47).

Similarly, Warner (2001a) emphasized the particular importance of empathy and relational depth in difficult process, while Berghofer (1996) discussed disabling therapist reactions including fear and how to get beyond such obstacles in order to stay with the emotional experience of the client.

Warner (2001a) saw boundaries and contracting as important whilst Berghofer (1996) discussed issues of closeness, distance and boundaries and the need for flexibility. Lambers (2003) discussed the crucial nature of therapeutic context and attention to issues such as a safe holding environment. Mearns (2003) also discussed contextual issues and flexibility of working, balanced against being fully in control of the work, working within limits and being fully supported.

Although its outcome results are generally uninterpretable, the Wisconsin Study (Rogers, Gendlin, et al, 1967) found that that UPR and genuineness appeared to be the most effective elements for this client group. The therapy group had a slightly better rate of hospital discharge and showed positive personality changes, less psychological vulnerability and was better able to deal with themselves and their environments. According to Rogers (1967b), the study showed an overall reduction in psychopathology in both PCT and usual treatment groups thus PCT did not demonstrate any particular advantage in reducing psychopathology, or in improved ability to handle relationships. The study also found that less disturbed patients had more helpful

experiences of PCT. Rogers noted that his results indicated that “the deeply disturbed psychotic” was unable to perceive or report understanding, warmth and genuineness to the same degree as the less disturbed person. However, as therapy progressed Rogers noted that the patients became able to perceive a higher level of these therapist conditions (Rogers, 1967b, p. 75) Finally, over the past fifteen years, Prouty (1990) and colleagues’ writings on the theory and practice of pre-therapy (see also Sanders 2007c) has become increasingly conceived as an effective way to help clients re-establish contact functions when these have been disrupted by, for example, psychotic process. Pre-therapy is a person-centred approach to restoring psychological contact — a prerequisite to engaging in a relationship. Once there is a shared reality the client may be more able to benefit from therapy or other contact.

Perceived changes as a consequence of PCT

Teusch et al (1983) reported a study in Essen involving PCT within a multidimensional therapy model including drug therapy with sixty patients with a schizophrenia diagnosis involving a total of 517 sessions for all clients combined. Improvements were shown in areas of reduced psychopathology and better social adjustment. The study found evidence of personality change over therapy, with clients becoming less emotionally distanced and less vulnerable, having fewer physical complaints, and reporting less depressive mood. Patient self-assessment showed more self confidence and sociability, with less frustration and less restraint (Teusch, 1990). Seventy-five percent of patients (excluding three patients who dropped out) “showed a distinct reduction in psychopathology and a distinctly better social adjustment on a global clinical rating” (Teusch, 1990, p.639).

Warner's (2001b) case study of Luke, a man diagnosed with schizophrenia, also showed increased engagement in social activities amongst other positive changes.

Prouty's work (1990) has become increasingly influential in addressing the issue of establishing psychological contact and Pre-therapy research studies (reviewed by Prouty, 1990, and Dekeyser, Prouty & Elliott, 2007) showed positive outcomes. Changes noted included substantial client gains in areas including affective and communicative functions, more motivation to articulate, more frequent and better attempts to communicate, increased sociability, more eye contact, less autistic and ritualistic behavior, higher self-esteem, more bodily contact, greater awareness of therapist as person, better grooming habits, less hallucinating, less aggressive and maladaptive behaviors, and higher emotional stability (Prouty 1990). This research includes quantitative small-sample controlled studies and several case studies documenting client pre-post change but as yet no group studies with samples larger than ten have been carried out.

In summary, particular benefits of person-centered ways of working with clients may include increased social skills, reality contact, and reduction in 'psychopathological' symptoms.

The aim of the present study was to develop an understanding of contemporary UK person-centered therapists' views of their practice with clients who experience psychotic process. We hoped to gain insight into what appears most useful to the therapists and to compare the results to previous studies. This practitioner study has provided grounding for a client focused current clinical trial of PCT with psychotic process with an embedded case study design.

METHOD

Participants

The sample consisted of participants were in the role of counselor, psychologist or psychotherapist. Other participants were practicing in an exclusively client-centered way in the context of other roles such as support worker or mental health practitioner. The sample broke down into twenty UK based person-centered practitioners (fourteen female, six male) who had worked with at least one client in a psychotic process. Fifteen participants had completed person-centered diplomas. Other participants had substantial training in the person-centered approach, extensive Rogerian courses or creative expressive person-centered training. All practitioners described the way they worked with “psychotic process” as person-centered and most referenced literature and additional training beyond their diploma or core training.

Procedure

Following ethical approval from the University of Strathclyde participants were recruited via national counseling journals, person-centered journals, person-centered websites, organizations and groups, and word of mouth.

Unstructured interviews were conducted with prompts relating to the key research questions indicated below. Participants were asked to

- Describe their training and any additional short courses or influences
- Describe their background and work context
- Describe their experience of working with clients in psychotic process

- Describe the practice they offered to clients who experienced psychotic processes and any difference from usual practice.
- Discuss any particular aspects of practice which seemed particularly helpful to clients
- Describe client changes perceived and how they came to this view (e.g., evaluation tools, observations or client feedback)
- Describe their perceptions of unhelpful practice and any possible negative outcomes.
- Discuss any additional issues which they felt were important

The contract included the opportunity of de-briefing as needed. Of the twenty interviews, fifteen interviews were conducted with face-to-face and five by telephone. Nineteen interviews were taped and transcribed (except where a participant objected, in which case notes were taken and later verified where possible). The twenty interviews discussed over forty clients.

Data analysis

The data were analyzed and audited using the principles of grounded theory (Glaser & Strauss, 1967, as interpreted by Rennie, Quartaro & Phillips, 1988) allowing themes to emerge from the data. The analysis involved immersion in the data. Results were grouped into categories and subcategories as themes recurred.

RESULTS

What practitioners thought they did that was particularly helpful

Helpful factors themes are presented in Table 1. Figures in the table are numbers of incidents rather than the number of practitioners reporting a particular experience (unless explicitly stated).

Most practitioners described more than one client (who had presented with psychotic process within the therapy) and practice often changed to incorporate pre-therapy or other enhanced practice. Most practitioners initially used basic PCT and then developed practice, incorporating pre-therapy or other practice as they became more experienced and skilled. Results are therefore more accurately reflected by reporting incidents rather than number of practitioners.

Overall Theme. Three practitioners reported that they used *the core person-centered approach only* and felt that their practice with clients who experience psychotic processes did not vary from usual practice. The other seventeen practitioners reported that they later came to work differently after accessing education and reading, especially in relation to pre-therapy and contact reflections (see Table 1). Each practitioner discussed one or more clients thus later clients discussed may have experienced different person-centered practice such as pre-therapy.

Six practitioners explained general ways in which they attempted to make contact with clients. One practitioner discussed observing and gently feeding back an invitation whilst another described checking out if clients were in contact with them. Eleven therapists sometimes used *pre-therapy* as a way of working; all found this effective. For some practitioners the discovery of Prouty's work was a revelation and changed their practice, confidence and, they believed, the outcome. Pre-therapy was discussed by one person as helping to link a client to reality, whilst others discussed using contact reflections and two talked of working closely to "Garry's book". Some practitioners had attended short courses in pre-therapy and applied this learning. One practitioner commented, "The Garry Prouty reflections were useful in trying to establish a

connection between both of us-working in the here and now and reinforcing the reality of the moment”.

Other practices informed by specific theory were also mentioned. For example, four practitioners discussed the value of Margaret Warner’s work in difficult client processes, and one person followed her fragile process paper with a client, staying close to the clients’ words.

Specific Approach: Building a PCT relationship. Eight practitioners named genuine care as an important issue, e.g., showing warmth, compassion and love. Seven practitioners discussed *relational depth*. One practitioner discussed her relationship with a client saying that there were, “Those moments where you meet eye to eye and something happens ... special moments ... soul moments ... as if a barrier has gone — a spiritual connection”. Practitioners described feeling close to the client, and one counselor described the relationship as empowered and deep.

Six practitioners explicitly referred to *being real, striving to be real, or use of self*. Comments included practitioner’s feeling that being themselves was important. As one practitioner noted, “The relationship is the therapy” and is especially crucial where people have been stigmatized. Six therapists discussed issues around *minimizing the power dynamic* and empowerment.

As for the person-centered therapeutic conditions fifteen practitioners discussed the particular importance of *Unconditional Positive Regard*. Themes included accepting all parts of the client. One practitioner commented that clients who experience psychotic process often feel guilt, shame or rejection, so UPR is crucial.

Eight therapists identified particular issues around *care in the use of congruence*. Congruence was clearly an area which required particular thought with some variation in how practitioners approached this matter. Two practitioners felt that clients in psychotic process could be more sensitive to incongruence and that being congruent was therefore of particular importance.

However, several other practitioners were less congruent with clients in psychotic process. They felt that there needed to be less edge of awareness work or more negotiating with sensitive or fragile clients regarding what was safe to “name”. Four practitioners were particularly sensitive in the use of congruence and varied their stance according to perceived individual client needs and processes.

Eight practitioners discussed the particular importance of *empathy*, with several emphasizing the need for deep empathy and staying close to clients.

Specific Themes: Working with psychotic content. Fourteen practitioners described working with the psychotic content. Three of these described *staying with “the clients frame” and owning their own, different reality from the client*. Three practitioners discussed *entering into the client’s reality or accepting the client’s reality*, e.g., staying with a client’s world to the extent that it involved understanding the responsibility and associated emotions of being both a religious leader and a specific celebrity. Three practitioners discussed *staying in the clients frame whilst privately holding their own sense of what was “not true”*. Some practitioners sometimes felt distracted when holding two realities, e.g., one practitioner reflected that she had no idea what was true, and it was not her job to judge. Nevertheless she was aware that her own reality was

different and tried to put the thought aside and tried to understand what the client believed. Five practitioners discussed how they dealt with their *own reactions to psychotic content of sessions*. Some practitioners tried to avoid distraction or panic when confronted with “psychotic content” and tended to grow increasingly comfortable with such material, often processing it in supervision. Typically participants described their increasing familiarity with psychotic material enabling them “to stay with” the client. Five practitioners described dealing with own feelings and reactions to psychotic content such as initial fear or shock and some revealed this to the client. This helped the therapist and client to enter into deeper relationship. Practitioners mentioned the need for self care in order to stay with client and deal with sometimes horrific material, describing a need to ground themselves in, and after, sessions.

Eight therapists discussed issues regarding *adapting parameters to accommodate client needs* with twenty responses on this theme. Four responses referred to the use of space, e.g. working in a large space was necessary for some clients whilst respecting the distance and closeness needed by individual clients was discussed as needs changed. Practitioners also thought attention to boundaries and contracting was important. Examples included the need for flexibility regarding client telephone calls, missed sessions or regarding the length of sessions. Other issues included the importance of having a contract the client understood and having firm boundaries which were not rigid.

Other specific Themes were discussed. Six practitioners discussed supporting *coping strategies or educational elements* (offered to the client within the multi-disciplinary context of care).

Some therapists supported clients to understand what was happening to them but avoided giving

advice. Ten practitioners also discussed the importance of *getting beyond labels and illness*, e.g. by focusing on the person rather than the “illness”.

Fifteen responses referred to examples of *exercising particular care and attention*. Several participants wanted or needed more than one therapist in room or to have co-therapists. One participant explained that this was to hold the process and for therapists to be able to look after each other in such a demanding situation. Seven practitioners discussed a multi-disciplinary approach for vulnerable clients and to help the practitioner to stay with the client. Six practitioners discussed the issue of supporting the client to manage risks to self and others.

Perceived changes in clients

More connected. Thirty out of approximately forty clients discussed involved clients feeling more connected. Nine referred to *increased contact with reality* being achieved. One practitioner explained that she and the client began to have intermittent contact where they would share that reality for a few moments or a few minutes. One participant commented on “seeing someone for want of a better word, come out of a psychosis, become more connected within a relationship and less distressed.” Twenty four responses related to outcomes associated specifically with *improved social skills and ability to be with and relate to others*. This was the most frequently mentioned outcome. Socializing was described as being easier for many clients discussed. One client, described as initially going for days without saying anything other than “hello” to anybody moved to “striking up conversations with people and ... striking up almost friendships”.

A further example involved pre-therapy that continued until a 'disconnected' person was able to attend an occupational therapy group and engage in activities.

Decreased difficulties with problematic experiences. Two practitioners reported clients having *less need for treatment*. One client was able to withdraw from antipsychotic medication.

Four practitioners identified the *client's improved ability to manage voices or hallucinations*. Typical comments referred to clients accepting their voices, learning to cope more effectively with voices or other hallucinations, and becoming less likely to act on them. One client recognized alcohol as a trigger to worsen hallucinations and consequently stopped drinking. Two comments referred to occasions where *voices or hallucinations were reduced*. One client reported to their therapist that the voices became quieter. Four counselors described clients being *more accepting of hallucinations*.

There were ten examples of *improvement in mood or anxiety levels in clients*. One practitioner saw all three clients mood improve. Nine referred to *less risk of harm to self or others*. One client, who previously talked about delusional beliefs regarding his family, felt that the sessions helped him to process feelings such as anger and hatred and feel fewer urges to hurt others.

Improvements in sense of self. Twenty four responses referred to *improvements in sense of self*. Three practitioners reported that their clients said they *felt more accepted/ less judged*. Three clients were described as showing *change in self acceptance/confidence*. A practitioner reported that the client felt accepted and became more self accepting and more accepting of others. Six

clients were described as feeling *more in control/empowered*. Seven clients were described as showing an increase in *insight or self awareness*, and five as becoming more *integrated*. Three situations involved clients who explored issues around sexual identity and one moved from confusion to entering a sexual relationship at the end of therapy.

Improvements in quality of life were referred to in fifteen instances. Nine clients were reported as experiencing increased resilience. This included examples of clients being more able to cope with life and stressful situations. General improvement was also reported by six practitioners.

Negative Responses or contra-indications. Three practitioners gave examples of some negative responses with some of their clients. Practitioners discussed the need for tempering of intensity, identifying potential triggers if applicable and being provided with adequate guidance. Some clients might be identified as being better suited to other types of therapy and could be referred if appropriate.

DISCUSSION

Several important themes regarding person-centered practitioners' perceptions of their practice emerged from the data. The most popular additional practice was pre-therapy, either as part of formal therapeutic work, or in the form of pre-therapy contact work, used in the context of a supportive relationship. The influence of Prouty's work on practice was widely cited as having led to very positive outcomes (cf. Dekeyser et al., 2007). The introduction of pre-therapy or pre-therapy contact work as part of PCT practice seemed to increase the ability of practitioners to

make contact with clients, leading to perceived positive outcomes. Margaret Warner (2000) was also a strong influence for several practitioners.

Consistent with Sommerbeck (2003), practitioners generally identified UPR as the most important therapeutic condition for clients with psychotic processes. Similarly, Prouty's suggestion that labels can be oppressive and lead to judgment and stigma was supported by these informants' views. Indeed within the study we are aware of our own use of psychotic process as a process label, and struggle with the feeling that we are colluding with society to judge these informants; at the same time, we feel the need for a useful term for describing these informants' process. The term, "psychotic" was supported by the user groups who were consulted during the course of the study, and yet we are left feeling uneasy and wondering what would be acceptable and yet widely understood. Individuals with psychotic processes are often socially rejected and labeled by lay people and mental health professionals alike. PCT, however, can provide an antidote to social exclusion by providing individuals with a sense of being truly seen and accepted as people, a view highly consistent with the writings of Laing (1965) and others (Davidson & Stayner, 1997) on work with clients with psychosis.

Findings indicated that psychotic content was approached in a variety of ways and could sometimes be distracting or unsettling for practitioners. Therefore, practitioners particularly valued short courses, supervision and other inputs that provided them with ways of staying grounded and working productively with these processes.

Paralleling Warner (2001) and Mearns (2003), the results suggest that responsible practice when

working with psychotic processes may involve sensitive and appropriate adjustment of therapeutic parameters. Informants noted the need for supervision and careful reflection to enable them to discern when to either extend or tighten boundaries. For example, in some situations, it might be valuable to conduct part of the session outside the therapy room (e.g., when the client is reacting negatively to the space). In contrast, it might sometimes be important for the practitioner to keep explicit time boundaries, have clear risk management contingencies and carefully observe the limits of their competence (e.g. referring the client on if they need a higher level of care). This may reduce the risk of practitioner burn-out and supports client safety and continuity of care. Explicit contracting with clients appears to be very important, because of the risk that clients may misunderstand or later reframe remembered events in unpredictable ways. The experience of these practitioners suggests a value in being explicit about the limits of what they can offer and great care when they consider extending boundaries.

In our view, the most dramatic and general finding in this study was the role of PCT in enhancing client social and interpersonal skills. Given the degree of social isolation and interpersonal avoidance in this population, this kind of change is essential for helping clients improve their quality of life (Davidson & Staynor, 1997; Harding, 1987). Although this is consistent with the results of the Wisconsin (Rogers et al., 1967) and Essen studies (Teusch, 1990), we do not think that this point has been emphasized adequately in the literature. Thus, in PCT, including pre-therapy (and other forms of therapy for psychotic processes), the therapist strives to provide an opportunity for the client to form a therapeutic relationship that may then provide a model for other fulfilling relationships.

“The task of psychotherapy is to help the person achieve, through a special relationship with the therapist, good communication within himself. Once this is achieved he can communicate more freely and more effectively with others.” (Rogers 1961, p.330)

Our finding that the therapy relationship seemed to enhance the client’s sense of self and ability to be with others, finds support from a study by Lysaker, Buck and Roe (2007) of narrative integrative psychotherapy, conducted by eight therapists with thirty clients with a diagnosis of schizophrenia. The study demonstrated how a nonhierarchical therapy relationship appeared to enhance social worth, an integrated sense of self and experience, and symptom reduction.

In this study many clients were reported to have improved mood and decreased “symptoms”. Indeed Bentall (2009) recently reviewed research supporting the idea that the therapeutic alliance (in both CBT and Rogerian psychotherapy) is causal in improving both mood and “symptoms” in clients with psychosis.

In addition, our results suggest the need for practitioners to consider tempering the intensity of the relationship, in order to prevent negative effects on clients. This fits with theories of high expressed emotion, in which high levels of critical comments, hostility or over-involvement were a significant factor in client relapse (Vaughn & Leff, 1976). This may involve helping clients to find the best working distance (neither overwhelmed nor cut off from difficult experiences), as suggested by Gendlin (1984a). Davidson and Stayner (1997) describe how people diagnosed with schizophrenia may have magnified sensitivities which may influence social withdrawal and how establishing meaningful social contact can pose a major challenge. Our study suggests how

person-centred therapy may be an approach suited to this type of presentation because it is less intrusive than many approaches and matches the pace of the client to process experiences and connect without pressure.

The two main limitations of this study were the small sample and the fact that client perceptions were not assessed in addition to therapist views. In addition, client outcomes may have been affected by other factors. PCT therapists are also likely to be highly biased in evaluating their own work. Nevertheless, this study was a realistic way to identify emerging trends and areas for further enquiry. The study led to the development of a basic pilot resource manual for participant practitioners. This resource manual is the basis for an ongoing process-outcome study of PCT with clients experiencing psychotic processes.

These contextual factors suggest that it may be important to manage complex client issues by working within competences, receiving support from managers and high levels of clinical supervision, operating within a multidisciplinary team, and promoting the client obtaining support from a variety of sources. For optimal practice, the therapist may need to use more flexible ways to help clients manage risk, in order to contain and help the client maintain themselves between sessions. This may involve greater directivity than many PCT therapists are used to. For example, at the end of sessions clients may need to be assessed for disorientation and intention to harm; when these are present, it is important for the therapist to support the client in order to be safe and to reduce risk.

The further elaboration and testing of these and other principles is the subject of ongoing research. This research is aimed at improving the care and ultimate well-being of this underserved and often disadvantaged client group. It is our hope that this study will encourage others to focus research on humane and effective therapies for clients living with psychotic processes.

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Table 1. Helpful factors

<u>Category</u>	<u>No Practitioners</u>
I. Overall approach	
Core PCT approach only	3
Incorporated other PCT approaches	17
	<u>Frequency of occurrence</u>
Contact work	6
Pre-therapy /pre-therapy contact work	11
Other practices re specific theory (e.g. Warner)	4
II. Specific Theme	
A. <i>Building a PCT relationship</i>	
<i>1. Person-centred values</i>	28
Genuine Care	8
Relational depth	7
Being real/use of self	6
Minimizing power dynamic	6
<i>2. Core conditions</i>	31
Unconditional positive regard especially important	15
Congruence more important	2
Important to be less congruence	2

Congruence individually adjusted	4
Empathy especially important	8
<i>B. Working with psychotic content</i>	14
1. Owning own reality (whilst accepting client's)	3
2. Accepting/entering into client's reality	3
3. Staying in client frame whilst holding private sense of what's "not true"	3
4. Therapist dealing with own reaction to psychotic Content	5
<i>C. Adapting therapeutic parameters</i>	
1. Flexible use of space	4
2. Boundaries and contracting	16
<i>D. Other specific strategies</i>	
1. Getting beyond labels and illness	10
2. Supporting educative/coping strategies	6
<i>E. Exercise particular care and attention</i>	15
1. Multi-disciplinary support	7
2. Risk management	6
3. Sensitivity	2

Table 2: Perceived Changes

<u>Category</u>	<u>Frequency of Responses</u>
<i>I. More Connected</i>	33
A. More connected to reality	9
B. Improvement in social interaction/relationships	24
1. Improved social skills/relationships	13
2. More connected/socially oriented	9
3. Better relationship with therapist	2
<i>II. Decreased difficulties with problematic experiences</i>	31
A. Less need for psychiatric treatment	2
B. Less trouble with voices/hallucinations	10
1. Better management of voices/hallucinations	4
2. Reduction in voices/hallucinations/delusions	2
3. Client more accepting of voices, etc	4
C. Affective changes-mood/anxiety	10
1. Positive change in mood	6
2. Less anxiety	4
D. Decreased risk	9
1. Less harm to self	7
2. Less harm to others	2

<i>III. Improvements in sense of self</i>	24
A. Feeling more accepted/less judged	3
B. Increase in self acceptance/self confidence	3
C. More sense of control/empowered	6
D. Self-integration	12
1. Increase in client insight/self awareness	7
2. More integrated/stable identity	5
<i>IV. Improvements in quality of life</i>	15
A. Increase in resilience/coping	9
B. General improvement	6
