

**Study Title: Experiences of Feeling Exceptional: Finding Meaning and Balance in Everyday Life
- A Proof-of-Concept Multiple Baseline Single Case Experimental Design Series Testing the
Feasibility, Acceptability, and Potential Clinical Benefits of Treating Harmful Grandiose
Delusions**

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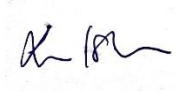
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Confidentiality Statement

This document contains confidential information that must not be disclosed to anyone other than the Sponsor, the Investigator Team, HRA, host organisation, and members of the Research Ethics Committee, unless authorised to do so.

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1. KEY CONTACTS

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Funder(s)	National Institute for Health and Care Research (NIHR) (https://www.nihr.ac.uk/)
Statistician	This is a single case experimental design study, where the analysis will be completed by the CI (contact details above) with support from Dr Rumen Manolov*, Dept Social Psychology & Quantitative Psychology, University of Barcelona. Email: rrumenov13@ub.edu <i>(*Dr Manolov is an expert in SCED studies and wrote many of the computer analysis packages that will be used in the analysis).</i>

2. LAY SUMMARY

Background:

Grandiose delusions – false beliefs about having special powers, mission, wealth, or identity – are experienced by one in three patients diagnosed with severe mental health problems. Grandiose delusions can carry a huge burden and cause significant harm to self and others. For example:

- Stephen believed he had superpowers. He crashed his car at speed to try to demonstrate his abilities.
- Sophie believed that she was God. She stepped off heights as she expected to fly.
- Max believed he was an undercover special forces agent. He tried to conduct arrests and got into fights believing that he had back up from other agents.

Current talking therapies and medications do not work well enough for many patients experiencing harmful grandiose delusions. Therefore, we have developed a new understanding of why grandiose delusions persist for a person and are using this understanding to develop the first talking therapy specifically for the treatment of harmful grandiose delusions.

The therapy manual and materials are being developed in consultation with people with lived experience. The therapy targets three key drivers of grandiose delusions: the meaning that they give people, the time spent thinking about them, and behaving in line with beliefs. Strategies for managing unusual perceptual experiences (such as hearing voices) and very elevated mood (sometimes call mania), are also included because these can contribute to grandiose delusions in some people. In addition, harm-reduction strategies are provided. At the heart of the therapy is helping patients find alternative sources of meaning in their lives so that the grandiose delusions can fade. The therapy will be provided in up to 16 sessions.

Aim:

In this study, we will conduct preliminary testing of the new therapy. The objectives are to:

1. Provide initial evidence concerning whether the therapy is helpful.
2. Assess the acceptability of the therapy for patients with grandiose delusions.

Methods:

The project has two key elements:

1. Initial clinical testing. Nine NHS patients with harmful grandiose delusions will receive the therapy. There will be an initial baseline phase (between 4-6 weeks) before therapy starts. How long this baseline period lasts will be decided at random. Participants will complete assessments of grandiose delusions, harm, and each of the drivers of grandiose delusions at start-of-baseline, end of the baseline, mid-therapy, and end-of-therapy. They will also complete some brief assessments weekly during the baseline period, in every therapy session, and once more two weeks after the end of therapy. It will be seen whether: patients take up and are satisfied with the sessions, the drivers of grandiose delusions are blocked, and the grandiose delusions themselves reduce.

2. In-depth interviews. We will invite all nine participants to complete an in-depth interview to learn more about how the therapy is experienced. Any areas to improve the therapy will be identified.

Patient involvement:

There is an advisory group of people with lived experience of grandiose delusions who will contribute at all stages. Members of this group have been authors of the papers that have developed the understanding of grandiose delusions and they, together with others with lived experience of grandiose delusions, are contributing to the therapy development. People from racially-minoritized groups, especially those from Black-African and Black-Caribbean communities have poorer access to talking therapies. As such throughout the therapy development phase we have incorporated specific consultation with people with lived experience of grandiose delusions in these communities to ensure that the therapy meets their needs.

Funding:

The research is funded by a National Institute for Health and Care Research (NIHR) Advanced Fellowship.

3. SYNOPSIS

Study Title	Experiences of Feeling Exceptional: Finding Meaning and Balance in Everyday Life - A Proof-of-Concept Multiple Baseline Single Case Experimental Design Series Testing the Feasibility, Acceptability, and Potential Clinical Benefits of Treating Harmful Grandiose Delusions		
Internal ref. no. / short title	Experiences of Feeling Exceptional		
Study registration	Registration with ISRCTN will be completed following ethical approval.		
Sponsor	University of Oxford		
Funder	National Institute for Health and Care Research (NIHR)		
Study Design	Proof-of-Concept Multiple Baseline Single Case Experimental Design Series, with qualitative interviews.		
Study Participants	Patients (aged 16 years or older) with grandiose delusions in the context of a diagnosis of affective or non-affective psychosis attending NHS mental health services.		
Sample Size	09		
Planned Study Period	14/05/2026 – 14/07/2027 Individual participant involvement will be 22-24 weeks depending on length of baseline.		
Planned Recruitment period	14/05/2026 – 14/02/2027		
	Objectives	Outcome Measures	Timepoint(s)
Aim	To establish a preliminary indication of the clinical effectiveness and acceptability of a novel intervention to reduce harmful grandiose delusions in patients with psychosis attending NHS mental health services. Feedback from this study will be used to refine the therapy in preparation for a subsequent pilot RCT.		
Primary	i) To provide initial data on whether the treatment reduces harmful grandiose delusions.	PSYRATS-delusions (primary outcome measure) Also: SPEQ-G; individualised (idiographic) measure of grandiose delusion conviction using a 0-100% visual analogue scale (VAS).	All measures at start of baseline, end of baseline, mid therapy, and end of therapy; VAS also weekly in baseline and therapy phases and at one follow-up time point.
Secondary	i) To provide initial data on whether the treatment reduces the drivers of grandiose delusions and subjective harm.	TEEQ (repetitive thinking); IBQ (immersion behaviours); Gram/grams (meaning); SPEQ-AE & CFSA (anomalous experiences); ISS (mania) SHEEQ (subjective harm)	All measures at start of baseline, end of baseline, mid therapy, and end of therapy; VAS also weekly in baseline and therapy phases

		In addition to these formal measures, brief idiographic single-item measures, using VAS 0-100 scales, will be administered to provide brief assessments of each driver and of subjective harm.	and at one follow-up time point.
	ii) To provide initial data on the effect of the therapy on other psychotic and affective symptoms.	PHQ-9 (depression) GAD-7 (anxiety) R-GPTS part B (paranoia)	All measures at start of baseline, end of baseline, mid therapy, and end of therapy.
	iii) To provide initial data on the acceptability of the therapy to patients (measured by uptake and patient satisfaction).	Uptake: Number of patients completing a dose of therapy (at least 8 sessions). Patient satisfaction: Adapted CSQ	End of therapy
Qualitative	iv) To assess the acceptability of the therapy for patients with grandiose delusions.	Feedback from qualitative interviews	End of therapy
Intervention(s)	A psychological intervention designed to precisely target the key mechanisms which drive grandiose delusions and reduce associated harm. Central to the therapy is helping patients find alternative sources of meaning in their lives so that the grandiose delusions can fade. The therapy will be provided in up to 16 sessions. The intervention will be delivered by a mental health staff member (e.g. clinical psychologist, counselling psychologist, or CBT therapist) in up to sixteen one-hour one-to-one sessions over 16 weeks.		
Comparator	Standard care		

4. ABBREVIATIONS

CI	Chief Investigator
CRF	Case Report Form
GCP	Good Clinical Practice
GP	General Practitioner
HRA	Health Research Authority
ICF	Informed Consent Form
LEAP	Lived Experience Advisory Panel
NHS	National Health Service
REC	Research Ethics Committee

PIL	Participant/ Patient Information Leaflet
R&D	NHS Trust R&D Department
REC	Research Ethics Committee
RGEA	Research Governance Ethics and Assurance
SOP	Standard Operating Procedure

5. BACKGROUND AND RATIONALE

Alice: *“I was Alice Christ, the second coming of the messiah. What it led to was thinking ‘Alice you’re going to have to die’. As a Christian I know the story of Jesus – died and on the third day he rose from the dead. So my thinking was ‘you will rise from the dead’. This was my mission, to prove the resurrection in a modern age. This was very dangerous for me.”*

Brian who believed that he was Einstein: *“I needed to get to the highest point, so I could see the horizon. And that’s when they sectioned me because they thought I was going to commit suicide because I was over loads of electric wires. I was on the lamppost on the bridge, sitting on top of it. I just wanted to see the horizon. I was obsessed with space and that.”*

Summary: Many patients with severe mental health problems, despite treatment in mental health services, continue to have grandiose delusions that cause real harm. We need to develop a much better treatment specifically for harmful grandiose delusions.

Grandiose delusions – inaccurate beliefs about having special powers, wealth, mission, or identity – account for approximately one third of delusions experienced by patients diagnosed with non-affective psychosis (e.g. schizophrenia¹) and are experienced by up to 60% of people diagnosed with bipolar disorder².

Grandiose delusions can be extremely problematic. For example, Polly, who believed she had been chosen to marry God, went home with a stranger she met at a bus stop and was sexually intimate with him, believing that he was God. Sarah, who believed she got visions of the future in her dreams, described being so focused on having her next vision she neglected her teenage daughter. More than three-quarters of people with grandiose delusions report associated harms occurring within the past six months³. Grandiose delusions are associated with an increased risk of violence in patients recently discharged from inpatient admission⁴, and with increased offending behaviours in patients attending forensic services⁵.

Antipsychotics can reduce psychotic experiences such as grandiose delusions⁶ and CBT for psychosis can help too⁷. However, despite these options, current treatments for grandiose delusions do not work well enough for many patients. Approximately one-third of patients with psychosis continue to present with grandiose delusions despite receiving ongoing treatment from NHS mental health services⁸. There is no theory-driven targeted intervention specifically for grandiose delusions.

There is also a further issue to consider: inclusivity. Racially minoritized people, and particularly those from Black-African and Black-Caribbean communities, have higher rates of diagnosis of severe mental health problems such as schizophrenia and bipolar disorder⁹. However, they do not get the same quality of care as people of White-British ethnicity. For example, they are significantly less likely to access cognitive behavioural therapy for psychosis¹⁰.

Hence, there needs to be a targeted evidence-based psychological treatment specifically for grandiose delusions that is accessible and suitable for individuals from different backgrounds. This would be used in addition to existing treatment options such as medication.

The Oxford Cognitive Approaches to Psychosis research group has shown how a theory-driven targeted psychological treatment can greatly improve outcomes for *persecutory* delusions¹¹. The intention is to do the same for the treatment of *grandiose* delusions. Translating from our empirically established theoretical model^{3,8,12,13} we are currently developing a new cognitive treatment. The development is in consultation with individuals with lived experience of grandiose delusions from a range of backgrounds, including focused consultation with people from Black-African and Black-Caribbean communities to ensure the therapy is designed to be inclusive from the start.

The therapy is designed to produce large effect size reductions in persistent grandiose delusions. It targets three key drivers (mechanisms) which our empirical studies showed accounted for the most variance in grandiose delusions severity. These are:

- i. *Meaning making*: Grandiose delusions provide a sense of meaning and purpose in life that serves as a motivation for the patient to continue to believe the delusion. For example, Mark, who believed he worked undercover for security services, said “*I feel I am useful to society*” and Stephen, who believed he was one of the Avengers, said “*I feel like part of a team*”.
- ii. *Immersion behaviours*: Patients describe acting in line with the delusional identity or withdrawing from others and becoming engrossed with information that fits with the belief. Such immersion behaviours provide exposure to information that is taken by the individual as convincing evidence for the delusional belief.
- iii. *Repetitive thinking*: Patients report thinking about their grandiose delusions much of the time. For example, Mark said “*it fills my time. I’m always busy. In the past without this I’d be bored. But with this [being an undercover agent] I’m busy thinking all the time.*” This repetitive thinking brings the delusion to mind, elaborates the content, and increases the level of certainty that it is true.

Personalisation of an intervention is important, and our findings showed that, in a smaller proportion of patients, two other factors also need to be addressed: anomalous perceptual experiences (e.g. hallucinations such as hearing voices) and mania (the experience of extreme positive mood). We are therefore developing strategies to target these factors, as well as to minimise risk of harm.

The clear next step is to conduct preliminary tests of the therapy to determine whether there are indications that it is acceptable to patients and likely to have large clinical benefits. Following the current study, we will progress to a pilot randomised controlled trial (assuming progression criteria are met).

6. OBJECTIVES AND OUTCOME MEASURES

Aim

To establish a preliminary indication of the clinical effectiveness and acceptability of a novel intervention to reduce harmful grandiose delusions in patients with psychosis attending NHS mental health services. Feedback from this study will be used to refine the therapy in preparation for a subsequent pilot RCT.

Objectives:

Objectives	Outcome Measures	Timepoint(s) of evaluation of this outcome measure (if applicable)
Primary To provide initial data on whether the treatment reduces harmful grandiose delusions	PSYRATS-delusions (primary outcome measure) Also: SPEQ-G; individualised (idiographic) measure of grandiose delusion conviction using a 0-100% visual analogue scale (VAS).	All measures at start of baseline, end of baseline, mid therapy, and end of therapy; VAS also weekly in baseline and therapy phases and at one follow-up time point.
Secondary i) To provide initial data on whether the treatment reduces the drivers of grandiose delusions and subjective harm.	TEEQ (repetitive thinking); IBQ (immersion behaviours); Gram/grams (meaning); SPEQ-AE & CFSA (anomalous experiences); ISS (mania) SHEEQ (subjective harm) In addition to these formal measures, brief idiographic single-item measures, using VAS 0-100 scales, will be administered to provide brief assessments of each driver and of subjective harm.	All measures at start of baseline, end of baseline, mid therapy, and end of therapy; VAS also weekly in baseline and therapy phases and at one follow-up time point.
ii) To provide initial data on the effect of the therapy on other psychotic and affective symptoms.	PHQ-9 (depression) GAD-7 (anxiety) R-GPTS part B (paranoia)	All measures at start of baseline, end of baseline, mid therapy, and end of therapy.
iii) To provide initial data on the acceptability of the therapy to patients (measured by up-take and patient satisfaction)	Uptake: Number of patients completing a dose of therapy (at least 8 sessions). Patient satisfaction: adapted-CSQ	End of therapy
iv) Qualitative: To assess the acceptability of the therapy for patients with grandiose delusions.	Feedback from qualitative interviews	End of therapy

7. STUDY DESIGN

The study comprises a series of three multiple-baseline single-case experimental designs (SCEDs), each entailing a replication of an ABA (baseline-intervention-follow-up) sequence across three participants. In other words, a total of 9 patients will be recruited in cohorts of three, and within each cohort the baseline phase will be randomised to five, six, or seven weekly assessment points (i.e. a four-, five- or six-week baseline). In a multiple baseline single-case experimental design, randomising participants to staggered baseline lengths strengthens internal validity by demonstrating that outcome changes systematically follow intervention onset rather than time or external factors. Allocating 9 participants across three baseline tiers provides sufficient replication to demonstrate experimental control, consistent with What Works Clearinghouse standards and recommendations for rigor in such designs.

The treatment phase will be 16 weekly sessions for all participants. Brief measures of the key outcomes and targeted mechanisms will be collected on a weekly/sessional basis during the baseline and intervention phase and there will be a further brief assessment at two-week follow-up. A more extensive outcome assessment pack will be completed four times (start-of-baseline, end-of-baseline, mid-therapy, end-of-therapy). An embedded qualitative evaluation will assess the patient experience of therapy. A diagrammatic overview of the assessment schedule is provided (see Figure 1). Individual participant involvement will be 22-24 weeks depending on length of baseline. The 16-session, manualised, intervention which aims to reduce harmful grandiose delusions will be delivered individually by a clinical psychologist. Measures of treatment fidelity and quality will be collected. The study will take place in Oxford Health NHS Foundation Trust.

Note on design: SCEDs are ranked as Level 1 evidence for treatment decision purposes in individual patients¹⁴. The proposed design is particularly robust. It provides internal validity (by randomising to three different baseline phase lengths¹⁵ and external validity (replicating the initial SCED a further two times to explore the generality of the intervention effects). A non-concurrent design (whereby participants do not wait for the recruitment of other participants before commencing participation¹⁶) will be adopted, providing a pragmatic and ethical approach to recruitment. The design is consistent with good practice guidelines, and relevant methodological and reporting recommendations (including RoBiNT¹⁷, SCRIBE¹⁸, and What Works Clearinghouse (2022) guidelines¹⁹) will be followed.

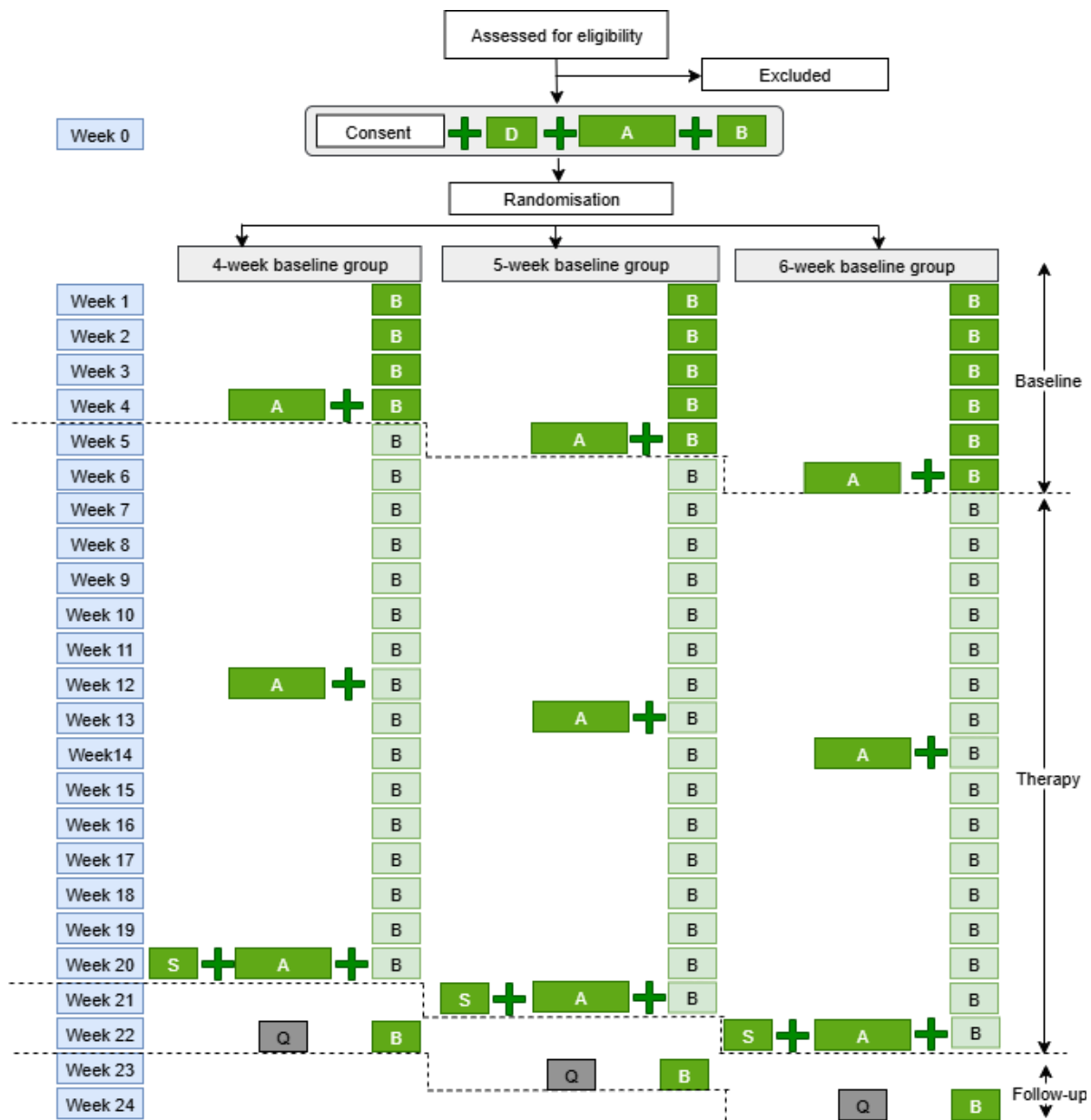
8. PARTICIPANT IDENTIFICATION

8.1. Study Participants

Participants will be NHS patients diagnosed with affective or non-affective psychosis, with a current harmful grandiose delusion. In accordance with the Mental Capacity Act people will be assumed to have capacity. If there are any concerns then an assessment of their capacity will be carried out by a clinical psychologist.

8.2. Inclusion Criteria

- Participant is willing and able to give informed consent for participation in the study.
- Aged 16 years or older.
- Attending NHS mental health services for the treatment of affective or non-affective psychosis.
- Persistent (at least 3 months) grandiose delusion (as defined by the Schedules for Clinical Assessment in Neuropsychiatry²⁰), held with at least 60% conviction.
- No planned significant medication changes at the outset of participation.

Figure 1: Study flow chart and assessment schedule**Study Flow Chart Key:**

D = Demographic questionnaire

A = Assessment pack A (standardised measures)

B = Assessment pack B (brief idiosyncratic measures)

S = Service-use and therapy satisfaction measures

Q = Qualitative interview (completed by research team)

Dark green box = Measures completed by the research assistant are shown in dark green.

Light green box = Measures completed by the therapist are shown in light green. NB These measures will be completed during the therapy sessions, so the light green boxes are also indicative of the therapy sessions offered to the participant.

8.3. Exclusion Criteria

The participant may not enter the trial if ANY of the following apply:

- A primary diagnosis of another mental health condition (e.g. substance use disorder) that would be the first clinical priority to treat.
- Current engagement in any other intensive individual psychological therapy or a significant change in medication.
- In forensic settings or Psychiatric Intensive Care Unit (PICU).
- Command of spoken English inadequate for engaging in the therapy.
- Significant learning difficulties that would prevent the completion of assessments or the therapy.
- A participant may also not enter the trial if there is another factor (for example, current active suicidal plans that need to be the focus of intervention), which, in the judgement of the investigator, would preclude the participant from providing informed consent or from safely engaging with the trial procedures. Reason for exclusion will be recorded.

9. PROTOCOL PROCEDURES

A schedule of events is available in Appendix A.

After screening, consent, start-of-baseline assessment (which will usually take place at the same time as consent) and randomisation (which occurs after the start-of-baseline assessment), participants will have up to a further 24 study visits. This depends on the length of the extended baseline which will be 4-6 weeks.

All participants will complete four assessment visits – start-of-baseline, end-of-baseline, mid-therapy, end-of-therapy. Participants will also complete weekly brief measures of grandiose delusions, harm, and the target mechanisms, throughout the baseline and intervention phases and two weeks after the end of therapy. In the baseline phase these can be done remotely, and during therapy will be completed within the therapy session to minimise burden. There is an additional qualitative interview after the final assessment. The assessment schedule is shown in Figure 1

9.1. Recruitment

The recruitment target is nine participants. The principal method of recruitment will be via seeking referrals to the study from the relevant clinical teams in the participating mental health trust (adult community mental health teams; early intervention services, and inpatient units). Research registers will be used when available. Patients interested in taking part will be approached by the research team with the approval of the clinical team, given information about the study, and screening conducted.

Oxford Health NHS Foundation Trust's "Count Me In" process will also be utilised for recruitment purposes. Authorised Oxford Health researchers and staff including honorary staff (who may not be part of the direct care team) may use search output from electronic patient record to identify potentially eligible patients and make contact to share information about the study. These searches are conducted strictly in accordance with ethically approved inclusion and exclusion criteria and for the purpose of identifying participants for approved studies. Use of patient information is subject to confidentiality obligations. All Information will be handled in compliance with UK GDPR, DPA 2018, Trust's

confidentiality policies and the role based access controls in place. Patient information will not be used or disclosed beyond what is necessary for screening research participants.

Our Lived Experience Advisory Panel (LEAP) has also emphasised the importance of patients in participating trusts being able to self-refer to the study. This will minimise the chances that patients are overlooked by clinical teams or because their clinician was not present at a referral meeting. Hence we will also advertise the study to patients (including via posters in NHS buildings). However, in all instances we will seek to confirm that a member of the clinical team gives approval for a patient to enter the trial and to complete the necessary check of eligibility and risk status. All suitable patients will be given at least 24 hours to consider taking part in the study, although in practice it is typically a week.

The intervention is designed for approximately sixteen sessions, and this will be provided during the study. This specialist intervention will not be available after the end of the study, however, if indicated the study therapist will liaise with the participant's clinical team and recommend referrals to other appropriate services (e.g. within service standard psychological therapy) if required.

9.2. Screening and Eligibility Assessment

The eligibility check will be conducted by a research team member, most commonly a research worker under the supervision of a clinical psychologist. First, eligibility criteria are discussed with the referring clinical team. Second, a meeting is held with the patient, which may be at an NHS clinical base, a patient's home, or online. The eligibility check will include confirmation of the key clinical problem of a harmful grandiose delusion with harm being established either via a specific concern identified by the clinical team (objective harm) or the participant themselves reporting harm or difficulties in association with the grandiose delusions (subjective harm). If an individual is not eligible to participate at the time of the eligibility check then a future check will be permitted. The baseline assessment must commence within 4 weeks of the eligibility check. If it is after this period, a brief check will be conducted to re-confirm eligibility.

No exceptions will be made regarding eligibility – in other words – participants must satisfy all approved inclusion and exclusion criteria of the protocol.

9.3. Informed Consent

Written informed consent will be obtained by the research team. This will be after the clinical team's approval to approach the patient, provision of the Patient Information Sheet (PIS) to the patient, opportunities to ask questions, and at least 24 hours to decide.

Written – including electronic and, if needed, verbal - versions of the PIS and Informed Consent Form (ICF) will be presented to the participants detailing no less than: the exact nature of the study; what it will involve for the participant; the implications and constraints of the protocol; the known side effects and any risks involved in taking part. It will be clearly stated that the participant is free to withdraw from the study at any time for any reason without prejudice to future care, and with no obligation to give the reason for withdrawal.

The participant will be allowed as much time as wished to consider the information, and the opportunity to question the Investigator, or other independent parties to decide whether they will participate in the study. Written informed consent will then be obtained by means of participant dated signature and

dated signature of the person who presented and obtained the ICF. A copy of the signed ICF will be given to the participant. The original signed ICF will be retained at the study site. We will also accept written informed consent electronically. Oral consent can be taken over the phone using the remote consent version of the ICF, which will be signed and dated by the person who obtained the informed consent verbally. If collecting consent orally or electronically, the Consent Form will be sent to the participant via secure post or password-protected email.

Young people aged 16-18 years can be considered competent to consent to research and therefore for all participants aged 16 years and over, no parental consent to participate in the project will be sought.

Copies of the consent form will be retained in the researcher site file, provided to the participant, and uploaded to the participant's electronic medical records.

9.4. Randomisation

A total of nine patients will be recruited in cohorts of three, and within each cohort the baseline phase will be randomised to five, six, or seven weekly assessment points (i.e. a four-, five-, or six-week baseline phase). As participants will be recruited at a rate of 4 every 3 months it will take on average 9 weeks to recruit each cohort of three. So as to maximise study retention and not to extend the wait for therapy excessively, the cohort will not start their baseline together. Rather, randomisation for each cohort will be done in advance, but only revealed to the investigator upon the first participant in that cohort being recruited. Randomisation will be completed following the Wampold-Worsham randomisation scheme for a multiple baseline design. Simple computer-generated random numbers and sealed envelopes will be utilised.

9.5. Blinding and code-breaking

The participant, assessor, and therapist will not be blinded to the study phase or length of baseline. However, the randomisation block size (i.e. randomisation within a cohort of three) will not be revealed to the recruiting research worker. This means that they should not be able to predict the length of baseline for a participant in advance of the participant's recruitment.

9.6. Description of study intervention(s), comparators, and clinical procedures

Participants will be offered up to sixteen sessions of a cognitive behavioural therapy (CBT), designed to specifically target harmful grandiose delusions, in addition to their usual care. These sessions will occur between the baseline and post-intervention assessments.

Individual one-to-one sessions will be provided by a clinical or counselling psychologist or CBT therapist who is part of the research team. In addition to these sessions, supportive telephone calls or texts between sessions will be offered by the therapist. Sessions are usually one hour in length but this is flexible. The intervention will adhere to core CBT principles – for example therapy will be collaborative, goal oriented and incorporate sessional measurement to track progress and inform treatment decisions. Therapy sessions will be conducted in NHS buildings, the patient's home, and/or community settings depending on patient preference and clinical need.

The aim of the treatment is to reduce harmful grandiose delusions by targeting three key psychological drivers: meaning making, repetitive thinking, and immersion behaviours. The primary focus of the

therapy will be to support patients to build up meaningful activity that provides a comparable sense of purpose to that gained from the grandiose belief (i.e. new activity matched to the function of the grandiose delusions). This will reduce the extent to which the grandiose belief is required to provide a sense of meaning or purpose in life, and means there is less time for repetitive thinking and immersion behaviours.

In a subgroup of patients, two additional factors also need to be addressed: anomalous perceptual experiences (e.g. hallucinations such as hearing voices) and mania (the experience of extreme positive mood). Therefore the therapy has modules to target these, alongside harm reduction techniques, which are incorporated into treatment where needed.

During the course of the intervention, brief notes regarding the clinical contacts (research assessments and therapy appointments) will be uploaded onto NHS medical records so as to keep the clinical team informed. The research team will maintain close links with the clinical teams. Where information needs to be shared (e.g. risk information) this will be done primarily via emails between two NHS email accounts. Where this isn't possible, emails may be sent with password-protected attachments.

The therapy will primarily be delivered by the CI (a consultant clinical psychologist) with a small number of participants potentially seen by another suitably qualified member of the research team (a senior CBT therapist/clinical or counselling psychologist). The CI is an accredited therapist with the British Association for Behavioural and Cognitive Psychotherapies (BABCP) and a national lead in the training and supervision of CBT for psychosis. She set up and runs the University of Oxford's PGCert and PGDip in CBT for Severe Mental Health Problems, is a member of the National Severe Mental Health Problems CBT Consortium (a national group of leads for courses delivering CBT for psychosis training), and was a member of the expert panel who wrote the Health Education England CBT for Severe Mental Health Problems national curriculum. The CI's experience makes her well placed to ensure that therapy is delivered within the study in a competent and consistent manner across therapists. She will provide supervision for any suitably qualified member of the research team conducting therapy and will herself receive clinical supervision from Prof Daniel Freeman, a world expert in CBT for psychosis. Within the intervention participants will complete weekly measures which will provide a clear indication of whether the patient is stable, worsening, or improving. These scores will be discussed in weekly supervision to inform the intervention. As is standard in routine clinical CBT practice, consent will be sought from patients to audio record therapy sessions for the purposes of supervision. Where this is given (in our experience the majority of patients typically provide consent for these purposes), sections of recordings will be reviewed within the supervision to ensure that therapy is being delivered in a consistent and competent way. The Assessment of Core CBT Skills (ACCS), a formal measure used to assess CBT competency, will be utilised within supervision". The recordings are not part of the research data, and participants may choose whether or not to have sessions recorded. Their decision does not impact on their eligibility for the study. Recordings will be stored securely as described in section 12 and deleted at the end of the study once write-up is complete.

9.7. Baseline Assessments

For most participants, the baseline assessment will start immediately following the consent process (depending on patient preference, starting on another occasion is feasible). The baseline assessment will last approximately 90 minutes. It may be conducted over multiple visits to reduce participant burden. The assessments are self-report measures. They can be conducted in person, typically in clinic rooms or

at home (for patients who find it difficult to leave their residence) or conducted remotely (for example using telephone, online, or postal versions) if necessary. Basic demographic and clinical data will be collected (e.g. age, gender, ethnicity, clinical diagnosis) from self-report and medical records screening.

Measures

Primary measure: Severity of grandiose delusions assessed by the Psychotic Symptoms Rating Scale - Delusions (PSYRATS)²¹. This is the standard measure of delusions used in clinical trials and is the primary outcome measure.

Secondary measures:

- *Outcomes*
 - Grandiosity: SPEQ-G²²
 - Idiographic measure of grandiose delusion conviction, 0-100% VAS scale
 - Subjective harm (SHEEQ³).
 - Idiographic measures of subjective harm (frequency and distress), 0-100% VAS scales.
- *Mechanisms:*
 - Repetitive thinking (TEEQ³),
 - Immersion behaviours (IBQ³),
 - Meaning (gram/grams⁸),
 - Anomalous experiences (SPEQ-AE²² & CFSA²³)
 - Mania (ISS²⁴).
 - Idiographic measures of repetitive thinking, immersion behaviours, meaning, anomalous experiences, and mania, each on 0-100% VAS scales.
- *Psychiatric symptoms:*
 - Depression (PHQ-9²⁵)
 - Anxiety (GAD-7²⁶)
 - Paranoia (R-GPTS Part B²⁷)

9.8. Subsequent Visits

9.8.1 Extended baseline

Participants will be randomised to an extended baseline of 4-6 weeks. At the end of this baseline period they will complete the same assessment pack as outlined above at the start of baseline. This assessment will be conducted in exactly the same way as the baseline assessment described above.

Additionally, on a weekly basis during the baseline phase participants will complete a brief (10-minute) assessment of grandiose delusion conviction, subjective harm (frequency and distress), meaning in life (degree of meaning in life as a whole; and proportion of meaning in life coming from grandiose delusion), repetitive thinking, immersion behaviours, anomalous experience and mania. Items will be idiographic visual analogue scales. These assessments can be done remotely to minimise burden.

9.8.2 Follow-up assessments

Follow-up assessments will be conducted mid-therapy (after 8 therapy sessions) and end-of-therapy (after 16 therapy sessions). These follow-up assessments will last approximately 90 minutes and may be conducted over multiple visits to reduce participant burden. The follow-up assessments will be conducted in exactly the same way as the start- and end- of baseline assessments already described. The measures included will be the same, however at the end-of-therapy timepoint there will also be an assessment of satisfaction with the therapy (adapted CSQ^{30,31}) and of service- and medication-use (adapted CSRI^{28,29}).

Additionally, the same brief (10-minute) assessment that was conducted weekly during the extended baseline, will be administered weekly during the therapy phase, and then again two weeks after the therapy has completed. To minimise participant burden, these brief assessments will be administered within the therapy sessions during the therapy phase. The final assessment, two weeks after the end of therapy, can be done remotely to minimise burden. The research team will also extract some information from clinical records (e.g. adverse events, service utilisation) for research purposes.

9.8.3 Qualitative interview

There is an additional qualitative interview, after the final assessment, which will provide key insights regarding participants' experience of, and satisfaction with the therapy, and their perceptions of what has led to change (or lack thereof). All participants will be invited to take part in an in-depth qualitative interview. The interview schedule will be developed in collaboration with the LEAP. Interviews will be conducted by the CI and another suitably qualified member of the research team who will have a detailed understanding of the therapy process. This will enable them to ask questions likely to elicit richer data regarding aspects of the therapy experienced by participants as particularly helpful or unhelpful. To support participants to feel able to give honest reflections however, interviewers will not interview participants for whom they were the therapist. A reflexivity strategy will be employed.

Interviews can take place online or in person and will last approximately an hour. These would typically be completed within a single session but may be split into more than one session to fit with participant preference.

Interviews will be audio-recorded, transcribed verbatim, and analysed using reflexive thematic analysis^{32,33}. This methodology facilitates the development, analysis, and interpretation of patterns across the data and to develop themes. Core to this is the recognition that the researchers' influence is necessary and unavoidable so a reflexivity strategy will be employed³⁴.

9.9. Sample Handling

No samples will be taken.

9.10. Early Discontinuation/Withdrawal of Participants

During the course of each study a participant may choose to withdraw early from the study treatment at any time. This may happen for several reasons, including but not limited to:

- the occurrence of what the participant perceives as an intolerable AE,
- inability to comply with study procedures,

- participant decision.

Participants may choose to stop treatment and/or study assessments but may remain on study follow-up. Participants may also withdraw their consent, meaning that they wish to withdraw from the study completely. Withdrawal from the study or study intervention will not affect their usual care.

According to the design of the study, participants may have the following three options for withdrawal:

- 1) Participants may withdraw from active follow-up and further communication but allow the study team to continue to access their medical records and any relevant hospital data that is recorded as part of routine standard of care.
- 2) Participants can withdraw from the study but permit data obtained up until the point of withdrawal to be retained for use in the study analysis. No further data would be collected after withdrawal.
- 3) Participants can withdraw from the study and decide that data previously provided should not be used for future study reports or analysis. However, data cannot be removed from any reports that we have already produced and the clinical outcome database will retain a full audit trail of all data entered into the system.

In addition, the Investigator may discontinue a participant from the intervention at any time if the Investigator considers it necessary for any reason including:

- ineligibility (either arising during the study or retrospectively having been overlooked at the eligibility check),
- an adverse event which requires discontinuation of the intervention,
- clinical decision.

If the participant is withdrawn due to an adverse event, the Investigator will arrange for follow-up visits or telephone calls until the adverse event has resolved or stabilised.

The reason for withdrawal will be recorded in the Case Report Form (CRF).

9.11. Definition of End of Study

The end of the study is the date of the last study contact for the last participant.

10. SAFETY REPORTING

Adverse events are rare in our studies even though this patient group has a higher rate than the general population for the occurrence of adverse events. For example, in a randomised controlled trial of a psychological intervention for another delusion subtype, persecutory delusions, there was no evidence that the intervention led to any serious adverse events¹¹. Adverse events are likely to come to the attention of the assessor or the therapist delivering the psychological intervention but each participant's medical notes will be systematically checked for serious adverse events following completion of the final assessment to ensure all adverse events are recorded.

Adverse events will be recorded from the point of informed consent. The following events are pre-specified as adverse: 1. All deaths. 2. Suicide attempts requiring medical treatment. 3. Serious violent incidents. 4. Admissions to hospital. It is relatively common for this patient group to have serious adverse

events, typically psychiatric hospital admissions, physical health hospital admissions, and suicide attempts.

10.1. Definition of Serious Adverse Events

A serious adverse event is any untoward medical occurrence that:

- results in death
- is life-threatening
- requires inpatient hospitalisation or prolongation of existing hospitalisation
- results in persistent or significant disability/incapacity
- consists of a congenital anomaly or birth defect.

Other 'important medical events' may also be considered a serious adverse event when, based upon appropriate medical judgement, the event may jeopardise the participant and may require medical or surgical intervention to prevent one of the outcomes listed above.

NOTE: The term "life-threatening" in the definition of "serious" refers to an event in which the participant was at risk of death at the time of the event; it does not refer to an event which hypothetically might have caused death if it were more severe.

10.2. Reporting Procedures for Serious Adverse Events

A serious adverse event (SAE) occurring to a participant should be reported to the REC that gave a favourable opinion of the study where in the opinion of the Chief Investigator the event was 'related' (resulted from administration of any of the research procedures) and 'unexpected' in relation to those procedures. Reports of related and unexpected SAEs should be submitted within 15 working days of the Chief Investigator becoming aware of the event, using the HRA report of serious adverse event form (see HRA website).

11. STATISTICS AND ANALYSIS

11.1. Statistical Analysis Plan (SAP)

The plan for the statistical analysis of the study are outlined below. There is not a separate SAP document in use for the trial.

11.2. Description of the Statistical Methods

For the acceptability data, the number of sessions completed by participants and mean (SD) scores on the adapted-CSQ will be reported. The number (and percentage) of participants completing assessments at each timepoint will also be reported.

For the assessment packs completed at start-of-baseline, end-of-baseline, mid-therapy, and end-of-therapy, descriptive summary statistics will be provided for the outcome variables. This includes mean (SD) that will be plotted graphically. Effect sizes (Cohen's d) will be calculated by dividing the change score by the standard deviation at baseline and will be reported alongside a 95% confidence interval. Following the recommendations that analysis of proof-of-concept studies should "mainly be descriptive or focus on confidence interval estimation"³⁵, no p-values will be reported.

For the weekly measures, analysis of visual displays of single-case data will be conducted. This will include exploration of the differences between phases in terms of the central location, trend, variability, and extent of overlap in scores. Consistency across the three tiers within each cohort and across cohorts will be assessed. Non-overlap and randomisation tests will be completed. Effect size estimates will be calculated. To control for potentially improving baseline trends and the expected progressive effect of the intervention, multilevel models will be used, providing quantifications both on average (for each cohort and for all 9 participants) and for each participant separately^{36,37}.

Statistical testing will be completed using web-based applications (Shiny) or R (CRAN packages: SCVA, SCRT, SCMA, SCDHLM) and additional software^{38–41}. The analysis will be completed by the CI in consultation with an expert in Single Case Experimental Design methodology, Dr Rumen Manolov.

Qualitative interviews will be audio-recorded, transcribed verbatim, and analysed using reflexive thematic analysis^{32,33}. This methodology allows us to develop, analyse, and interpret patterns across the data and to develop themes. Core to this is the recognition that the researchers' influence is necessary and unavoidable so a reflexivity strategy will be employed³⁴. The qualitative data will be analysed by the CI in consultation with a qualitative expert (Dr Anne-Marie Boylan) and expert in the development of psychological therapies for psychotic symptoms (Professor Daniel Freeman). To increase credibility, LEAP members will contribute to the analysis – for example considering the appropriateness of initial themes and suggesting new codes/themes.

12. DATA MANAGEMENT

The plan for the data management of the study are outlined below. There is not a separate Data Management document in use for the study.

12.1. Source Data

Source documents are where data are first recorded, and from which participants' CRF data are obtained. These include, but are not limited to, hospital records (from which medical history and previous and concurrent medication may be summarised into the CRF), interview recordings, and study assessment measures.

We keep data from the assessments, collected on paper from the participant assessments. All documents, including electronic files, will be stored safely in confidential conditions. On all study-specific documents, other than the signed consent, the participant will be referred to by the trial participant number, not by name. CRF entries will be considered source data if the CRF is the site of the original recording (i.e. there is no other written or electronic record of data) (e.g. self-report questionnaires).

12.2. Access to Data

Direct access will be granted to authorised representatives from the Sponsor and host institution for monitoring and/or audit of the study to ensure compliance with regulations.

12.3. Data Recording and Record Keeping

All study data will be entered on paper or electronic CRFs and transcribed or entered directly to the clinical data management system. Data will be pseudonymised using a unique study ID. Personal data

and participant identification codes will be kept separately from the research data. Access to these data will be strictly on a need-to-know basis.

Data will be transferred from paper CRFs to the clinical database or recorded directly on eCRFs as soon as possible after the study visit. Validation of all data entered into the clinical database is achieved through manual review. All critical data items are 100% checked against original source documents, where applicable, to ensure accuracy and an error rate is established across all fields to ensure a consistently accurate dataset.

Electronic data will be kept on a secure university server (the University network drive and Onedrive). Hard copies of data will be kept in a locked filing cabinet in a locked room at the University of Oxford.

For the qualitative interviews, once the interview is complete the recording will be sent securely to a transcription service contracted by the university. Transcriptions will be de-identified, and transcribers will delete their audio files on completion. The interview recording will be password protected and also stored on a secure university server as detailed above. In line with the University Policy on Management of Data, all data (including these recordings) will be kept for a minimum of three years. The recordings will be deleted as soon as the analysis has been completed or at three years (whichever of these is the longer duration). The remainder of the data will be kept for 10 years following publication of the results. The report of the study will not identify any individuals

13. QUALITY ASSURANCE PROCEDURES

The study may be monitored, or audited in accordance with the current approved protocol, GCP, relevant regulations and standard operating procedures.

13.1. Risk assessment

The study will be conducted in accordance with the current approved protocol, GCP, relevant regulations and standard operating procedures. Data will be evaluated for compliance with the protocol, standard operating procedures, GCP, and accuracy in relation to source documents. All electronic data entry is double checked against the source documents. There is minimal risk associated with this cohort series, and risk will be monitored by the trial therapists (including the CI) who will regularly and closely oversee the study participants.

13.2. Study monitoring

As the study is a small case series, with minimal risk, there is no requirement for a DMEC. The research team will oversee the management of the study and ensure that the study is conducted and data are generated, documented and reported in compliance with the protocol, GCP and the applicable regulatory requirements.

13.3. Study Committees

This small study with 9 participants does not require any oversight committees.

14. PROTOCOL DEVIATIONS

A study related deviation is a departure from the ethically approved study protocol or other study document or process (e.g. consent process or administration of study intervention) or from Good Clinical Practice (GCP) or any applicable regulatory requirements. Any deviations from the protocol will be documented in a protocol deviation form and filed in the study master file.

A standard operating procedure should be in place describing the procedure for identifying non-compliances, escalation to the central team and assessment of whether a non-compliance /deviation may be a potential Serious Breach.

15. SERIOUS BREACHES

A “serious breach” is a breach of the protocol or of the conditions or principles of Good Clinical Practice which is likely to affect to a significant degree –

- (a) the safety or physical or mental integrity of the trial subjects; or
- (b) the scientific value of the research.

In the event that a serious breach is suspected the Sponsor must be contacted within 1 working day. In collaboration with the C.I., the serious breach will be reviewed by the Sponsor and, if appropriate, the Sponsor will report it to the approving REC committee and the relevant NHS host organisation within seven calendar days.

16. ETHICAL AND REGULATORY CONSIDERATIONS

16.1. Declaration of Helsinki

The Investigator will ensure that this study is conducted in accordance with the principles of the Declaration of Helsinki.

16.2. Guidelines for Good Clinical Practice

The Investigator will ensure that this study is conducted in accordance with relevant regulations and with Good Clinical Practice.

16.3. Approvals

Following Sponsor approval, the protocol, informed consent form, participant information sheet and any proposed advertising material will be submitted to an appropriate Research Ethics Committee (REC), and HRA (where required) and host institutions for written approval.

The Investigator will submit and, where necessary, obtain approval from the above parties for all substantial amendments to the original approved documents.

16.4. Other Ethical Considerations

We anticipate few ethical concerns for patients entering this study. Participation in the study does not change existing treatment receipt, so there is no disadvantage in taking part. Participants will be free to discontinue the study at any point, without needing to give an explanation. Our therapy studies obtain high up-take and excellent retention (90+%) because of the quality of our procedures and the care of study staff. We consult with our PPI group, which anticipates any potential issues. We are highly responsive to the needs of patients, and will, for example, shorten the number of assessments if a participant is finding them too many. The study questionnaires ask participants about their mental health, which may be considered a sensitive topic. However, these are issues that participants are managing outside of the study, and they will have experience of talking about them as part of the treatment they are receiving from NHS services. Our lone working standard operational procedure will be followed by all staff.

16.5. Reporting

The CI shall submit once a year throughout the study, or on request, an Annual Progress report to the REC Committee, HRA (where required) host organisation, Sponsor and funder (where required). In addition, an End of Study notification and final report will be submitted to the same parties.

16.6. Transparency in Research

Prior to the recruitment of the first participant, the study will have been registered on ISRCTN.

16.7. Participant Confidentiality

The study will comply with UK General Data Protection Regulation (UK GDPR) and Data Protection Act 2018, which require data to be de-identified as soon as it is practical to do so. The processing of the personal data of participants will be minimised by making use of a unique participant study number only on all study documents and any electronic databases. All documents will be stored securely and only accessible by study staff and authorised personnel. The study staff will safeguard the privacy of participants' personal data.

16.8. Expenses and Benefits

Reimbursement of participants, including payment for their time at research assessments and travel, are calculated following guidance from the McPin Foundation and NIHR guidelines. Participants will be compensated £15 for their time for each of the research assessments conducted outside of therapy sessions, as follows: £15 for each large assessment packs (start-of-baseline, end-of-baseline, mid-therapy, end-of-therapy), £15 for the combined brief assessments, and £15 for the qualitative interview. Reasonable travel expenses for any visits additional to normal care will be reimbursed on production of receipts, or a mileage allowance provided as appropriate.

17. FINANCE AND INSURANCE

17.1. Funding

The study is funding by an NIHR Advanced Fellowship (reference NIHR305420).

17.2. Insurance

The University has a specialist insurance policy in place which would operate in the event of any participant suffering harm as a result of their involvement in the research (Newline Underwriting Management Ltd, at Lloyd's of London). NHS indemnity operates in respect of the clinical treatment that is provided.

17.3. Contractual arrangements

Appropriate contractual arrangements will be put in place with all third parties.

18. PUBLICATION POLICY

The Chief Investigator will be involved in writing and reviewing drafts of the manuscripts, abstracts, press releases, and any other publications arising from the study. Authorship will be determined in accordance with the ICMJE guidelines and other contributors will be acknowledged. All participants will be offered a copy of the results.

19. DEVELOPMENT OF A NEW PRODUCT/ PROCESS OR THE GENERATION OF INTELLECTUAL PROPERTY

Ownership of IP generated by employees of the University vests in the University. The University and Oxford Health will ensure appropriate arrangements are in place as regards any new IP arising from the study.

20. ARCHIVING

Archiving will be completed after publication of the study outcome. Research data, including consent forms, will be stored securely at the University of Oxford for 10 years post publication. Hard copies of research data will be digitised for this long-term storage. Once the electronic versions have been created, the original hard copies of research data will be securely destroyed. The research data, with the exception of the consent forms, will be stored as anonymised data in the context of this long-term storage. Any personal data which is not research data (e.g., contact details form) will be kept securely for 3-6 months after the study has finished in order for the research team to keep in contact with participants about the research study and share the findings. Electronic data will be kept on a secure University of Oxford server. Any hard copies of data will be kept in a locked filing cabinet in a locked room at University of Oxford facilities.

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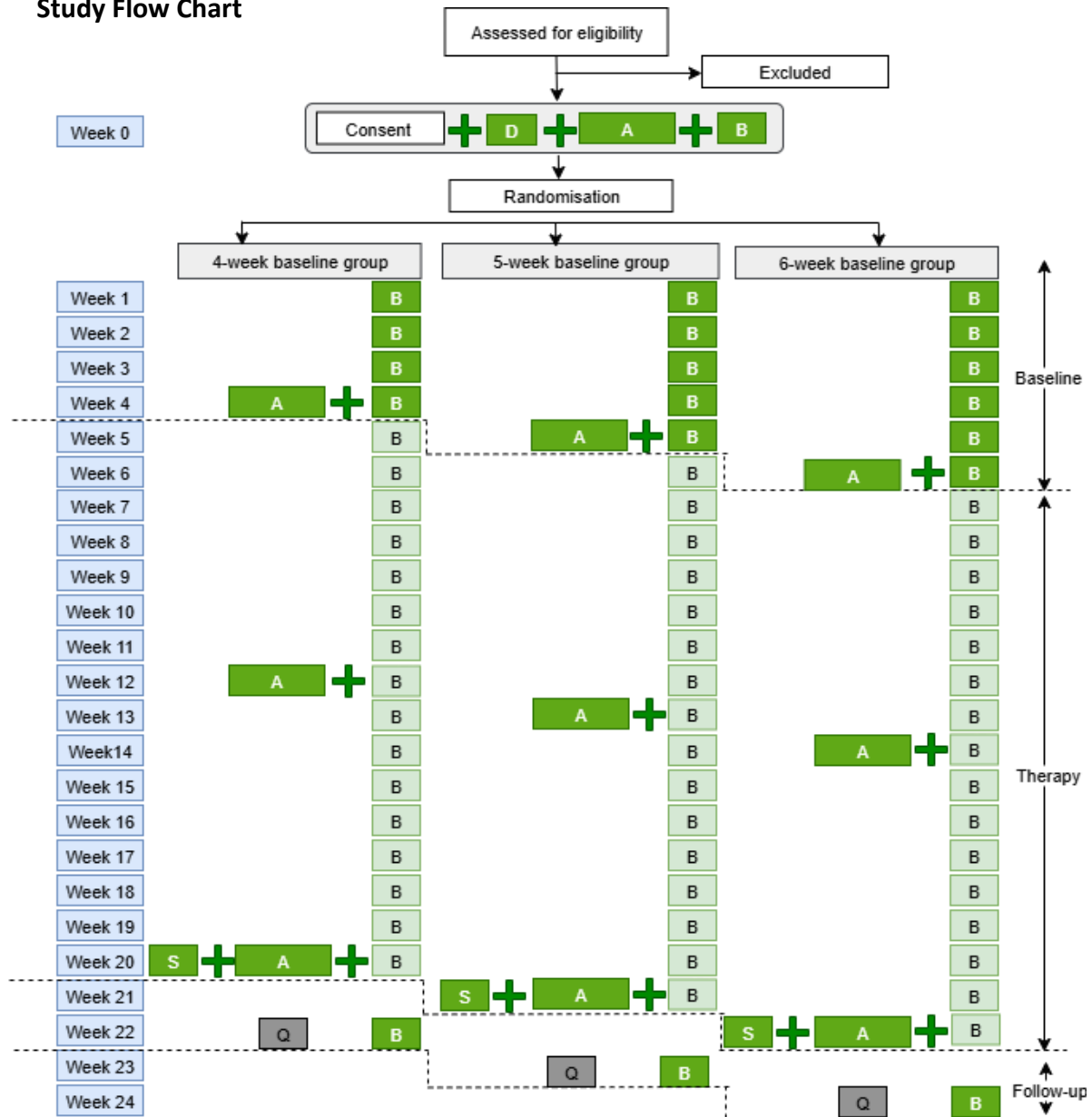
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19. APPENDIX A: SCHEDULE OF STUDY PROCEDURES (see also Study Flow Chart on following page)

Procedures	Screening	Start of Baseline (0 weeks)	During baseline Group1: 1-3 weeks Group2: 1-4 weeks Group3: 1-5 weeks	End of Baseline Group 1: 4 weeks Group 2: 5 weeks Group 3: 6 weeks	Treatment sessions Group 1: 5-20 weeks Group 2: 6-21 weeks Group 3: 7-22 weeks	Mid-therapy Group 1: 12 weeks Group 2: 13 weeks Group 3: 14 weeks	End-of therapy Group 1: 20 weeks Group 2: 21 Weeks Group 3: 22 Weeks	Two-week follow-up Group 1: 22 weeks Group 2: 23 Weeks Group 3: 24 Weeks
Eligibility assessment	X	X (brief)						
Informed consent		X						
Demographics		X						
Randomisation		X						
Brief idiographic measures of grandiose delusions, subjective harm, & drivers of grandiose delusions, on 0-100% VAS scales		X	X	X	X	X	X	X
Measures of grandiose delusions (PSYRATS-delusions; SPEQ-G)		X		X		X	X	
Measure of subjective harm (SHEEQ)		X		X		X	X	
Measure of drivers of grandiose delusions (TEEQ, gram/grams, IBQ, SPEQ-AE, CFSA, ISS)		X		X		X	X	
Measures of psychotic and affective symptoms (RGPTS, PHQ-9, GAD-7)		X		X		X	X	
Service receipt & medication (adapted CSRI)							X	
Qualitative Interview								X
Treatment as usual	X	X	X	X	X	X	X	X
Adverse event assessments	X	X	X	X	X	X	X	X

Study Flow Chart



Study Flow Chart Key:

D = Demographic questionnaire

A = Assessment pack A (standardised measures)

B = Assessment pack B (brief idiosyncratic measures)

S = Service-use and therapy satisfaction measures

Q = Qualitative interview

= Measures completed by the research assistant are shown in dark green.

= Measures completed by the therapist are shown in light green. These measures will be completed within each therapy session and, as such, the pale green boxes are indicative of the therapy sessions offered to the participant within this study.

20. APPENDIX B: AMENDMENT HISTORY

Amendment No.	Protocol Version No.	Date issued	Author(s) of changes	Details of Changes made
	1.2	14.04.2026	Louise Isham	Sample size reduced from 12 to 9; recruitment and study window amended; additional recruitment method (use of Oxford Health's "Count Me In" system) is incorporated; minor change to personnel conducting qualitative interviews incorporated; minor changes to text to improve clarity included

List details of all protocol amendments here whenever a new version of the protocol is produced. This is not necessary prior to initial REC / HRA submission.

Protocol amendments must be submitted to the Sponsor for approval prior to submission to the REC committee and HRA (where required).