Exploring the delivery of family interventions to people facing recent-onset psychotic symptoms: The experience of navigating the family system

Thesis submitted in partial fulfilment for the degree of

Doctorate in Clinical Psychology (DClinPsy)

University of Leicester

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University of Leicester

Submission: 13th May 2016
Declaration

I, David Haggarty, can confirm that this thesis is my own work. It has not been submitted for any other academic qualification.
Exploring the delivery of family interventions to people facing recent-onset psychotic symptoms: the experience of navigating the family system

David Haggarty

Thesis Abstract

The experience of an episode of psychosis can be distressing and confusing. Families can encounter issues of grief and loss and may have difficulties navigating complicated healthcare structures. Family interventions (FIs) have been under-researched and have been difficult to implement in general clinical practice. Healthcare systems usually concentrate resources on acute and inpatient services. The delivery of evidence-based psychosocial treatments which support families are often overlooked.

Part 1:
A systematic review of the quantitative research literature on the effects of FIs on relapse and rehospitalisation in people with recent-onset psychosis was conducted. Searches of four bibliographic databases were completed and ten studies met the criteria for inclusion. FIs were either delivered as a discrete intervention or as part of a multi-element intervention. Findings highlighted that multi-element interventions were effective in reducing time spent in hospital. These treatment gains were robust and conferred long-term advantages. FIs delivered as a discrete intervention had mixed success in reducing the likelihood of readmission. However, there was some evidence that they reduced time in supported living environments as a whole. FIs have some success in reducing relapse and readmission for people with recent-onset psychosis. There have been difficulties in implementing FIs in routine clinical services. Existing research has focused on exploring family workers’ experiences with questionnaires. Further in-depth research is required to capture their experiences in rich detail.

Part 2:
The research study used Interpretative Phenomenological Analysis (IPA) to investigate the experience of delivering FIs to people with recent-onset psychosis and their families. Five care coordinators from early intervention psychosis (EIP) services were interviewed. Five superordinate themes were identified: A) External supports to delivering family work, B) Balancing the care coordinator and family worker roles, C) Barriers to engaging families, D) The internal world of the family worker and E) Family communication and relationships. The themes were considered in relation to the current understanding of FIs and the wider psychological literature. The findings highlight the need for establishing supportive and enabling conditions for FIs to thrive. Family workers face many clinical dilemmas and conflicts in the course of the work. It is important that high-quality clinical supervision is appropriately provisioned in order to help navigate these.
Part 3:
The researcher’s reflective account of the research journey. This incorporates the logistical processes, strengths and weaknesses of the study and personal learning as a critical appraisal.
Acknowledgements

I would like to thank the five participants who agreed to take part in the research study. Despite working in incredibly busy teams they were able to give their valuable time and talk openly about their experiences.

I would also like to acknowledge the support of my research supervisor, Dr Jerry Burgess. His calm enthusiasm and supportive manner have allowed us to work through the many dilemmas of the research process together. He allowed me the space to reflect and to reach my own conclusions. I benefitted from his encouragement and calm reflections. He was able to contain my many emotions and make research supervision a positive experience. I have learnt a great deal from him. My field supervisor Dr Jon Crossley provided a wealth of knowledge about family therapy. His ability to help me to simplify things when I overcomplicated them was extremely important. I want to thank him for all the time and support he provided. I am sure he will remember this year. However, this may be more closely related to the performance of Leicester city football club.

I have had the amazing support of the 2013-2016 cohort. It has been important to have the help and understanding of this small group of individuals. I have felt like we have journeyed through the DClinPsy as a team. A team that was always there to motivate and encourage each other when things got tough. It has been great to train with a group of insightful individuals who have made the process fun and light hearted when it needed to be.

Finally, to my wife Joanna and my daughter Isla. The last three years have been really difficult. Mammoth commutes and endless assignments have really limited our time together. Thank you for the words of encouragement when I needed them. I am incredibly grateful. I could not have done it without your support. Isla, thank you for your words. “You can do it, Daddy” and “do your work Daddy” have spurred me on and given me the motivation to continue. I cannot wait for more quality time together.
## Word count

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**Word count for main thesis (Parts 1, 2 & 3):** 21,765

**Total word count for mandatory appendices:** 4,608

**Total word count for non-mandatory appendices:** 1,652
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Addenda

Transcripts have been provided separately in electronic form on a memory stick.

Recording 1: Chris*
Recording 2: Elizabeth
Recording 3: Alex
Recording 4: Lesley
Recording 5: Hannah

* Pseudonyms used to maintain anonymity
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Part 1: A systematic literature review of family interventions in recent-onset psychosis: Effects on relapse and rehospitalisation

Abstract

Episodes of psychosis often manifest in late adolescence. Families have an essential role in providing care. Health care systems should provide support to families from the first-episode of psychosis. There is a general lack of availability of family interventions (FIs) in clinical practice. FIs reduce rates of hospital readmission significantly in adults with schizophrenia. However, the issues facing a family affected by a first-episode may be different. The current review aims to estimate the effects of FIs on relapse for people experiencing recent-onset psychosis. Four databases were methodically searched for literature on relapse following the provision of FIs to people experiencing recent-onset psychosis. Sixteen papers from ten studies were deemed appropriate for inclusion in the review. FIs were delivered either as part of a multi-element treatment programme or as a discrete intervention. Comprehensive treatment programmes including FIs are effective in reducing time spent in hospital. FIs delivered as a discrete psychological treatment have mixed success in reducing the likelihood of readmission to hospital. FIs may improve the long-term adaptation to an experience of psychosis by reducing the time spent in hospital and supported living accommodation. FIs are helpful for people experiencing a recent-onset psychosis, though they need to be appropriately adapted. There is a need to use manualised approaches flexibly and to focus on the elements of the interventions which resonate most with individual families.
1.1 Introduction

Psychosis and schizophrenia

Psychosis and schizophrenia are terms that have been used interchangeably to represent a major mental health problem in society. The diagnostic concept of schizophrenia is highly contested. It has been widely asserted that schizophrenia represents a brain dysfunction based upon considerable genetic influence (Cardno & Murray, 2002). The illness model regards the course as being chronic and unrelenting (Fenton & McGlashan, 1991). Alternative perspectives have emerged which are critical of the diagnostic reification of the term schizophrenia and assert that it is neither a valid nor reliable concept (Read et al., 2004; Boyle, 1990). The current review distinguishes between ‘the psychoses’, an umbrella term incorporating schizophrenia, schizoaffective disorder and manic depression from ‘a psychosis’. The term psychosis is used in the current review to reflect an acute and episodic experience. The use of this term enables the analysis of pre-existing literature. Recent-onset psychosis (ROP) is used to define a clinical diagnosis of psychosis within three years of the first psychotic episode.

Biomedical perspective

A distinct disease entity for what is now understood as psychosis was first created in 1896 with the introduction of the diagnostic term ‘dementia praecox’. Schizophrenia was later used to describe a heterogeneous group of disorders with common characteristics by Eugen Bleuler in 1911 (Hunter & Woodruff, 2005).

The psychotic state is ascribed when a person has seriously transgressed the intersubjective bounds of rationality (Parnas et al., 2010). This denotes an abnormal experience which lies out of the current social consensus. Schizophrenia is defined as a cluster of disorders in which perceptions, thoughts, mood and behaviour are significantly altered. Current diagnostic approaches, such as the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5; American Psychiatric Association, 2013) and the International Classification of Diseases (ICD-10; World Health Organization, 1990) describe symptoms of delusions, hallucinations, disorganised
behaviour and speech, alogia, avolition, and flattened affect. Schizophrenia has been consistently ranked within the top ten causes for disease-related disability worldwide (Murray & Lopez, 1996; World Health Organisation, 1979; World Health Organization, 2001) and the estimated prevalence is 0.7 percent (Saha et al., 2005).

The aetiology and pathogenesis of schizophrenia have defied definition and classification despite over a century of scientific observation. Biomedical perspectives propose a number of causal factors and mediators of risk. These include genetics (Gottesman & Shields, 1982), neurochemistry (Carlsson, 1978; Tandon, 1999), obstetric complications and perinatal factors (Byrne et al., 2007).

**Developmental perspective**

Episodes of psychosis often manifest in late adolescence (Cannon & Clarke, 2005). Adolescents often face obstacles in meeting the developmental challenges of completing education, forming identity, living independently and enjoying close relationships. The process of adolescence seems to involve the activity of individuation. De-idealisation of parental figures occurs when overvalued ideas fade into human evaluations which incorporate parents’ fallibility. People with psychosis are significantly more idealistic (Harrop, 2000). Family systems are primed to alter in order to renegotiate boundaries, roles and authority. Conflicts may arise from areas that adolescents want to control and parents wish to retain authority over (Smetana, 1989). Harrop and Trower (2003) suggest that the process of adolescence can result in a crisis which threatens the construction of a robust self-concept and may lead to the development of an insecure or alienated-engulfed self.

**Systemic perspective**

Patterns of interaction within families have historically been implicated in contributing to the aetiology and course of psychosis. Possible hypotheses have included invalidating family environments (Lidz et al., 1958), covert expressions of family conflict (Bowen, 1961), double bind patterns of communication (Bateson et al., 1956), parental communication deviance (Singer & Wynne, 1963) and family homeostasis (Jackson,
Discordant family communication patterns are theorised to be an important factor when families are coping with mental distress.

**Stress-vulnerability perspective**

This perspective proposes that psychosis is an environmentally sensitive experience that has been acquired or inherited. The stress-vulnerability model integrated pre-existing genetic and developmental models. It proposes that individuals have unique biological, psychological and social elements. These include strengths and vulnerabilities for coping with stress (Zubin & Spring, 1977). Individuals experiencing a psychotic episode are faced with iatrogenic, societal and situational stressors which are implicated in future relapse. Susceptibility to situational stressors means that the nature of the environment is critical. A reduction in situational stress created and exacerbated by family interactional patterns are hypothesized to reduce relapse.

There has been a failure from gene linkage studies to identify causal unitary genetic factors (Harrison & Weinberger, 2005). Multi-factorial interactional aetiology is more likely. A number of environmental causal factors and risk mediators have been demonstrated, including childhood abuse (Read et al., 2005) adolescent cannabis use (Arseneault et al., 2004), migration (Cantor-Grae & Selton, 2005), urban environment (Kelly et al., 2010; Krabbendam & van Os, 2005) and socioeconomic deprivation (Jones, 1994). Van Os et al. (2008) described a conditional synergistic co-participation of genes and environment.

**From categorical to continuum**

Models of the phenotypical presentations of psychosis suggest that symptoms exist along a continuum from culturally normal experiential phenomena to clinically significant psychosis (Johns & van OS, 2001). Delusional beliefs and hallucinatory experiences have been found to be present in healthy populations (Freeman et al., 2005; Johns et al., 2004; Peters et al., 1999). Many clinical presentations are subtle and the boundary between psychoses and normal mental states are often unclear. Each
individual experience of psychosis is constituted by a distinct phenomenological structure which is more complex than the presence or absence of symptoms.

**Family care**

An emphasis has been placed on the need for partnership working with carers (Department of Health, 1999). Following an initial episode of mental ill health in the UK, over sixty percent of individuals return to live with family members (Gibbons et al., 1984). Families frequently perform the role of primary care provider. This role often accommodates informal case management and crisis intervention. Families are the first and last resort for their relatives, and as such can provide hope to counteract helplessness (Marsh & Lefley, 2003). Providing community care for someone experiencing an episode of psychosis places a high level of burden upon family members (Kuipers & Bebbington, 2005).

**Rationale for change**

In the past a diagnosis of schizophrenia has led to some individuals receiving inadequate treatment by healthcare systems. People have been treated away from their families in conditions likely to invoke hopelessness (Anderson et al., 1986). The advent of community care (National Health Service and Community Care Act 1990) led to families having an essential role in providing ongoing support. However, there has been a lack of availability of family interventions (FIs) in clinical practice (Fadden, 2006). Healthcare systems often concentrate resources on inpatient care during acute episodes. The delivery of evidence-based psychosocial treatments during the intervening periods is often overlooked.

**Expressed emotion**

FIs are predicated on the assumption that high levels of stress within the familial interpersonal environment can exacerbate symptoms. This environment is characterised by high ‘expressed emotion’ (EE). High EE ratings are assigned by trained clinicians’ observations of critical comments, hostility and over-involvement during
structured interview (Camberwell Family Interview; Vaughn & Leff, 1976). This measure is based on how carers spontaneously interact with the individual experiencing a psychosis. Relapse is more likely if individuals live with people who are excessively critical, hostile and/or overinvolved. In such cases the environment is classified as high EE (Leff et al., 1982). High EE environments have been linked to increased relapse rates (Brown et al., 1972; Bebbington & Kuipers, 1994), more frequent hospitalisations (Huguelet et al., 1995) and increased length of hospitalisations (Schulze-Monking et al., 1997).

**Family interventions (FIs)**

FIs were first developed with the aim of reducing relapse rates. With families viewed as a resource for the community treatment of psychosis (Dixon & Lehman, 1995). The intention in FIs is to modulate environmental stress, improve emotional health and build upon family strengths. Family problem-solving is used to achieve functional goals and reduce the risk of recurrent episodes. FIs have been shown to reduce rates of readmission significantly in adults with schizophrenia (Bustillo et al., 2001; Pilling et al., 2002) and have been found to be a cost effective intervention (Mihalopoulos et al., 2004). Family work may also provide the opportunity for a prophylactic defence against future psychotic relapse (Anderson, 1986).

Current guidelines for the treatment of schizophrenia and psychosis recommend that FIs are “offered to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user” (National Institute for health and Care Excellence; NICE, 2014 p.276). Interventions should include the individual with psychosis, comprise a minimum of ten sessions over a duration of three months to one year and take account of family preference for single or multi-family groups. The focus is on attempting to improve the interpersonal environment by providing the key elements of assessment, formulation, psycho-education, problem solving, family support, and crisis management.
A Cochrane review of FIs for schizophrenia found that they may reduce risk of relapse and rehospitalisation, help with medication concordance and reduce family burden (Pharoah et al., 2010). Askey et al. (2007) reviewed FI literature in first-episode psychosis and found there was limited and conflicting evidence for the efficacy of the intervention. Bird et al. (2010) evaluated early intervention services, cognitive-behavioural therapy and FIs in early psychosis. It was concluded that individuals receiving FIs were less likely to relapse or be admitted to hospital than individuals receiving standard care.

**Early intervention**

Relatives of recently diagnosed individuals indicated that help needs to be provided from the first onset of the psychosis (Kuipers & Raune, 2000). The key elements of the early intervention paradigm are early mobile psychosis assessments to reduce the duration of untreated psychosis (DUP) and engagements which are positive and safe (McGorry, 2015). These comprise a case management approach, sustained treatment following the acute episode, low dose pharmacotherapy and a number of psychosocial treatment interventions.

**Early intervention: Using FIs**

Current guidelines for the use of FIs in ROP are based upon schizophrenia research evidence. The issues facing a family affected by ROP may be different from those faced by individuals and their families with longer term experiences. The current review aims to estimate the effects of FIs on relapse and rehospitalisation for people experiencing ROP.
1.2 Method

Search strategy

The literature was examined using a systematic search process. An initial scoping search was conducted in August 2014 which developed the review focus and shaped search parameters. A computerized literature search of the bibliographic databases PsycInfo, Medline, Scopus and CINAHL was conducted. The databases were searched from inception to November 2015. These databases provide an acceptable breadth of psychological and medical literature. The search was restricted to peer-reviewed English language papers. Boolean logic was used to concentrate the results of the search and ensured that different forms of the research terms were incorporated. The search strings were categorized to cover the key areas of population (ROP), intervention (FI) and outcome (relapse). The full search strings used to target the relevant literature are in Appendix A. Reference lists and citations were used as further sources of information.

Results of the search were initially evaluated for relevance. Experimental studies evaluating an FI for ROP were selected for review. A database was used to collate the articles retrieved. A total of 3924 articles were originally retrieved. Following an initial review of titles for relevance 180 were included. After the removal of duplicate articles 129 articles were included. Appendix B provides a diagrammatic process tree of the article selection. Abstracts were then examined using the following criteria.

Inclusion criteria

- Implementation of an FI which included problem solving or communication skills.
- FI delivered face-to-face.
- The use of a population who had experienced recent-onset psychosis (previously defined).
- Quantitative design.
- A minimum of ten families in the intervention group (to remove underpowered pilot studies).
- Use of a control group.
- An intervention protocol of at least seven sessions (NICE guidelines recommend interventions of at least ten sessions. However, protocols of seven sessions or more provide more than simply psychoeducation and inform the research base).

Studies on populations of schizophrenia (long-standing) or affective psychosis were excluded at the initial relevance phase. The main reasons for later exclusion were ‘not ROP’ (39) and ‘no control group’ (22). Details of exclusion categories and the number of studies excluded are contained in Appendix C. Full-text copies of the papers which remained following the application of the inclusion criteria were screened.

**Quality appraisal**

Study details were entered into a proforma and reviewed for methodological quality. A data extraction proforma (Appendix D) enabled the collation of general information for each study. A modified quality assessment tool was used to rate the methodology of the studies (Downs & Black, 1998). This included component ratings for reporting, confounding, bias, external validity and power. The checklist was used as it was able to assess the quality of both randomised and non-randomised studies. A global rating was completed which informed inclusion in this review (Appendix E). Studies which were not rated as ‘good’ or ‘excellent’ were excluded. Appendix F demonstrates the final short-listing process.

**Outcome measures**

The primary outcome measure was relapse or readmission to hospital. Relapse is often viewed as the return to a disease state. There is an absence of a clear relapse definition criterion within psychological and medical literature (Olivares et al, 2013). No single standard measurement of a psychotic relapse exists. Relapse is a complicated construct which incorporates exposure to risk as well as the social and situational factors that give
rise to coping skills. Readmission is a useful proxy for relapse, despite incorporating socio-political contexts and national healthcare practices. Therefore the current review adopted the definition of relapse used by each individual study.
1.3 Results

There were 16 papers from 10 studies that were deemed appropriate for review following the employment of the quality assessment\(^1\). Of the 10 studies, nine were randomised controlled trials (RCT’s) and one was a cohort study. The selected studies have been separated for comparison into three categories. These are:

- Multi-element early psychosis intervention vs treatment as usual (TAU)
- Relapse prevention therapy vs specialist early intervention psychosis treatment
- Family intervention vs TAU

These are considered in turn in three separate sections. FIs incorporate a range of different modes of delivery. FIs can be delivered to single or multiple family groups. The person with psychosis may be present or absent. The most common of the approaches are behavioural family therapy (Falloon et al., 2004) and multiple family group psychoeducation (Mcfarlane et al., 1995). The results of the various studies have not been pooled, as they were not sufficiently homogenous in terms of the intervention and operationalised definitions of relapse. This variation between studies precluded the use of meta-analysis. A narrative discussion of the studies is presented.

Table 1 demonstrates the characteristics of the multi-element intervention studies. Table 2 illustrates the particular characteristics of the FIs used in the multi-element intervention studies.

\(^{1}\) Rated as good or excellent quality
<table>
<thead>
<tr>
<th>Author, Date &amp; Country</th>
<th>Aims</th>
<th>Participants</th>
<th>Follow-up</th>
<th>Duration of family intervention</th>
<th>Outcome parameter (relapse/rehospitalisation)</th>
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<tr>
<td>Craig et al. (2004)</td>
<td>To evaluate the effectiveness of a service for early psychosis</td>
<td>144 participants First presentation of non-affective psychosis Aged 16-40</td>
<td>1.5 years</td>
<td>1.5 years</td>
<td>Rate of relapse</td>
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<tr>
<td>LEO trial (UK)</td>
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<td>Readmission to hospital</td>
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<td>Mean number of readmissions</td>
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<td></td>
<td></td>
<td></td>
<td>Mean number of bed days</td>
</tr>
<tr>
<td>Cullberg et al.</td>
<td>To evaluate the effectiveness of a needs-adapted treatment programme on a large scale basis</td>
<td>388 participants (253 EI vs. 71 HC vs. 64 PC) First-episode psychosis Aged 18-45.</td>
<td>1 year</td>
<td>5 years</td>
<td>Days spent in psychiatric ward</td>
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<tr>
<td>(2002)</td>
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<td></td>
<td></td>
<td></td>
<td>Admission to psychiatric ward</td>
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<tr>
<td>The Swedish Parachute</td>
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<td></td>
<td></td>
<td>Days spent in crisis/residential home</td>
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<tr>
<td>Project (Sweden)</td>
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<tr>
<td>Gleeson et al. (2009)</td>
<td>To evaluate the effectiveness of a psychosocial treatment designed to prevent the second episode of psychosis compared with standardized early psychosis care</td>
<td>82 participants First episode of a DSM-IV psychotic disorder Aged 15-25</td>
<td>7 months</td>
<td>7 months</td>
<td>Relapse rate</td>
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<td>The episode II</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Time to relapse</td>
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<tr>
<td>trial (Australia)</td>
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<tr>
<td>Grawe et al. (2006)</td>
<td>To evaluate the effects of evidence-based integrated biomedical and psychosocial interventions in routine services</td>
<td>50 participants Recent-onset DSM-IV schizophrenia disorders Aged 18-35</td>
<td>2 years</td>
<td>2 years</td>
<td>Admission to hospital</td>
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<td>No. of hospital admissions</td>
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<tr>
<td>Peterson et al.</td>
<td>To evaluate the effects of integrated treatment for patients with a first episode of psychotic illness</td>
<td>547 participants First episode of schizophrenia spectrum disorder Aged 18-45</td>
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<td>1.5 years</td>
<td>Mean no. of days in hospital</td>
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<td></td>
<td></td>
<td>Numbers not hospitalised</td>
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<td></td>
<td>Numbers not living independently</td>
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<td></td>
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</tr>
<tr>
<td>Ruggeri et al. (2015)</td>
<td>To evaluate the effectiveness of an integrated multi-element psychosocial intervention.</td>
<td>510 participants First-episode of psychosis Aged 18-54</td>
<td>9 months</td>
<td>9 months</td>
<td>Number of admissions</td>
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<tr>
<td>GET UP PIANO trial (Italy)</td>
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<td>Mean length of admissions</td>
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Table 2: Characteristics of the multi-element family interventions

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<th>Setting</th>
<th>Delivery</th>
<th>Focus</th>
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<tr>
<td>Craig et al. (2004) LEO trial</td>
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<td>Not stated*</td>
<td>Outpatient</td>
<td>Not stated*</td>
<td>Not stated*</td>
</tr>
<tr>
<td>*further information requested from author</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
| Cullberg et al. (2002) The Swedish Parachute Project | Single               | Present             | Outpatient| Delivered when needed         | Understanding strains and resources of the family  
  Develop common understanding of psychotic reaction  
  Psychoeducation                                                                                                                                 |
| Gleeson et al. (2009) The episode II trial | Single                | Present             | Outpatient| Not stated                    | Relapse prevention  
  Psychoeducation  
  Communication skills training  
  Problem solving                                                                                                                                 |
| Grawe et al. (2006) International optimal treatment multi-site project | Single               | Present             | Outpatient| 1 hour weekly (first 2 months), every three weeks (year 1), monthly (year 2). | Structured family psychoeducation  
  Cognitive-behavioural family communication  
  Problem solving skills training                                                                                                                                 |
| Peterson et al. (2005) OPUS trial          | Multiple family group  | Present             | Outpatient| 90 minutes twice weekly       | Problem solving  
  Skills to cope with the illness                                                                                                                                 |
| Ruggeri et al. (2014) GET UP PIANO trial    | Single                | Present             | Outpatient| 10-15 sessions over 9 months  | Psychoeducation  
  Improving communication  
  Task setting                                                                                                                                 |
**Multi-element first-episode psychosis programme vs. TAU**

This section on multi-element interventions contains five studies. Four are RCT’s and one is a cohort study.

**RCT’s**

**OPUS trial**

This large randomized multi-centre trial compared an integrated treatment (IT) with a standard treatment (ST). The main elements of the integrated treatment were case management, 1:10 caseloads, assertive community treatment, social skills training, low-dose pharmacotherapy and multi-family group psychoeducation. The study provided six or more FI sessions to 42.7 percent of participants. Petersen et al. (2005) demonstrated that at one-year follow-up the IT group spent significantly fewer days on average in hospital (62.2 days IT vs. 78.9 days ST). The calculated effect size was trivial\(^2\) (Cohen’s d = 0.17; n = 507). A significantly larger proportion of the IT group also remained out of hospital (41% IT vs. 29% ST). Individuals provided with the IT were also significantly less likely to live in supported residential accommodation than the ST group at one-year follow-up (4% IT vs 7% ST). Over the two-year follow-up period the IT conferred a trend for a reduction in duration of hospital admissions (89 days IT vs 114 days ST; ns). There was no difference in the proportion of the groups living independently at two-year follow-up.

Five-year follow-up demonstrated that initial treatment gains were not sustained (Bertelson et al., 2008). Between years two and five there was an average difference of 13 days in hospital (58 days IT vs. 71 days ST; ns). However, over the entire five-year follow-up period individuals that received the IT spent significantly fewer days as inpatients (149 days IT vs. 193 days ST). A significantly greater proportion of individuals from the ST group were living in supported accommodation at five-year follow-up (4%)

\(^2\) Likely due to the large standard deviations (94.6 IT vs. 104 ST)
IT vs 10% ST). The individuals in the IT group also spent significantly fewer days in supported housing between years 2 and 5 (57 IT vs. 102 ST). The calculated effect size was trivial (Cohen’s $d = 0.18$; $n = 547$) again likely due to large standard deviations (213 IT vs. 282 ST).

Secher et al. (2015) conducted a 10-year follow-up in which 63 percent of individuals involved in the original study took part. Over the 10-year period the IT groups use of psychiatric bed days was significantly different from the ST group, however, the significance is not present for individual time points after the first three years. Individuals from the IT group used supported housing significantly differently from the ST group over the first six years.

*Lambeth Early Onset (LEO) trial*

The LEO trial was a medium scale RCT. It compared early intervention (EI) with standard care (ST). The EI provided an out-of-hours service, low dose pharmacotherapy, cognitive behavioural therapy for early psychosis (CBT-P), family counselling and vocational strategies. Operationalised criteria for recovery and relapse were applied to extracts of clinical case notes rated by clinicians. The uptake of FIs in the EI group was 56 percent. Craig et al. (2004) found that individuals in the EI group were less likely to experience a further relapse following recovery (30% EI vs. 48% ST; ns$^3$), more likely to be in recovery at follow-up (83% EI vs. 66% ST; ns$^3$) and less likely to be readmitted to hospital (33% EI vs 51% ST; ns$^3$). Over the 18-month period, individuals in the EI group spent an average of 19 fewer days in hospital (35.5 days IT vs. 54.9 days ST; ns$^3$). The mean number of readmissions for the ST group was significantly larger than that of the IT group (0.4 EI vs. 0.8 ST). The calculated effect size was small (Cohen’s $d = 0.46$; $n = 144$).

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$^3$ With post-hoc corrections for gender, ethnicity and previous episodes of psychosis
Grawe et al. (2006)

The RCT investigated the effectiveness of an integrated biomedical and psychosocial intervention delivered under ordinary clinical conditions. Participants were randomly allocated to an integrated treatment (IT) or standard treatment (ST). The IT group received case management, low caseloads (1:10), behavioural family intervention, home crisis management and individual cognitive-behavioural strategies. Grawe et al. (2006) found that at two-year follow-up a fewer proportion of the IT group were admitted to hospital (33% IT vs. 50% ST; ns) or experienced multiple admissions (13% IT vs. 30% ST; ns). There were no differences in the number of major recurrences (33% IT vs. 35% ST; ns). The ST group experienced significantly more minor recurrences (20% IT vs. 50% ST).

Sigrunarson et al. (2015) conducted a twelve-year follow-up and found little long-term effect on the use of services. There were no significant differences in the use of hospital bed days (364 days IT vs. 420 days ST; ns) or the number of admissions (4.4 IT vs. 6.0 ST; ns). There was a significantly larger proportion of involuntary admissions in the ST group (39% IT vs 71% ST).

GET UP PIANO trial

This large scale RCT investigated an integrated multi-element psychosocial intervention in Italy. Individuals were randomized to either the experimental intervention (EI) or the standard intervention (SI) and followed up after nine months. The EI comprised of CBT-P, FIs and case management. A majority of the relatives in the EI group (71.4%) received more than 10 FI sessions4. Ruggeri et al. (2014) found no significant difference in the number of individuals admitted to hospital (16.9% EI vs. 15.8% SI; ns) or the number of days that were spent in hospital (20.8 days EI vs. 23.5 days SI; ns).

4 The mean number of sessions that were received was 9.3.
Cohort study with historical and prospective controls

*Swedish Parachute Project*

The project assessed a ‘needs adapted’ treatment. This was more tailored to the specific needs of individuals and families. Treatment focused on psychotherapeutic and family approaches and low dose pharmacotherapy was prescribed. A historical comparison group (HC) and a prospective comparison group (PC) were used as controls. The parachute patients (PP) received community care, crisis intervention, family meetings, five-year specialised treatment. Cullberg et al. (2002) established that at one-year follow-up individuals in the PP group had spent less time in hospital when compared with the HC and PC groups (22 days PP vs. 42 days HC vs. 65 days PC). However, most of the individuals in the PP group had access to a crisis house. There was a significant difference between the PP and PC groups in total overnight care days used (46 days PP vs. 48 days HC vs. 65 days PC). Cullberg et al. (2006) conducted a three-year follow-up and found that the average number of nights spent in overnight care (psychiatric ward and crisis/residential home) was significantly lower for the PP group when compared with the PC group (100 days PP vs. 160 HC vs. 212 days PC).

Multi-element interventions vs. TAU summary

The most commonly used measure of relapse was the mean number of days spent in hospital. Four of the five studies reported this. [Figure 1](#) illustrates the mean length of hospitalisations. Three of the five studies reported longer term follow-up of the average length of hospitalisations, demonstrated in [Figure 2](#).
Sample sizes ranged from 50 to 510. The total sample size was 1,639. The Peterson et al. (2005; OPUS 1) and Cullberg et al. (2002; Parachute 1) studies demonstrated that the EI resulted in a significant reduction in the use of hospital days. The Craig et al. (2004) and Ruggeri et al. (2014) studies showed non-significant reductions in the use of hospital days. The reduction in use of hospital days ranged from 2.5 days to 43 days. The Grawe et al. (2006; Optimal Treatment Project) study demonstrated a trend towards a reduction in the proportion of admissions to hospital.

The Bertelson et al. (2008; OPUS 2) study demonstrated that the reduction in the use of hospital days remained significant up to five years later. The Sigrunarson et al. (2015; Optimal Treatment Project 2) showed a trend for a reduction in the use of hospital days was present at 12-year follow-up. These long-term follow-ups demonstrated reductions in average annual use of hospital days of between 4.6 and 8.8 days.
Overall, these studies demonstrate a reduction in the use of hospital bed days following the provision of a multi-element treatment programme which included FIs. The treatments provided lasting effects in reducing the length of hospital admissions in the two long-term follow-up studies. There was also some limited evidence for reduction in minor recurrences, number of readmissions, involuntary admissions and use of supported housing.

**Family relapse prevention therapy vs. high quality TAU**

There is one study in this category which compares a novel relapse-prevention multi-element treatment with an early intervention treatment programme.

**Episode II trial**

The trial compared a multimodal individual and family cognitive-behavioural therapy for relapse prevention with standard treatment. Participants were randomly allocated to treatment-as-usual (TAU) or relapse prevention therapy (RPT). The TAU group had access to a range of psychosocial interventions. The RPT group received a written...
relapse risk formulation, phased cognitive behavioural interventions for relapse prevention, parallel individual and family sessions for relapse prevention and supervision which was specifically focused on relapse prevention as an adjunct to TAU. The FI in the RPT group was provided by a trained family therapist. The FI was provided to 58 percent of the RPT group. They received an average of ten therapy sessions. Gleeson et al. (2009) found that within a seven-month follow-up period the relapse rates were significantly greater in the standard care group (21.8% TAU vs. 5.3% RPT). The number needed to treat (NNT) in order to prevent one relapse was six. The calculated effect size was small (Cohen’s d = 0.48; n = 82). Relapses occurred significantly earlier on average in the TAU group than in the RPT group (32 days earlier). Gleeson et al. (2013) demonstrated that the difference in relapse rates remained significant up to 12 months (28.2% TAU vs 10% RPT). There were no significant differences between treatment groups for relapse rates at thirty-month follow-up.

Summary

The study demonstrated that treatments focused on relapse prevention with a high quality FI can further reduce the relapse rates when compared with early intervention programmes. However, these treatment gains were lost at long-term follow-up and may be short-lived.

Family interventions vs. treatment as usual

Table 3 demonstrates the overall characteristics of single-element FI studies included in the review. Table 4 illustrates the setting, mode of delivery and focus of the FIs used.
<table>
<thead>
<tr>
<th>Author, Date &amp; Country</th>
<th>Aims</th>
<th>Participants</th>
<th>Follow-up</th>
<th>Duration of family intervention</th>
<th>Outcome parameter (relapse/rehospitalisation)</th>
</tr>
</thead>
</table>
| Calvo et al. (2014) PIENSA programme (Spain) | To assess the efficacy of a structured psychoeducational group intervention | 55 participants Early-onset psychosis (DSM-IV schizophrenia disorders) Aged 14-18 | 9 months  | 9 months (15 sessions)         | ➢ Patients hospitalised  
   ➢ Mean days hospitalised  
   ➢ Emergency department visits |
| Leavey et al. (2004) (UK)            | To assess the impact of a brief educational and advice support service | 106 participants First-episode psychosis No specified age range                | 9 months  | 9 months (7 sessions)           | ➢ Readmission to hospital  
   ➢ Number of days in hospital                                          |
| Linszen et al. (1996) The Amsterdam relapse prevention study (Netherlands) | To compare the effect of individual orientated psychosocial intervention (IPI) & individual and family orientated intervention (IPFI) across levels of expressed emotion (EE) on relapse | 76 participants Recent-onset DSM-III-R schizophrenia or related disorder Aged 15-26 | 12 months 5 years (Lenior et al., 2001) | 12 months (18 sessions) | ➢ Relapse based on BPRS ratings  
   ➢ Relapse based on clinical case notes |
| Zhang et al. (1994) (China)          | To confirm the usefulness of family intervention in the rehabilitation of schizophrenic patients in China | 78 participants First-admission schizophrenia No specified age range          | 18 months | 18 months post discharge         | ➢ Readmission to hospital                                                  |
### Table 4: Characteristics of the single-element family intervention

<table>
<thead>
<tr>
<th>Study</th>
<th>Single or multi-family</th>
<th>Presence of patient</th>
<th>Setting</th>
<th>Delivery</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calvo et al. (2014) PIENSA programme</td>
<td>Multiple family group</td>
<td>Separate groups for patients and carers</td>
<td>Outpatient</td>
<td>3 individual sessions of 50 minutes</td>
<td>➢ Structured family psychoeducation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12 group sessions of 90 minutes</td>
<td>➢ Problem solving strategies</td>
</tr>
<tr>
<td>Leavey et al. (2004)</td>
<td>Single</td>
<td>Not stated</td>
<td>Outpatient</td>
<td>7 1-hour sessions provided weekly</td>
<td>➢ Cultural issues (religious beliefs, family composition)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>➢ Psychoeducation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>➢ Problem solving</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>➢ Communication skills training</td>
</tr>
<tr>
<td>Linszen et al. (1996) The Amsterdam relapse prevention study</td>
<td>Single</td>
<td>Present (apart from initial 2 sessions)</td>
<td>Inpatient &amp; outpatient (clinic based)</td>
<td>18 sessions provided weekly over 12 months</td>
<td>➢ Psychoeducation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>➢ Problem solving</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>➢ Communication skills training</td>
</tr>
<tr>
<td>Zhang et al. (1994)</td>
<td>Single (common problems) or Multiple family group (complex problems)</td>
<td>Present (apart from initial session)</td>
<td>Outpatient</td>
<td>Every three months (Minimum of 6 sessions)</td>
<td>➢ Life event triggers to psychotic episode</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>➢ Relapse prevention</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>➢ Attitudes to illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>➢ Reducing hostility and over-involvement</td>
</tr>
</tbody>
</table>
Randomised controlled trials

Zhang et al. (1998)

The RCT aimed to investigate the efficacy of FIs in China with a male population. The participants were randomised to either the experimental intervention (EI) or to the standard intervention (SI). SI involved visits to an outpatient department, no regular appointments and no assertive follow-up for non-attenders. The EI consisted of regular family counselling sessions as well as outpatient appointments. Families who did not attend were followed up assertively and individual sessions were conducted in their homes.

The rate of hospital readmissions was significantly lower for the EI group at 18-month follow-up (15.4% EI vs. 53.8% SI). Individuals receiving the SI were three and a half times more likely to be readmitted to hospital. The time to readmission was significantly extended in the EI group (245 days EI vs. 130 days SI). The study demonstrated the additive nature of both pharmacological and psychological interventions. Readmission for individuals who were non-concordant with medication and did not receive the FI was significantly higher than for individuals who were both concordant and in receipt of a FI (76.5% vs. 9.7%).

Leavey et al. (2004)

This RCT for FIs was conducted in North London. Participants were randomized to the experimental intervention (EI) or standard intervention (SI). The EI group received a brief FI in their home. The family workers held at least a certificate in counselling. There were no significant differences between the groups for numbers readmitted to hospital over nine months (10% EI vs. 12% SI; ns) or for the number of days spent in hospital.

Amsterdam relapse prevention study

This was a medium scale RCT conducted in the Netherlands. Participants were randomised to either ‘individual orientated psychosocial intervention’ (IPI) or to
‘individual and family orientated intervention’ (IPFI) and stratified into high or low EE environments. The FI was delivered by two co-therapists with at least one year’s experience. Psychotic relapse was defined by monthly scores on the Brief Psychiatric Rating Scales (BPRS-E) and psychiatric relapse was based on the assessment of clinical records. Linszen et al. (1996) found that the addition of the FI did not significantly reduce relapse rates (13% IPFI low EE vs. 0% IPI low EE, 18% IPFI high EE vs. 23% IPI high EE). A five-year follow-up by Lenoir et al. (2001) demonstrated a trend for the IPFI condition to reduce the total duration of psychotic episodes on average (18.82 months IPI vs. 16.35 months IPFI; ns). Individuals who received the IPFI spent significantly less time in institutions than those who received the IPI (21.18 months IPI vs. 10.87 months IPFI). The calculated effect size was medium (Cohen’s d = 0.56; n = 64). The IPI intervention demonstrated that it was extremely effective in its own right by the low relapse rates. The continuity of care provided from the milieu inpatient environment, inpatient family work and the development of relapse prevention plans in the community may have acted as an extremely effective intervention beyond TAU. Linszen et al. (1996) indicated that the focus on improving communication skills was interpreted by some parents in the IPFI group as implying defects in their intra-familial relationships and raised stress in these sessions.

**PIENSA program**

Calvo et al. (2014) conducted an RCT to assess the efficacy of a psychoeducational multi-family group intervention. Participants and their families were randomized to either a psychoeducational group (PE) or a non-structured group (NS). The PE group received multi-family group treatment adapted for a Spanish population. The NS group received a comparable support group approach. There was a trend for more individuals in the NS group to be hospitalized during the nine month follow-up period (11.1% PE vs. 32.1% NS; ns). There was no significant difference in the average number of days of hospitalisation (4.08 days PE vs. 13.64 days NS; ns). A significantly fewer number of individuals required emergency care in the PE group (14.8% PE vs. 39.3% NS).
Discrete family intervention summary

All four of the studies reported on the proportion of readmissions to hospital. Figure 3 illustrates the readmission rates. Figure 4 shows the readmission rates for the Linszen et al. (1996) study which used EE condition and intervention condition as variables.

The sample sizes ranged from 55 to 106. The total sample size was 315. Zhang et al. (1998) demonstrated that the provision of FIs resulted in a significant reduction in readmissions to hospital. Calvo et al. (2014) found a trend towards a reduction in readmissions. Leavey et al. (2004) found that there was no significant differences between admission rates for the experimental and control conditions. Linszen et al. (1996; Amsterdam Relapse 1) revealed that the provision of FIs to low EE environments resulted in increased inpatient admissions. There is a mixed profile of evidence for discrete FIs and the proportion of readmissions to hospital. There is some evidence that the provision of FIs results in large reductions in readmissions. There is also conflicting evidence which highlights that the intervention is ineffectual, or even destabilising in
low EE conditions. There was limited evidence for discrete FIs reducing use of emergency care and increasing the time to readmission. Lenoir et al. (2001; Amsterdam Relapse 2) demonstrated that despite initial ineffectual results, there was a trend towards a reduction in total duration of psychotic episodes for those who received FIs. The FI condition also conferred a significant reduction in the time spent in institutions for psychiatric patients, reducing this by almost half over the five-year follow-up period.

Figure 4: Readmission rates stratified by EE

![Figure 4: Readmission rates stratified by EE](image)

**Table 5** demonstrates the statistically significant outcomes for the studies included in the current review.
<table>
<thead>
<tr>
<th>Study</th>
<th>Outcome</th>
<th>Follow-up</th>
<th>Difference</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bertelson et al. (2008) OPUS trial</td>
<td>Mean number of days in hospital</td>
<td>5 years</td>
<td>44 days</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td>Living in supported housing</td>
<td>5 years</td>
<td>6%</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>Mean number of days in supported housing</td>
<td>2-5 years</td>
<td>45 days</td>
<td>0.05</td>
</tr>
<tr>
<td>Calvo et al. (2014) PIENSA programme</td>
<td>Emergency department visits</td>
<td>9 months</td>
<td>21%</td>
<td>0.04</td>
</tr>
<tr>
<td>Craig et al. (2004) LEO trial</td>
<td>Mean number of readmissions</td>
<td>1.5 years</td>
<td>0.4</td>
<td>0.03</td>
</tr>
<tr>
<td>Cullberg et al. (2002) The Swedish Parachute Project</td>
<td>Mean usage of overnight care days</td>
<td>1 year</td>
<td>19 days (between PP &amp; PC)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Cullberg et al. (2006) The Swedish Parachute Project</td>
<td>Mean usage of overnight care days</td>
<td>2 years</td>
<td>60 days (between PP &amp; PC)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Gleeson et al. (2009) The episode II trial</td>
<td>Relapse rate</td>
<td>7 months</td>
<td>16.5%</td>
<td>0.04</td>
</tr>
<tr>
<td></td>
<td>Time to relapse</td>
<td>7 months</td>
<td>32 days</td>
<td>0.02</td>
</tr>
<tr>
<td>Gleeson et al. (2013) The episode II trial</td>
<td>Relapse rate</td>
<td>1 year</td>
<td>18.2%</td>
<td>0.04</td>
</tr>
<tr>
<td>Grawe et al. (2006) International optimal treatment multi-site project</td>
<td>Minor recurrences</td>
<td>2 years</td>
<td>30%</td>
<td>0.03</td>
</tr>
<tr>
<td>Lenoir et al. (2001) The Amsterdam relapse prevention study</td>
<td>Average time spent in psychiatric institutions</td>
<td>5 years</td>
<td>10.31 months</td>
<td>0.04</td>
</tr>
<tr>
<td>Peterson et al. (2005) OPUS trial</td>
<td>Mean number of days in hospital</td>
<td>1 year</td>
<td>16.7 days</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td></td>
<td>Percentage not hospitalised</td>
<td>1 year</td>
<td>12%</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>Living in supported housing</td>
<td>1 year</td>
<td>7%</td>
<td>0.03</td>
</tr>
<tr>
<td>Secher et al. (2015) OPUS trial</td>
<td>Development of psychiatric bed day use</td>
<td>10 years</td>
<td>N/A</td>
<td>0.04</td>
</tr>
<tr>
<td></td>
<td>Development of supported housing use</td>
<td>10 years</td>
<td>N/A</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Zhang et al. (1994)</td>
<td>Rate of hospital readmissions</td>
<td>1.5 years</td>
<td>38.4%</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td></td>
<td>Time to readmission</td>
<td>1.5 years</td>
<td>115</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td></td>
<td>Rate of hospital readmissions (Medication concordant &amp; Fl vs non-concordant &amp; TAU)</td>
<td>18 months</td>
<td>66.8%</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
Methodological considerations

The modest sample sizes of a number of the studies may influence the robustness of the findings (Calvo et al., 2014; Craig et al., 2004; Gleeson et al., 2009; Grawe et al., 2006; Leavey et al., 2004; Linszen et al., 1996; Zhang et al., 1994). Studies with smaller sample sizes are less able to cope with heterogeneity amongst participants. This may lead to unmatched groups with significantly different baseline characteristics, as demonstrated in the LEO trial (Craig et al., 2004). Statistically significant results achieved with small sample sizes are less robust and more easily influenced by a small number of events. Walsh et al. (2014) suggest there is increased fragility of a result if a change in the status of a small number of participants (for example from no-relapse to relapse) could cause a change in crossing the threshold of significance. If the number of participants that were lost to follow-up is larger than the number of events required to cause this change then the results should be viewed with some scepticism.

A number of the studies used short follow-up periods (Calvo et al., 2014; Leavey et al., 2004; Ruggeri et al., 2015). Follow-up periods of one year or less seem insufficient to ascertain significant differences in hospital admissions and relapse rates. In order to assess the efficacy of FIs it seems necessary to ensure that the follow-up is extended into a post-intervention period to determine the effectiveness of the intervention when the family is not receiving ongoing support.

The generalisability of results is affected by selection bias. In two studies only approximately half of the sample who met the inclusion criteria agreed to participate (Leavey et al., 2004; Gleeson et al., 2009). These studies did not collect demographic information from non-participants. However, this may have helped to demonstrate that the sample was representative of the population from which it was drawn. The Zhang et al. (1994) study used only male participants which makes inferring conclusions to clinical populations difficult. Studies that used minimal exclusion criteria and drew participants from local populations (Craig et al., 2004; Cullberg et al., 2002; Leavey et al., 2004) increased confidence that the results of the studies are applicable to clinical practice settings.
There were a number of methodological anomalies in the delivery of the FIs. The Leavey et al. (2004) study delivered a short (seven session) intervention to a diverse population which may have been more difficult to support (57.5% people with minority backgrounds & 15.1% people with refugee status). The FI in the Linszen et al. (1996) study was provided in a clinical setting and supervision was requested only when needed. This is unusual in a behavioural family therapy protocol.
1.4 Discussion

The early years following an experience of psychosis are a critical period of influence for long-term recovery (Birchwood et al., 1998). Periods of inpatient admission constitute barriers to key developmental experiences. Decreasing the likelihood of relapses and length of hospital admissions is a fundamental way of improving long-term quality of life and minimising the impact of the experience of psychosis.

Following synthesis and appraisal of the evidence from studies incorporating FIs, a number of findings emerged. The results indicate that the effectiveness of FIs in recent-onset psychosis (ROP) is less conclusive than previously found in the area of schizophrenia (Mari et al., 1997; Pitschel-Walz et al., 2001).

The exclusion of studies which were rated as poor or fair at the quality appraisal stage was considered important to minimise risk of bias, as the studies included in the review were not weighted. This enabled increased confidence in the strength of the recommendations contained herein.

Comprehensive multi-element interventions

Early intervention paradigms mark an important development in the treatment of psychosis. FIs occupy a prominent position within these treatment paradigms. Multi-element interventions appear to be successful in reducing length of hospitalisations. FIs delivered in either single or multi-family format, provided regularly, with problem-solving and communication components may be an important aspect of this reduction in hospitalisation. It is difficult to ascertain what constitutes a clinically meaningful change regarding admission length. Long-term follow-up indicated that hospitalization could be reduced by up to a week per annum, on average, over the critical period. Time spent outside of hospital during a period of developmental growth may enable easier transitions back into the community, education and vocational activities.
Methodological issues

A majority of the studies suffered from larger attrition in the control conditions. This negatively affects the generalisability of the results and may have introduced bias. However, increased uptake of the experimental condition is an encouraging clinical outcome. The proportion of families receiving a therapeutic level of the intervention varied across the studies from under half to over two thirds. This is indicative of the clinical realities of motivating families to engage in FIs. Whilst intention-to-treat analyses are useful in providing methodological rigour, they do not take into account deviations from treatment protocols. Analysis of the outcomes of participants receiving a per-protocol intervention would have been a useful addition to the reported results.

Clinical implications

Unfortunately, many mental health services have not managed to get beyond the goal of implementing evidence-based interventions according to the original early intervention blueprint provided by McGorry in the early 1990’s. Multi-element interventions act to reduce the duration of untreated psychosis (DUP) and provide access to a protocol which is both separate and different from mainstream mental health services. Individual case management is provided throughout the ‘critical period’ identified by Birchwood and Macmillan (1993). FIs, CBT-P and social skills training are delivered in order to increase family coping, reduce the impact of symptoms and improve social functioning.

The next step is to use clinical knowledge to shape early intervention services further. Gleeson (1999) has advocated for the refinement of interventions to best suit individuals experiencing a first-episode of psychosis (FEP). Ensuring that interventions are best-fit, well timed and needs-adapted should be the goal of all early intervention services. The production and analysis of novel multi-element treatment approaches, such as relapse-prevention therapy (Gleeson et al., 2009) can only aid the future development of EI services.
Suggestions for further research

There are a number of ethical and logistical difficulties in conducting well designed studies investigating the effectiveness of multi-element treatment programmes. The incidence of psychosis is such that a large multi-site study would be required to provide a large enough population. There is also a well-established early intervention treatment paradigm and removing aspects of this may prove difficult, despite it being unusual in clinical practice to receive all of the elements. This may well explain the paucity of current research. The goal of the next generation of research should be to isolate the effective ingredients of a multi-element programme in order to deconstruct the key interventions. The experimental condition would contain variations on the various treatment components including case management, FIs, social skills training and CBT-P. It would be beneficial to conduct qualitative research in tandem, to investigate which parts of the intervention the families viewed as most influential.

Family interventions delivered as a discrete psychological intervention

FIs have some success in reducing the proportion of individuals readmitted to hospital. The positive effects are seen most starkly when the intervention is viewed against a backdrop of TAU. Working within diverse populations may make the delivery of FIs more difficult. The provision of a rigid intervention protocol may also be less suitable within low EE environments. The evidence is suggestive that the intervention may be effective in an FEP population, but perhaps need to be delivered more flexibly, using a modular format and in accordance with individual need.

Methodological issues

At present the numerous individual criteria used by different studies makes clear comparisons difficult. Operationalising and standardising relapse criteria would be of clear benefit to researching in the area of FIs for FEP. Short follow-up periods negatively impact on the ability of an effect to be found. Limited sample sizes led to a greater potential for negative findings due to studies being underpowered.
Clinical implications

FIs were initially developed for individuals with a diagnosis of schizophrenia and their families. The evidence suggests these interventions are helpful within a FEP population, though need to be appropriately adapted. The Linszen et al. (1996) study demonstrates the need to focus on the elements of the interventions which resonate most with individual families. The stringent adherence to a preconceived treatment plan may help to explain why FIs have been shown to be less successful in some cases. Responsiveness and adaptation are important elements of psychological treatment. Developing a therapeutic alliance and communicating positive regard and empathy are core processes in any psychological treatment (Norcross & Lambert, 2011). These are crucial principles in order to work effectively with families (Kuipers et al., 1992). Developing a therapeutic alliance and repairing any ruptures are skills which require development. Regular high-quality specialist supervision which provides the space to develop these skills is a necessity. The future of FIs may be in integrating the strengths of a manualised cognitive-behavioural approach with the developments in the field of systemic therapy, such as the open dialogue approach (Seikkula et al., 2001). This approach of integrating systemic and family management approaches has previously proven to be a viable intervention (Burbach & Stanbridge, 1998). However, the increased complexity and length of training may prove a difficult drawback to overcome in current healthcare climates.

Suggestions for further research

Focusing on the adaptation of FIs to an FEP population should be the goal of future research. The evaluation of novel treatments incorporating systemic and cognitive-behavioural approaches would be of benefit. The identification of the underlying mechanisms which facilitate a reduction in relapse and hospitalisation is also an achievable milestone. A study which investigated stringent adherence to protocol vs. flexible delivery of the FI across both high and low EE conditions would enable further conclusions to be drawn. There has been minimal qualitative research to understand the experiences of delivering and receiving FIs.
Conclusions

There is encouraging evidence that comprehensive treatment programmes including FIs are effective in reducing time spent in hospital. There is some evidence that treatment gains achieved during the intervention period are robust and confer a long-term advantage. However, it is difficult to draw clear conclusions about the efficacy of FIs from these.

FIs delivered as a discrete psychological treatment have mixed success in reducing the likelihood of readmission to hospital. FIs may improve the long-term adaptation to an experience of psychosis by reducing the time spent in supported living accommodation. More research is required to add to the research base. Future research which is more nuanced and investigates how different modes of delivery affect outcomes is essential.
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2 Part 2: Exploring the delivery of family interventions to people facing recent-onset psychotic symptoms: the experience of navigating the family system

Abstract

A first-episode of psychosis (FEP) is characterized by distress and confusion for families. Family interventions (FIs) consider the family as an important resource to help modulate environmental stress and reduce relapse. FIs have been difficult to implement in the routine clinical environment.

This research aimed to explore the lived experience of family workers delivering FIs to people with a FEP and their families. Interpretative Phenomenological Analysis (IPA) was used to analyse the accounts of five participants. These participants were care coordinators in early intervention for psychosis (EIP) services. Themes were developed from individual accounts which were later consolidated across the group.

Five superordinate themes were elicited. A) External supports to delivering family work, B) Balancing the care coordinator and family worker roles, C) Barriers to engaging families, D) The internal world of the family worker and E) Family communication and relationships.

Participants reported that delivering FIs was daunting and exhausting, but also rewarding. Family work was difficult to integrate into routine clinical work and could be superseded by other work pressures. Many conflicts and dilemmas presented in the course of the work. Some dilemmas may be overcome by service development and organisation. Dilemmas related to the complexity of the work may be addressed by high quality supervision, this is key to the development of the family worker.
2.1 Introduction

The diagnostic construct

The construct of psychosis is contested. The use of classification systems and the biological basis of mental illness has been strongly advocated by the neo-Kraepelinian stance (Klerman, 1978). However, the validity and reliability of this method of diagnosis has been questioned due to a lack of supporting empirical evidence (Boyle, 1990). The diagnostic concept provides little useful clinical information. The clinical picture of the first-episode of psychosis (FEP) may be complicated by substance abuse, depression, multi-faceted symptom profiles and the normal developmental issues of adolescence. The clinical use of specific symptoms rather than diagnoses is thought to be less stigmatizing and more useful (Bentall, 1990). The term psychosis will be utilised henceforth as the research base has been formed from this diagnostic term.

First-episode of psychosis

The FEP is the period of time when someone first begins to experience psychosis. This can be both a distressing and confusing period for families. It often becomes apparent during adolescence and early adulthood (Sartorius et al., 1986). The average onset of a FEP in the UK is 22 years of age (Department of Health, 2001). Onset can disrupt developmental tasks at a crucial moment. Adolescent FEP is associated with longer treatment delays, higher levels of negative symptoms and increased bizarre behaviour (Ballageer et al., 2005). The unusual experiences and beliefs associated with a psychosis can cause interpersonal conflict, resulting in alterations in self-awareness, relatedness to others and relatedness to the world (Parnas, 2005). This disturbance in perception can modify the experience of reality to the extent that it is not shared with others.

A FEP can result in loss, thwarted future aspirations, stigma, social exclusion and trauma (Tarrier et al., 2007). It is a time for developing independence, completing education and making significant life choices. The FEP often occurs when an individual is developing a sense of self and identity (Dunkley et al., 2015).
Identity and self-concept

The experience of an episode of psychosis has been associated with unbearable levels of anxiety. This distress can bring the self-concept towards dissolution. Individuals may develop a fixed self-position as intolerable parts of the self are expelled. A sense of integrated multiple self-positions is vital to the normal functioning of the mind (Hermans et al., 1992). The experience of psychosis has been conceptualised as a breakdown in dialogue within the self, and between the self and others (Lysaker & Lysaker, 2001). The FEP has been linked with both abnormal self-experiences and being unable to linguistically describe these experiences (Moller & Husby, 2000).

Family functioning

The experience of an FEP can be mystifying for families. Accessing treatment and support from healthcare systems can be a steep learning curve (Sin et al., 2005). The experiences of a family facing an FEP are qualitatively different from families affected by more long-term difficulties (Addington et al., 2001). An increased level of family distress is associated with both the first episode (Martens & Addington, 2001) and a younger age of onset (Addington et al., 2004). The family is a critical support following an FEP, as approximately 60 to 70 percent of individuals continue to live with their families (Addington et al., 2001). Emotional reactions including loss of control, hopelessness, disempowerment, disconnectedness, anger, shame and disbelief are associated with an individual’s experience of FEP (Dunkley et al., 2015). When families first learn a relative has developed a psychosis they are likely to react with anxiety, anger, helplessness and despair (Spaniol et al., 1992). The experience of caregiving for young adults with FEP is often characterized by burdensome responsibility (McCann, 2011).

During the early stages of adaptation to the experience of FEP, issues of grief and loss may be prevalent. Patterson et al. (2005) demonstrated that carers of individuals experiencing an FEP had high levels of unresolved loss. Consciously grieving this loss can
bring healing and rekindle hope in order to recover from the mental illness experience (Lafond, 1994).

Recovery

The recovery movement within mental health emerged from the accumulation of individual stories from people who used services. People communicated what life was like and what helped them to move beyond the role of a patient with a mental illness (Deegan, 1988; Leete, 1988). The adverse effects of medical treatment, unemployment and loss of future aspirations all had to be recovered from (Anthony, 1993). Hope is a central tenet to the concept of recovery (Andresen, 2003; Resnick et al., 2005; Jacobson, 2001). Hope is simply the belief that recovery is possible. Three distinct psychological events have been related to recovery experiences. A period of crisis, followed by the development of a more integrated sense of self, and later rebuilding healthy interdependence (Baxter & Diehl, 1998). Repper and Perkins (2003) state that recovery is about moving beyond problems and developing social roles and relationships that give life meaning.

Diathesis-stress model

Stress has been defined as the physiological, emotional or behavioural response to an environmental event perceived as beyond one’s ability to cope (Lazarus & Folkman, 1984). Individuals appraise events differently which affects the amount of stress experienced. The diathesis-stress model is an integrative approach developed by Zubin and Spring (1977). The diathesis is generally thought to be an inherited biological predisposition, however, life experiences can represent an acquired vulnerability. This acquired or inherited vulnerability is later modulated by environmental stressors. Individuals with low vulnerability may not reach the liability threshold to develop psychosis even during periods of high stress (Fowles, 1992). Equally, individuals with a high vulnerability may not reach threshold as sufficient episodic stress may not occur (Zubin, 1987). Thus the nature of the family environment is a critical factor.
Expressed emotion

Expressed emotion (EE) is a construct used to measure relational communication within environments. High EE was found to be strongly associated with more frequent relapses for people with schizophrenia (Brown et al., 1962; Brown et al., 1972). Carer’s emotional responses were rated using the technical terms of critical comments, hostility and emotional over-involvement. Anger can be expressed through criticism, and hostility represents intense anger and rejection. This anger may link with a sense of burden and lack of coping. Over-involvement represents anxiety and guilt, leading to dependence and separation anxiety. This may stem from perceived loss and attachment fears. Families that were excessively critical, hostile and/or overinvolved were designated as being high EE (Leff et al., 1982).

EE has been demonstrated to be changeable (Willetts & Leff, 1997). Raune et al. (2004) reported that high EE in FEP was linked with an avoidant coping style. Carers in families rated as high EE found that the situational stress exceeded their capacity to cope, which increased burden. The construct of expressed emotion (EE) has stimulated the evolution of interventions aimed at families. These may act to both modify family environments from high to low EE and cause clinical improvements in the individual with FEP.

Family interventions (FIs)

What are they?

The term ‘family intervention’ refers to programmes which are broadly psychoeducational. Education, however, is only one component, as they are based upon cognitive-behavioural principles which form a structured therapeutic approach. FIs should also include negotiated problem-solving or crisis management work (NICE, 2014). There is an emphasis on openness and collaborative working towards goals (Kuipers et al., 2002). The family are considered a resource to modulate the impact of environmental stress, thus reducing relapse. Prior to the provision of FIs there was minimal functional support for family members (Falloon et al., 1984).
Why are they useful?

FIs have been found to increase coping in families of individuals experiencing FEP (Stanbridge et al., 2003). This may be the route to helping carers feel less burdened and less critical of their relatives. Nilsen et al. (2016) found that the perceived benefits of the intervention were developing insight, recognizing warning signs, improving communication skills, learning to solve problems and becoming more independent. Allen et al. (2013) demonstrated that people with psychosis felt that FIs enabled them to feel contained and valued, created new meaning through the validation of multiple perspectives, supported empowerment, led to greater self-acceptance, increased ability to manage emotions and provided hope for the future. FIs may offer a safe environment for alternative dialogues to emerge.

Alternative approaches - Open Dialogue (OD)

Seikkula et al. (2001) described a novel approach with a burgeoning evidence base for the treatment of psychosis. This is a multi-element treatment programme based on a number of important premises. Immediate help is provided within 24 hours and support is organised from the surrounding social networks. Continuity of care is provided throughout inpatient and community treatment. The first priority of OD is to produce dialogue, the second to promote change. Problems are seen as being socially constructed and they are reformulated by every conversation. OD shares a key feature with FIs. Families are viewed as active agents of change who are competent partners in the process of recovery (Gleeson et al., 1999).

Behavioural family therapy (BFT)

Overview

BFT attempts to provide families with information, strategies and practical skills in order to increase their ability to cope with stressors (Falloon et al., 2004). The term ‘family’ is used to represent either people living as a household unit or people providing emotional support for an individual with psychosis. The programme can include individual
interviews with all family members, group family meetings, psychoeducation, relapse-prevention work, communication skills training and problem-solving training. The sessions usually take place in the family home for one hour and all household members are expected to attend. The FI extends to at least ten sessions over a three-month period. Sessions are highly structured and incorporate an assessment of progress, review of real-life practice, skills training and planning for practices and family meetings (Falloon et al., 1993).

Training

The Meriden training programme was implemented in 1998 and has delivered BFT training internationally. It has developed a multi-disciplinary whole-team approach to training. Training is delivered over five days and is primarily skills-based. The majority of the skills training is conducted through experiential role-play. Access to ongoing monthly clinical supervision is an important element of the model (Fadden, 2006).

Implementation

The three major factors involved in implementing family interventions into routine clinical practice are the clinicians, the recipients and the organisations (Fadden, 2006).

Clinicians

FIs require a significant time commitment. Clinicians find it difficult to integrate family work with other pre-existing responsibilities and work pressures (Kavanagh et al., 1993; Bailey et al., 2003; Fadden, 1997). The focus of many professional training courses is on the individual. Clinicians may have very little experience of theoretical models for working with families. It is therefore unsurprising that clinicians’ confidence in working with families is lacking (Fadden, 2006). Clinicians who lack confidence in delivering the approach may be less likely to prioritize FIs amongst regular responsibilities that they feel can be carried out with more assurance. Kavanagh et al. (1993) surveyed 48 therapists two years after training in FIs. The average number of families seen was 1.4. Following training many therapists do not feel adequately resourced to work with the
range of families that may be encountered in clinical practice (Burbach & Stanbridge, 1998). Families are complicated systems and incorporate a huge variability both within and across cultures. Providing FIs effectively requires a nuanced approach. Clinicians may find it demanding to develop the correct balance between structure and flexibility (Fadden, 2006).

Organisations

The organisational factors that have been identified as being important for the implementation of FIs are protected time, well-defined job roles and the availability of clinical supervision (Sin, 2014). Brennan and Gamble (1997) identified that clinicians felt unable to integrate FIs with their other responsibilities due to organisational difficulties. Smith and Velleman (2002) suggest that the approach must be supported by managers at all levels. Ensuring that senior managers, directors and board members are educated and engaged would improve the likelihood of the long-term continuation of the approach within routine clinical settings.

Recipients

Clinicians have reported concerns about being able to find appropriate families to work with and having difficulty engaging families in order to provide FIs (Fadden, 1997). Newly trained clinicians may be looking for families which are less complex and have a traditional family structure.

2.1.1 Aims

Previous research has used questionnaires to investigate the difficulties in implementing FIs. The use of closed questionnaires limits the options available to participants and the conclusions that can then be inferred. The current study aims to explore the lived experience of family workers and generate a greater variation of accounts by allowing more freedom of response.
2.2 Method

Research question

The principle aim of the research was to answer the question: “What is the experience of delivering BFT to people with first episode psychosis and their families?”

Design

A qualitative study design was selected to explore the subjective experiences of the delivery of BFT. Interpretative phenomenological analysis (IPA) has been chosen as the method of data collection and analysis (Smith, 1996; Smith & Osborn, 2003). The phenomenological approach holds that accessing idiographic meaning as directly as possible is essential. IPA provides a method of exploring phenomenological experience using a detailed procedural guide. It explores the meaning that particular experiences hold for individuals. IPA was chosen for the current study as there has been no qualitative research into the experience of delivering FIs. Alternative approaches that sought to provide an explanatory model of the experience of delivering FIs (Grounded Theory; Glaser & Strauss, 1967) or understanding how language shapes the activity of FIs (Discourse analysis; Potter & Wetherell, 1987) were rejected in order to reach the personal experiences of delivering FIs. Semi-structured interviews were used as the method for data collection. The aim was to generate rich information about experiences. A critical realist position was adopted for the current study (Appendix G). This position advances that scientific research is involved in the production of interpretations, open to future revision.

Participants

Recruitment

Clinicians working in a number of NHS trusts within EIP services were approached through team leaders, FI supervisors or team clinical psychologists. Potential participants were provided with an information sheet (Appendix H) a poster (Appendix
I) and a recruitment email (Appendix J). The researcher was available to visit the service and provide further information prior to agreement to the interview process. Participants were contacted following an expression of interest to their contact in the EIP team. Participants were given the choice of interviews being conducted at their place of work or at the University of Leicester.

Inclusion and Exclusion

The sampling was purposive and homogeneous via referral from gatekeepers. Convenience sampling across a number of trust sites was used. Participants were required to be NHS trust frontline staff members trained in BFT. Frontline staff denotes those who were practicing in an EIP team and who had carried out an intervention within 24 months of being approached. The roles included were psychiatric nurses, care coordinators, psychological wellbeing practitioners, healthcare assistants and any regional variants of those posts. Five individuals were recruited and interviewed. Between four and ten interviews are appropriate for professional doctorate research (Smith et al., 2009). All the participants were originally trained as psychiatric nurses and were working as care coordinators.

Ethics

The protocol was developed in accordance with ethical guidelines published by the British Psychological Society (BPS). The research study was approved by the University of Leicester Psychology Research Ethics Sub-committee and NHS trust research and development departments. Participant names and identifying details were anonymised to ensure confidentiality. A time-limited right to withdraw was offered within the consent form (Appendix K).

Data collection

The semi-structured interview schedule was developed to conduct interviews with participants about their experience (Appendix L). The interview schedule was used as a guide. The flexible use of the interview schedule enabled participants to have an
important stake in the areas covered during interview. The interview was conducted reflexively and was an interviewee-centred process. This allowed for the detailed examination of experiences and personal perceptions. The schedule was developed using the approach suggested by Smith et al. (2009). The interviews lasted between 40 and 70 minutes. The interviews were audio recorded and transcribed verbatim. The verbatim transcripts of the interviews served as the raw data in the study.

Data analysis

The analysis began with the researcher transcribing the audio recordings in order to become immersed in the data. The transcription involved a simple orthographic procedure. Conventions for IPA typically involve the identification of each speaker in turn and the use of standard orthography (O’Connell & Kowal, 1995). The next stage of analysis was an interpretative reading and re-reading of the first case in which descriptive, linguistic and conceptual ideas were drawn out separately. These initial notations were integrated into emergent themes. The themes were organised hierarchically and connections made between them. A table of superordinate and subordinate themes was created and linked with extracts from the transcript. This process was repeated for each case. After the analysis had been completed for each case, patterns were established and a master table of themes for the group was produced. An example of the analytic process can be found in Appendix M. A table of recurrent themes was used to establish the frequency of the themes across the sample (Appendix N). When themes occurred in over half of the sample they were categorised as recurrent. Extracts were chosen which were deemed to be well articulated, encapsulated the theme and which resonated most with the researcher’s understanding of the theme. The themes were reviewed and audited by a field supervisor to ensure that categories were warranted and credible. A qualitative research practice group was used to support the researcher throughout data analysis. The master table of themes was used to create a narrative account.
Quality Issues

Smith (2011) developed criteria to judge the quality of IPA studies. Research should clearly subscribe to the theoretical principles of IPA. Phenomenology involves capturing the meaning of an experience or event and trying to get as close to this as is possible. Accessing the perceived meaning, rather than an objective reality. The current research is interested in the participants’ accounts of delivering BFT. IPA is also ideographic. It is primarily interested in the detailed analysis of single cases. The researcher created an analysis of each of the individual accounts before consolidating across cases. IPA considers the research experience to be dynamic. The research produced is both subjective and interpretative. The double hermeneutic implies a two-way movement. The text produced does not simply represent the participant’s account nor the researcher’s interpretation (Sayer, 2000). The researcher is engaged in a reflexive process. Consideration was given to how the construction of the semi-structured interview, data collection and data analysis were influenced by preconceived ideas and pre-understandings. Consideration of this is provided in the critical appraisal. A detailed description of the research process and a table of theme recurrence is provided to ensure transparency.
2.3 Results

Five superordinate themes emerged from the analysis. The first theme related to the external supports which enabled the provision of FIs. The second theme considered the process of balancing different roles. The third theme encompassed the barriers to engaging families in FIs. These themes broadly constitute the capability of the family worker to carry out the intervention. The fourth theme described the internal world of the family worker. The fifth theme concentrated on the impact of the work on communication and relationships within the family. All of the superordinate themes had related subordinate themes. Figure 5 demonstrates the structural layout of the themes. This layout has emerged from the participant’s accounts. However, the order of the themes has been constructed to demonstrate the journey of the family worker.
Figure 5: Hierarchical representation of themes
Superordinate theme A: External supports to delivering family work

The first superordinate theme comprised three subordinate themes. ‘The beauty of team working’ (theme A.1), ‘Supervision is helpful’ (theme A.2) and ‘The benefits of the framework’ (theme A.3).

A.1) The beauty of team working

The colleagues of the family worker supported them in multiple areas. Co-working provided the impetus to begin. It also increased confidence in the ability to carry out the work. It brought about a reduction in responsibility, as this was shared. When difficulties arose there were twice the resources to call upon. Chris exemplified this feeling of being supported:

“I’d benefitted from having a co-facilitator there to pick up on things maybe I’d not asked. Because you have that other perspective...to see how things are going and step in when needed”

(1:418-421)

This co-worker seems to act as an extra observer, one with the ability to become active when necessary. They are able and willing to step-in when anything is missed or they judge that support is required. There are benefits to both the Family workers as they each brought with them skills, abilities and characteristics which complemented each other. Elizabeth also seemed to be reassured by the presence of a co-worker:

“You’re never the same kind of character as the person you’re with...if you feel you’re...being too boundaried and rigid and the other one can soften it, or if you are too soft then they can bring it back into order, it’s a comfortable thing to do with somebody else”

(2:134-138)

This conveys a real sense of balance between the co-workers. Hannah described the aid to creativity:

“You motivate each other and...spark ideas off people”

(5:454)

The co-working relationship also allowed valuable space to debrief and reflect about the sessions. Lesley talked about sharing:
“We were co-working which is the beauty of it, we were able to come away and share that in a way that if you were doing that on your own...you couldn’t have that supervision and...debrief that you have between colleagues”

It seems that the ability to share the experience with a colleague is important. Co-working acts as an informal supervision.

A.2) Supervision is helpful

Group supervision was important. It appeared to act as both a refresher and a motivator. It was a reminder of what was learnt during the original training. It also offered the opportunity to learn from the experiences of colleagues. Lesley felt that supervision helped to develop new ways of using the approach:

“supervision is immensely, immensely helpful,...we really must try to hold onto that opportunity to...be supervised, have supervision around family work, experience what other colleagues are doing and how they’re doing it and how they overcome the challenges that come with it...and innovative ways of using the approach”

The repeated use of the word immensely seems to emphasise the importance of supervision for Lesley. There is recognition that supervision is at-risk and the opportunity must be held onto lest it be taken away. Supervision may increase confidence to deal with challenges and may provide a blueprint in order to carry out the intervention. Alex suggested that it provided encouragement:

“having the supervisions once a month can help to just remember what it’s about and why you do it and...yeah just encourages, often we go round and say...what we’ve done and how it’s benefitted the family and all the problems we’ve had,...it’s just a good reminder really and encourager”

Alex described how supervision helped to keep family work on the professional agenda. Supervision enables the sharing of stories to provide some inspiration to continue working with families.
A.3) The benefits of the framework

The framework referred to training, BFT procedure, the manual and ground rules. This overall structure seemed to enable the delivery of FIs and was containing for the family workers. The structure provided direction which helped to reduce fear. Structure aided coping and reduced the family workers’ experiences of being overwhelmed.

Lesley felt that the setting of ground rules was important:

“Because you get the ownership of the family within it, you and they agree their safety rules...generally it works well because you are thinking of that from the beginning, how do you look after each other within this process” 

Lesley suggested that setting ground rules collaboratively helped the family to feel invested in the process. It seems to provide a useful scaffolding to ensure the safety of everyone involved. Chris felt the ground rules pulled people back from distress:

“We sit down and...because we've already established the ground rules...I think they're very helpful actually...thinking about ways of managing that as it comes up, and trying to have...an approach to manage that and really trying to be thinking, be mindful of the ground rules and be pulling people back to that if people become distressed during the meetings.”

Ground rules offer a useful way of managing difficulties. Chris’s description emphasises a confidence in these basic principles to set limits on the interactions within the session. Elizabeth said that the ground rules helped to organise the meetings. Structure allowed the work to come together:

“You have those individual interviews with each family member and then you have the joint sessions and the way it comes together...it just grows....I don't know how to say the way it comes together....it's reassuring”

Elizabeth finds it difficult to verbalise the natural progression of the family intervention. However, this organic growth against a background of structure helps to contain the anxieties of the family worker. Operating within predictable bounds is reassuring.
Superordinate theme B: Balancing the care coordinator and family worker roles

There were two subordinate themes. The first was ‘integrating family work’ (theme B.1) and the second was ‘avoiding the expert position’ (theme B.2).

B.1) Integration

‘Integration’ related to family work becoming an element of the overall role. There are difficulties in providing FIs and having a dual role as a care coordinator. There were concerns about ruptures in the therapeutic relationship. Family workers also felt a need to advocate for the original client of the service. Family work was an extra responsibility, but one which was felt to be important. The practice of family work was seen as enhancing general practice. Chris stated that it was important that the care co-ordinator was not the main lead for family work:

“If they withdraw from BFT and the care coordinator was leading it, how that would impact on their relationship”

This offered a layer of protection to ensure that the relationship was not adversely affected. Hannah felt that it needed careful consideration:

“If it’s a really good therapeutic relationship family work could work really well...because the care coordinator knows the family well, but then it also could hinder the relationship between the client and the care coordinator, so it is about just weighing it up”

Lesley also found there were difficulties in integrating family work alongside care coordination. However, the pre-existing relationship could have positive aspects:

“So you know them and so they’re warm to you, and they...already know you, they’re quite relaxed and willing to engage in the discussion...on an individual level and that was lovely”

The care coordination relationship seemed to complicate family work. Family workers described a general loyalty to the original client of the team. There seems to be a sense of duty towards this person. Chris worked to support the client:
“I think our client was reluctant to express her feelings at times, I think we tried to help her feel supported so she could do that”

Alex felt an affinity for this client after it was observed that he was trying to make changes:

“I just felt sorry for my client who was actually really trying, and he had…brought up the fact that…he had practiced…positive communication with his family and no-one had done it back to him.”

The use of the terms ‘our client’ and ‘my client’ suggests a possessiveness and demonstrates the pulls of the pre-existing relationship. Lesley described the difficulties of advocating for the original client whilst trying to remain equitable to other family members:

“You have that relationship and a lot of the time you’re advocating for them…which you are still doing…but you’re trying to be equitable to everyone else as well and…that can be challenged”

The original client is the person that the service aims to support. However, family work is about providing equitable treatment to all members. This seems to create an internal turmoil as there are conflicting demands for the differing roles which the family worker fulfils. Despite these difficulties, Chris has come to see family work as part of the job role:

“It’s extra on top of what we did before, but I think we’ve all accepted that and it’s all part of what we do, we all offer it…and we all make time for it”

Elizabeth suggested that the family work had enriched other casework with individuals:

“I think what it’s done for my practice with people that aren’t actually having BFT is it has…changed…my focus right from the initial assessment of a client…I’m more aware of the rest of the family and keep them involved, a little bit more intimately than I perhaps would have done.”

The process of integrating family work seems to be difficult. It offers obstacles which must be overcome. However, it is viewed as being beneficial. It has the potential to
shape wider practice and may even give family workers the ability to refocus on family contexts within individual work.

**B.2) Avoiding the expert position**

This theme related to the position of power. Family workers tried to engage the families as experts. They came from a position that families had the necessary capabilities to solve their own problems. However, there was a struggle between being able to listen and bear witness to what family members brought whilst avoiding a tendency to want to actively step in and help. Alex described this urge to do something:

> “It just felt quite nice that they...felt that they could open up to us...it did kind of make me feel like I wanted to do something to offer to help, but you can't always do that...it's just about acknowledging...their feeling was towards you and you're there to listen to them”

(3:216-220)

Alex manages to contain this impulse. Experiencing the situation is more important than trying to facilitate change. Chris said that it took more confidence just to be present and not offer solutions:

> “The tendency is always when someone is expressing a difficult feeling or a concern or a problem in the family is to step in and want to do something and I think the confidence to not do that and to, to sit with something is quite difficult and to let it be present in the room and not to leap in and want to act”

(1:292-296)

It seems that being with a difficult feeling is demanding. The family workers natural instinct is to do something to help but this seems to be tempered by just being present with the experience. Hannah felt there were times when the family worker needed to take a back seat:

> “We kind of stepped back and just let the discussion kind of happen...... it was just something that... needed to happen for that family”

(5:414-416)

Elizabeth avoided setting up as an expert:
“In the actual situation you’re explaining that you are looking to them to find their own answers and work out their own problems, that you are not there to say this is how you must do things or, you are not there to dictate in any way” (2:159-162)

Elizabeth was keen to set up as a facilitator. Avoiding the development of a critical or controlling relationship. Lesley described treating the family as the experts:

“You know we’re in this together but you, this is your family...you are the experts on your family, we’re just here to support, guide, bring some expertise, some knowledge that might help you...in communicating...so you’ve got to...be able to put aside the professional side of you really, it’s not about that really, in terms of you know that hat” (4:211-216)

There is a clear sense that Lesley put aside the usual professional proclivities in order to undertake family work. This is not about acting unprofessional, but altering the professional style which is used in other situations. It seems that the professional ‘hat’ is linked with the role of a care coordinator, which involves a more expert stance. The new family work role seems to require a gentle guiding within a structured framework.

Superordinate theme C: Barriers to engaging families

There were three subordinate themes. The first was ‘readiness for change’ (theme C.1), the second was ‘the need for flexibility’ (theme C.2) and the third was ‘work pressures’ (theme C.3).

C.1) Readiness for change

‘Readiness for change’ represents the family voluntarily agreeing to complete the FI. Many families appeared to be motivated to complete the intervention. However, withdrawal from the process was common. Talking honestly regarding personal anxieties about the work may be difficult for family members. This could be especially true when motivation levels differ between family members. Chris felt that people demonstrated when they were not ready:

“There were clear dynamics within the family about, some people spoke more than others, and the client, even in his body language and his position in the group was on the periphery, and just by his demeanour... communicated that he didn’t invest much in it” (1:177-180)
Alex felt frustrated when the intervention could not be continued:

“The family were all very engaged but the client themselves was...clearly not very happy to be there...it was just frustrating because we...have identified that there’s a need for communication between him and his family...I also...could see that he wasn’t very comfortable and...you try to kind of address any...barriers that were put up, but I think in the end it wasn’t the right time for him”

The process of family work may require disruption to the status quo and then further reorganisation. The process will require the energy of all involved. Elizabeth felt that people entered into the intervention willingly:

“You’re not inflicting something on somebody, it’s not like you know giving a restrained patient a depot, it’s nothing like that, it’s at the other end of the scale”

Elizabeth suggests that family worker is an intervention which is voluntarily engaged in. A comparison is drawn with physical restraint. However, the perceived pressure to comply may be no less overwhelming, purely more social in nature.

C.2) The need for flexibility

This theme refers to the difference between BFT training and working in a clinical environment. Families in clinical practice are all very different. The clinical reality is that rather than adapting the family to fit the model, the model has to be flexibly adapted to the family and their needs. Lesley suggested that “families aren’t in neat little boxes”:

“It wasn’t the...particular model of family that...we’d kind of been role playing...because normally you’re talking about that live together, so to have a foster family over there, with the child over there and the...birth mother of the child here.”

Hannah demonstrates the difficulties of clinical practice:

“I remember the first session we got there...and they had decorators in and the house was just chaos and manic and it was noisy and there was builders next door”

Chris stated that you had to be flexible in the delivery of the interventions:
“I think in the future...I’ll be clear that it can be as much as this and cover all these things or it could be as little as this.” (1:370-372)

“I think the risk is that it’s a turnoff, people think, oh you have to do all this, I don’t want to do all of that. You could offer it like a menu.” (1:379-381)

Chris accepts that the different modules of the intervention had to be offered in a flexible manner. The one-size-fits-all approach would not be suitable.

C.3) Work pressures

‘Work pressures’ is related to the multiple demands that are placed on the family worker. There was a particular emphasis on feeling overwhelmed by caseloads. Alex found that family work was not always at the top of the agenda:

“Often you can actually forget about BFT, I mean we have loads of pressure at the moment with our caseloads” (3:330-331)

Hannah felt that there were lots of other things to prioritise:

“We’ve got the, the targets around BFT...but also...targets around people with psychosis being offered CBT, being offered physical health checks...our waiting list...treatment to referral time being within two weeks” (5:328-331)

Lesley’s other responsibilities had already taken a toll:

“Especially like when you are doing all the other stuff you’re doing and you think oh gosh I’m frazzled” (4:176-177)

Elizabeth felt that capped caseloads were the only way to have enough hours in the day to deliver the intervention:

“You cannot put in those hours with a family, plus out of hours with a family, plus the basic everyday work with the client” (2:520-522)

Elizabeth feels that the extra family work on top of other responsibilities makes the situation untenable. There is a sense of frustration, due to being unable to do the work fully under current conditions.
Superordinate theme D: The internal world of the family worker

There were four subordinate themes. ‘Feeling daunted and anxious’ (theme D.1), ‘Like coming out of an exam’ (theme D.2), ‘Rewarding experiences’ (theme D.3) and ‘Bringing the self’ (theme D.4).

D.1) Feeling daunted and anxious

The sense of feeling daunted was due in part to the novel nature of the approach for the family worker. There was also a fear that the family work could be un-therapeutic and cause distress. The family workers wanted to ‘get it right’. This was an amalgamation of remembering everything, formulating the family situation well, making sure the family felt listened to and following the structure. One element of feeling daunted was the dynamic of working with families rather than individuals. Alex used the term ‘whole family’ which seemed to emphasise and enlarge the people in the family unit. Alex described walking in the room for the first time:

“I just remember going in…for the first time and everyone was…silent waiting for you to...explain what was gonna happen and they very much expect you to take the lead. (3:52-55)

The term ‘silent waiting’ highlights an awareness that the family had a number of expectations. There is a requirement to take the lead and to be the focus of attention, which may feel uncomfortable. Lesley had concerns about the intervention going “off-piste”:

“Trying not to miss things…you always strive for wanting things to go very well…you have to be competent so then you go along and then you’re delivering it and you’re thinking I’m not confident...really it can be tough” (4:417-427)

Chris was concerned about the potential for anxiety, anger and irritation in the initial meeting:

“Maybe it’s me catastrophizing but coming into the meeting I think oh it’s, this is gonna be an absolute maelstrom, there’s going to be so much flying around” (1:256-258)
Chris has an anticipatory fear of the meeting being uncontrollable. The use of a metaphor for weather phenomenon emphasizes this point. This seems to signify a helplessness to deal with the emotions and difficulties which the families may bring.

D.2) Like coming out of an exam

This theme demonstrated the internal state of the family worker following the provision of the intervention. The work involved juggling many processes. This included structuring the session and an awareness of family dynamics. It was a real challenge to attend to all of this. Sessions required a huge amount of mental energy. The family worker was thinking in a very intense way. Afterwards there was a feeling of exhaustion. This seemed to relate to both a cognitive and emotional tiredness. Chris felt that he was ‘performing’ during the intervention:

“It felt like coming out of an exam really, so I felt completely drained cause I felt like I was performing really” (1:412-414)

The work feels like an assessment of knowledge and skill. Lesley felt that it required a lot of attention:

“You’ve got a lot to remember, so it’s the challenge of…attending to it all, you know it’s quite emotionally demanding, psychologically I think it’s quite a demanding” (4:413-415)

Alex also stated that it took a lot of attention and energy. It was important to do the intervention correctly:

“Probably drained, depending how it goes, ….but I think it does take a lot of your attention…you have to be very aware of…where to go next and erm you’re, obviously it’s not just one person you’re talking to, you’re kind of erm talking between a lot of them…because I’m quite new to it, like it just does take a lot of my attention I guess, and energy…to make sure I’m doing the right things” (3:300-305)

Doing the right things requires holding oneself up against preconceived ideas. It seems difficult for participants to feel content with their performance.
D.3) Rewarding experiences

Family work was associated with rewarding experiences. It appeared that bearing witness to any sort of positive change of circumstances led to a satisfied feeling. Elizabeth found working with children provided a new flavour to the work. Elizabeth felt enlightened and privileged by the experience of delivering family work:

“A sense of a lot of learning, it was also the sense that I’d maybe overcome a bit of a hurdle because before you do it you are nervous, so I had overcome a hurdle…and I’d gained a lot of confidence.”

(2:456-458)

Elizabeth developed as a clinician and now feels comfortable providing FIs. Chris viewed a positive change in the family:

“Even if the family have come away from it feeling that we need to talk more openly, we need to meet as a family and talk through things, then…I feel that’s a positive”

(1:342-344)

Hannah was also pleased by positive changes:

“My most vivid memory is feeling really pleased that…they think the skill is going to be really helpful and that they can see it kind of making a difference”

(5:497-499)

Alex felt that offering the opportunity for family members to discuss their concerns was rewarding:

“A lot of them offload in their kind of individual assessments and you kind of see how it has impacted them as well, even if they don’t live in the family home or, so that’s really rewarding”

(3:205-208)

It seems that stories that have been previously overlooked start to emerge. Family members feel a sense of validation and restoration by being listened to. Bearing witness to this change leads to satisfaction for the family worker.

D.4) Bringing the self

This theme involved the personal characteristics and previous experiences of the family worker which influenced the intervention. When participants talked about the work it
raised questions about how aspects of their own identity influenced the family work. Alex’s transcript demonstrated that age influenced confidence:

“I’m their sons age or daughters age basically, and I’m having to….I’m not rude or anything” (3:386-387)

“A lot of them are older than me…it’s just making sure that you know what you’re doing before you go in” (3:37-39)

“He had practiced positive communication with his family and no-one had done it back to him...so how do I feel about it yeah, just frustrating...like really trying to erm get other people involved but I can’t do that much about it apart from shout” (3:184-190)

Alex felt frustrated, especially with a father in one family. Alex felt that it was very difficult to stop him dominating the session and verbalised a repressed wish to shout at him. Alex seems to feel passive and overpowered, the only recourse available being to switch into a more aggressive position and to shout. Age is a visible aspect of identity which Alex seems to equate with experience and power. Alex seems to be uncomfortable in this newfound position of authority. It may be that having this level of power felt unusual. Alex’s reticence to take control may relate to the position usually taken within the family of origin. Respect for family members from older generations may make it difficult to be assertive in the role of family worker. Elizabeth was able to consider how personal experiences of family influenced the work:

“My previous experience of children has been mainly my own family and ....you can’t assume every family is like your own” (2:54-56)

Hannah also felt that personal family experiences were relevant:

“I think you definitely...observe some families and it maybe makes you think of your own family or there’s something that a particular family member does and you have frustrations with someone in your family for a similar thing” (5:466-469)

Lesley was cautious about imposing or transplanting views onto families. Lesley felt that the content of the family interventions could resonate on a personal level and you had to be open and give something of yourself:
“when you are working with a family you think about your own family...when we were doing the training and you’re role playing you’re drawing on sometimes your own personal, you know things that come from you...you get a script but you bring what you know...part of your experiences within a family itself and especially culturally [description of personal gender, cultural and family roles which are brought to family work follows5]”

Lesley felt that personal family experiences were relevant. Common cultural experiences and particular family roles could cause strong pulls towards individuals and an identification with their experiences. Lesley’s understanding of families seems to have been made within a personal cultural context.

Superordinate theme E: Family communication and relationships

There were three subordinate themes. The first was ‘family work is unifying’ (theme E.1), the second was ‘understanding the family in context’ (theme E.2), and the third was ‘emotion in the room’ (theme E.3).

E.1) Family work is unifying

This theme suggested that at the simplest level the intervention offered the opportunity for the family to spend time together. The time spent together allowed for increased communication. It offered the opportunity to hear other perspectives. The regular contact seemed to allow focus to move onto the needs of all the family members. There was also a unifying experience between the family worker and the family. The bond was felt to have changed from purely professional into something more human. Alex stated it opened up channels of communication:

“It was more just kind of opening up those conversations between the family...I think there was a lot of things that weren’t being said...it just...clarified where everyone’s view was at.”

(3:104-107)

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5 Removed to protect anonymity
Elizabeth felt more involved despite retaining a professional detachment. Elizabeth observed the family in unity:

“It also took the focus from the mother as being always the centre of, well, she’s poorly, we’ve got to work around her, everything’s focused around her and it put the focus very much on the children and their goals...and the whole family supported each individual so well”

Hannah felt that the expansion of social resources was helpful:

“You could see that involving his family and them becoming part of the support network for him had been massively helpful”

Chris stated that the family were more able to communicate:

“They do meet as a family, outside of, and it’s not just over a meal or watching TV, I think they do have a timeout and talk as a family about what’s been going on”

The meetings outside of the sessions provide the opportunity to engage in meaningful discussions. Lesley described the intervention as a “forum for expression” and suggested that it resulted in “powerful exchanges” for family members. Lesley’s relationship with the family also evolved:

“I don’t know if I fully appreciated the extent to which you kind of bond with people...you are a care co-ordinator but I, I guess my role had...sort of evolved”

It seems that for Lesley the professional façade is stripped back. What is left is the humanity of the family worker appreciating the distress of the family. This human experience seems to create a heightened sense of understanding.

E.2) Understanding the family in context

This reflects the family worker developing a more insightful understanding of the original client and the family as a whole. There seems to be a broadening of perspectives. The individual client is initially viewed in isolation. However, the family workers understanding evolves to incorporate the interchange between family members. A depth of understanding develops from viewing family members
communicate with each other and also by beginning to hold the different perspectives of family members in mind. The intervention allowed for moments of profound changes in understanding for the family worker. Alex’s “eyes had been opened”:

“Really helped in...understanding a bit more about my client...I spoke to the dad...and he was very much talking about the other son...he was diagnosed with schizophrenia, he stabbed his brother and all of this had happened in the family and I had no idea, and that’s why my client was really scared about a diagnosis of schizophrenia” (3:280-285)

It is clear that there are real gaps in understanding prior to engaging in family work. The specific fears of the client are now be understood in relation to their familial experiences. Chris formed an understanding of the relational processes:

“There had been difficulties in the family in terms of communication, arguments leading to...risk behaviour from the client, and basically a lot of the clients risk behaviours seemed to be secondary to disputes within the family” (1:213-216)

It seems that a new understanding of the risk behaviours develops. Chris is able to identify that the risk behaviours form a pattern of interactions within the family. Elizabeth cited that “no man is an island entire of itself”. Elizabeth developed a better understanding of the wider situation:

“It’s just given me a broader view of people’s situations and circumstances and more of an appreciation of...the impacts that they have on their family and that the family has on them, it’s more of an appreciation of that interchange.” (2:540-543)

Lesley appreciated all the layers that that were involved in understanding the individual:

“we help people to understand their experiences in terms of psychosis and mental health...and then you have the cultural everything layered on top and there is so much to understand...so when you see that, somebody talking about their own experience in their context and what it means to them, and see somebody else receive that...it is very powerful...to see them receive it in a way that’s not stigmatized and not shaming...is powerful” (4:569-576)

Witnessing the exchange had a profound effect on Lesley. The family work has helped to see beyond mental health and into the multiple contexts that exist for the individual. In the mental health profession individuals are often reduced down to illnesses and
symptoms. The family work may be expanding the individual beyond these definitions which seems to be liberating, but also adds complexity.

E.3 Emotion in the room

This theme demonstrated what it was like for the family worker to engage with the emotions which were present for the families during the intervention. It also included the strategies of the family worker to avoid too much emotion. Lesley felt privileged to bear witness to poignant moments. Lesley described the sense of equality which developed as being “a great leveller”:

“we were just...privileged to see that...and my colleague and I felt quite emotional at the same time...I guess when you talk about equity you know, we didn’t we didn’t break down or anything like that....it was appropriate, it was appropriate, you know because how can you be a stone wall when you see that, when that’s happening in front of you” (4:530-536)

Lesley saw the benefit in emotion being present. The repeated use of the phrase “it was appropriate” suggested that Lesley has some concerns about the emotional reactions that were shared with the family. This may suggest that feeling emotional in the presence of clients is not a regular occurrence and feels unfamiliar. Lesley can’t be a ‘stone wall’. It is not possible to shut down and disengage from the situation. There is a sense that of wanting to be able to listen to and hear the family, however painful this might be. Chris described the strategy of identifying less difficult examples of problems to try to avoid strong emotions developing in the room:

“There was some really negative emotions from the two sisters towards the client, and the client towards those sisters, so I think I would have struggled with that, but I think we would’ve been looking to give examples of communication that weren’t as emotionally charged, so that we weren’t talking about really heavy difficult stuff” (1:392-397)

Chris seems to perceive that strong negative emotions would have been difficult to manage. Chris views this ‘heavy difficult stuff’ as a threat to the therapeutic nature of the family intervention. Hannah tried to make sure that emotions were contained by the end of the session:
“Even if things had been a bit difficult it was always ended on a... contained as a kind of a... relaxed session”

Elizabeth chose to pick topics which would not arouse emotions:

“So let’s pick a topic that isn’t going to arouse any emotions and we’ll practice the skill and not focus on anybody’s problems or faults or failings”

Perhaps the focus of the BFT framework on skill building has led to Elizabeth viewing emotion as negative and impacting on the ability of the family to learn new skills.

Summary

Family workers felt daunted about completing the work. They felt drained after delivering sessions. However, bearing witness to positive change was rewarding. The family workers felt that they had developed as clinicians and acquired new skills.

Team working made family workers feel more confident. Supervision was also viewed as being immensely useful. It acted as a refresher and also facilitated a sharing of experiences. The structured approach provided a framework which was containing and reduced fear.

Being both a care coordinator and a family worker added complexity. Family work required the participants to provide equitable treatment to all family members, however, the pull of loyalty towards their original client was strong. Family workers tried to avoid the expert position and reflect problems back to families to solve for themselves. However, it was hard just to remain present with the family and not to act.

The participants wanted to integrate family work into their practice as they found it enriching. There were benefits to their individual work as they began to view people within multi-layered contexts.

The intervention offered many positive changes to the family situation and also increased the family workers understanding. Families seemed to be more unified. They had the opportunity to share different perspectives in a safe environment. This allowed for a refocusing on both the difficulties and goals of the wider family unit. Family
workers also felt unified by this process. Their relationship evolved. Problems and people became understood in their context. Family workers now had access to view the family from different angles. This allowed for a broadening of their perspective.

Emotion in the room was dealt with in different ways. Two family workers strategized to avoid emotion, one ensured that it was contained by the end of the session and another felt that bearing witness to it was a privileged experience.

Work pressures made integration difficult. Family workers already had multiple demands placed upon them. High caseloads left them feeling tired and without enough hours in the day. Families encountered in clinical practice were extremely heterogeneous. The role-plays during training did not completely prepare family workers for all the difference that they would face. Family workers felt that they had to be flexible. The intervention had to be fitted to individual family units and their needs. Individuals and families also need to be ready to engage in the intervention otherwise there will be high levels of drop-out, which can cause frustration.

Family work is delivered by a person. That person brings with them their own personal experiences of family. Their personal characteristics and identity all influence their delivery of the intervention. Who they are shapes the way that they work. The family work also places the worker in a different position to their other roles. This causes areas of conflict. It also results in a variety of emotions.
2.4 Discussion

The aim of the current research was to explore the experience of delivering FIs to people with recent-onset psychosis and their families. This helped to understand the emotional, logistical and psychological aspects of undertaking this work. This study represents the first in-depth exploration of the experiences of family workers delivering FIs to people diagnosed with psychosis. The participants in this study illustrated the complexity of delivering FIs. There were a number of conflicts and dilemmas which emerged. Balancing roles, taking positions, being positioned by others and managing uncertainty. Five superordinate themes were identified which helped to describe this experience.

A) External supports to delivering family work

Structure was reassuring and provided the scaffolding for the intervention. It created something which was known in amongst a number of unknowns. Structure seemed to increase the family workers perceived ability to cope.

Participants valued clinical group supervision highly. Supervision allowed family workers to discuss difficulties. It also functioned as an encourager and helped to develop innovative practice. Post-training on-going supervision has been found to be important for the successful delivery of FIs (Sin et al., 2014). Group supervision can create a supportive atmosphere which allows for the sharing of anxieties (Hawkins et al., 2000). FI supervision has been found to be a resource to avoid discouragement (Anderson, 1986) and to act as a think-tank for improving practice (Leff & Gamble, 1995).

The co-working relationship allowed for sharing. Family workers appreciated the opportunity that co-working offered for informal supervision. Short post-intervention sessions between co-workers enable the processing of difficult feelings (Burbach & Stanbridge, 2009). Co-working also helps individuals gain experience without being overwhelmed by responsibility (Anderson, 1986).
The ground rules are particularly important. These rules acted as a behavioural contract with families. It enabled the creation of a safe space and avoided sessions becoming chaotic. Treatment contracts can act as a map to guide clinicians (Anderson et al., 1986).

B) Balancing the care coordinator and family worker roles

There was a difficulty in balancing the roles of care coordinator and family worker. It required integrating the new role of family worker into pre-existing ways of working. Family workers felt a loyalty to the original client of the service. Family workers demonstrated attempts to provide equitable treatment, but often felt pulled back to the “original client”. Palazzoli et al. (1980) introduced the concept of neutrality to describe the avoidance of aligning with one particular position and imparting blame. Family workers grappled with neutrality, and felt that at times they were not able to be impartial. Hedges (2005) suggests that working with individuals can result in the acceptance of a single ‘correct’ position. Family work engendered a shifting of focus from one position to many. The desirability and capacity for complete neutrality has been questioned. The concept was reframed by Cecchin (1987) as an open invitation for curiosity. This introduced the idea of using self-reflexivity to identify potential areas of bias and finding ways to address this bias to fully engage all those involved in family work.

Family workers appeared ambivalent about the ‘expert position’. They felt urges to actively step-in and solve problems whilst also wanting to avoid positioning themselves as experts. This may reflect the uneasy fit between medical and psychosocial models of mental health. The ‘basic contraindications’ between psychiatry and family therapy may cause uncertainty (Rice, 2016). Care coordination requires supporting people towards a ‘known’ better place. Family work involves working alongside families to open up paths to ‘unknown’ destinations.

Positioning theory (Harre & Langenhove, 1999) can help to make sense of the dilemma that participants experienced. The sense of self is influenced by taking a position or being positioned by others on a continuum. Family workers experienced a pressure to
act. This pressure to act may have resulted from being positioned as experts by families and by their own professional experience.

A continuum with the polarities of knowing and not knowing can help to describe this process. Clients may position the family worker towards the knowing position. Whilst family workers position themselves more towards ‘not knowing’. This position of uncertainty may be novel and provoke anxiety. Mason (1993) suggested that a position of ‘safe uncertainty’ described a stance of authoritative doubt, which is a balance of expertise and uncertainty. Family workers begin in a position of ‘safe certainty’, they are trained in mental health problems and are positioned by others as being able to offer permanent solutions.

C) Barriers to engaging families

Readiness for change is an important element of families being able to complete FIs. A number of interventions were initiated and later came to a premature end. Making conscious efforts to change can be difficult. The trans-theoretical model of change (Prochaska & Velicer, 1997) described common processes of change across all therapeutic modalities. Five stages of change were developed to demonstrate how change processes were used (Prochaska et al., 1992; Prochaska & Norcross, 2001). Assessing readiness for change may avoid interventions being targeted at families who are not able to undertake the work. Families and individuals not at a state of readiness could be provided with more targeted interventions. Frequently some family members are more motivated for treatment than others. Campbell (2004) described a reluctance to engage from service users which was overcome by carer enthusiasm.

The realities of clinical practice meant that family workers had to be flexible and adaptable in order to implement FIs. When translating research into practice it is necessary to consider the dilemma between fidelity and flexibility. Cohen et al (2008) found that therapists were often required to make modifications to treatment protocols to accommodate individual circumstances. Clinical variability is typical in working with people with psychosis and their families. Tailoring support to the individual needs of the
family may offer the most therapeutic benefit (Onwumere et al., 2011). Leff and Gamble (1995) suggest that FIs are a set of skills that need to be employed flexibly to suit individual families.

Family workers found that a difficult barrier to overcome was care coordination caseloads. Previous research has demonstrated that family work competes with core case management roles (Kavanagh, 2016; Onwumere et al., 2016). Department of Health policy stipulates that care coordinators should have maximum caseloads of fifteen clients (Department of Health, 2003). Higher caseloads have been found to be a key barrier to implementing BFT (Fadden, 2006).

D) The internal world of the family worker

The theme of ‘feeling daunted and anxious’ demonstrated that family workers were not confident in their ability to carry out the intervention. Michie et al (2007) previously found that clinician self-doubt and fear were barriers to implementation. This may reflect the developmental stage of family workers providing a novel therapeutic approach. The beginner level has been characterized by anxiety and attempting to find the ‘right answer’ (Stoltenberg, McNeil & Delworth, 1998). Self-efficacy represents the belief of one’s own capabilities in a specific situation. Bandura (1977) stated that performance accomplishments, vicarious experience, verbal persuasion and emotional arousal all informed self-efficacy. Training in BFT is practical and incorporates role-play, video observation and repeated encouragement. This provides family workers with a number of personal experiences and observations of performance accomplishments as well as reassurance in their ability. However, levels of emotional arousal still appear to be very high for prospective family workers. Perhaps it is at this emotional level that further support is needed to help family workers feel less stressed and anxious prior to carrying out interventions.

The theme ‘like coming out of an exam’ reflected the feeling of exhaustion that family workers experienced after carrying out the intervention. This demonstrates the importance of protecting time for a short debrief amongst co-workers (Burbach &
Stanbridge, 2009). This allows for a containing experience to process the heightened emotions which family work can provoke.

Rewarding experiences provided family workers with a sense of a job well done. This links with an increase in self-efficacy. Not only is it rewarding to view positive change. It also raises the confidence levels of family workers and makes them feel more comfortable in delivering the intervention. These performance accomplishments provide a sense of personal mastery (Bandura, 1977). This raises future expectations of ability and enables individuals to overcome difficulties.

Reflexivity is important in delivering family work. Self-reflexivity is the ability to turn the lens inwards and make oneself the object of one’s own observation. Reflexivity involves observing one’s own therapeutic practice and using the learning from this to influence future practice (Burnham, 1993). Family workers found that they were influenced by their own personal characteristics and experiences of family. Family workers identified with certain family members and family situations. The behaviour and characteristics of family members also brought out certain responses. Having an understanding of reflexivity would be of great benefit to family workers. This would enable them to understand the push and pulls of family work and reflect on any intense emotional reactions. Supervision is an ideal opportunity for family workers to develop skills in self-reflexivity which can then be translated into therapeutic situations. Using a framework such as the social GRRACCEESS (Burnham et al., 2008) may enable family workers to consider power and privilege and its influence on the family work.

The family workers in the current study found that their relationship with families had evolved. This may have led to a conflict developing which is central to providing therapeutic family work. How to remain both part of a group and also separate.

E) Family communication and relationships

There was a unifying aspect to family work for both the families and the family workers. Family workers reported that increased communication emerged from this. Allen et al
(2013) found that people with psychosis receiving family work valued the ‘shared containing space’ that it offered.

Family workers also found that their understandings shifted and became more insightful. Linear understandings of the individual had begun to develop into a more interactional understanding of communication patterns. Family workers began to view actions and behaviours as more than fixed personality traits. People were observed to function in a multidirectional system where feedback had profound effects. Systemic perspectives have created a shift from the individual to the interpersonal. This has helped to move from a linear understanding to making sense of the communication patterns within systems (Bateson, 1972).

‘Emotion in the room’ described the experience of emotion in the sessions. High EE environments being indicative of increased relapse (Brown et al., 1962; Brown et al., 1972) may have led family workers to seek to avoid emotion and work on a purely cognitive level. Emotion may have been viewed as negatively impacting the learning of new skills. However, relatives provided with FIs have previously responded that the task-focus interfered with their ability to deal with issues of grief and loss (Linszen et al, 1996). Working flexibly and collaboratively with families seems to be key. Working with families on the emotion in the room may help them to develop an understanding of the patterns of interaction that create emotions.

Conclusion

Family work is best able to thrive when provided with conditions that are enabling. A supportive team with the opportunity for co-working, high-quality monthly clinical supervision and team acceptance of family work all contribute to this. The themes which resulted from discourse with family workers seemed to demonstrate a number of clinical dilemmas. These clinical dilemmas seem to be punctuated throughout the history of family therapy. It highlights the need for space to develop as a clinician and make personal decisions about what feels right, rather than there being one ‘correct
way’. Fidelity to the overall model must be balanced with flexibly delivering BFT based on what the family needs.

There is a distinct lack of synchronicity between treatments that have proven efficacious in controlled research settings and their availability in clinical practice. Greenhalgh et al. (2004) modelled the complexity of implementing innovations within health services. Barriers to implementation must be understood in order to identify strengths to overcome the potential challenges (Cook et al., 2012). Implementation has been deemed to be more difficult when innovations are complex (Denis et al., 2002) and when dedicated time and resources are not present (Gustafson et al., 2003; Rogers, 1995). The possibility for adaptation has also been found to be important for the implementation of innovations into local contexts (Gustafson et al., 2003; Rogers, 1995). The ‘social ecology’ of settings should be considered in order to improve implementation (Atkins et al., 2016). An Acknowledgement of setting-specific factors is important in order to facilitate alignment and sustainability of the intervention with the environment.

One potential mistake at an organisational level is to ‘throw good money after bad’ by repeatedly training individuals to conduct FIs and then returning them to teams where it is difficult for them to do so. Within EIP services, it is important that caseloads are managed more effectively so that there is space for FIs. Unfortunately, investing in training for large numbers of clinicians within EIP services and then returning them to services which are under resourced is unlikely to affect any meaningful change in the proportion of families receiving FIs.

Staff barriers to implementation also play an important role. Burnout is a syndrome of emotional exhaustion experienced by individuals working within the ‘helping professions’ which can lead to deterioration in the provision of quality care (Maslach, 1981). Greenhalgh et al. (2004) found that individuals’ psychological processes influence the implementation of innovations. Burnout may impact upon motivation levels and
also cause a shift in values. If there are high levels of staff burnout, the implementation of novel treatments is likely to prove difficult.

Family work benefits wider clinical practice and allows for growth and development. However, there seems to be the potential for further training in family approaches. The initial training in BFT could be a foundation level training that allows family workers to carry out the work. Further training in a range of systemic concepts, such as self-reflexivity, safe uncertainty (Mason, 1993), Social GRRAACCEESS (Burnham, 2012) and systems and feedback (Bateson, 1972) also seems important. This may help to move beyond the realm of BFT or systemic family therapy and into an integration of the two approaches. The structure of BFT provides important reassurance and containment at first, but as the family worker becomes more comfortable working with families they may feel able to deliver family work more flexibly.

Limitations and suggestions for further research

There are a number of limitations of the current study. Recruitment was difficult and a small sample size has been used. The accounts of the experience may have been skewed towards a particular perspective. Participants that agreed to talk about their experiences may have had more positive accounts. Inclusion criteria necessitated a completed intervention. Those individuals who trained in BFT and did not complete an intervention have been overlooked. It seems that this population would offer a different perspective and it would be important to capture their views.

This research and the conclusions therein represent the experiences of a particular population of family workers. The experiences encountered when delivering FIs may lead to “theoretically generalisable conclusions” (Willig, 2001). These results therefore provide a valuable reference point for training providers, supervisors and Family workers to understand the processes which are likely to be faced. Some of the difficulties can be overcome through service development and organisation. Other dilemmas related to the complexity of the work and the conflicts the family worker
experiences may be addressed through high quality supervision, which will be the key to the development of the family worker.
2.5 References


Kavanagh, D. J. (2016). What the problem may be with family intervention...and with dissemination more generally: A commentary. *Australian Psychologist, 51*, 69-72.


Sartorius, N., Jablensky, A., Korten, A., Ernberg, G., Anker, M., Cooper, J. E. et al. (1986). Early manifestations and first-contact incidence of schizophrenia in different cultures: A preliminary report on the initial evaluation phase of the WHO Collaborative Study on determinants of outcome of severe mental disorders. *Psychological Medicine, 16*, 909-928.


Part 3: Critical appraisal

This is a reflective account of the research process for the author. The research process is a complex journey. Whilst attempts were made to record the different stages in a research diary, much of the content of the critical appraisal is made based upon reflections from the overall experience.

Research topic selection

When I began clinical training I had a clear idea of a research project theme. I had worked for nine years in the field of adult mental health following the completion of my undergraduate degree in psychology. It was whilst working in this role that I became interested in ‘the family’ and mental health.

I worked in a community rehabilitation project for people who had experienced mental health difficulties. Most of the service users required support to transition back into the community, usually following long periods of hospitalisation. This project was cited as being one of the first halfway hostels in the country for people who had experienced mental health difficulties. It was opened in 1958, with the aid of a pioneering social psychiatrist. The project aimed to act as a stepping stone leading to integration in the community (Clarke, 1967). Following publication in the Lancet (Clarke & Cooper, 1960) visitors came from all over the world to view the model of care. The underlying vision changed little over the years and the project maintained the original ethos of treating service users as normal people.

Whilst working with people who had been given diagnoses of psychosis and schizophrenia I came to recognise the influence of situational stressors. I observed that contacts with family members could have profound effects on the people that we worked with. These experiences were varied. They had the potential to be rewarding, cause upset, and on occasion these contacts provoked behaviours which were challenging for people around them.

I learnt about the concept of expressed emotion (EE) and began to understand the influence of situational stressors on mental health. I worked hard to consider how my
own interactions and those of the wider staff team might influence the service users that we worked with. The team tried to produce a warm atmosphere and positive interactions within the community. Critical comments and hostility were kept to a minimum. The aim was to support people to drive their own recovery. The emphasis of the programme of care was to foster independence and social competence.

I became more interested in the experiences of people diagnosed with psychosis. I came upon family interventions (FIs) when completing an MSc in mental health studies. A lecture from Professor Julian Leff on FIs (Leff et al., 1982; Leff et al., 1985) sparked my interest further as his passion for the approach was infectious. I was amazed that I had never seen or read about FIs in the case notes of anyone that I worked with. This intervention was clearly not available on a large scale. It was an evidence-based intervention that seemed logical to me, based upon my experiences. Pharmacological interventions were abundantly available, however, there seemed to be little provision for this practical psychosocial intervention. I felt passionate about understanding more about why these interventions were not available.

Designing the research

Initially I was interested in family work in relation to people who had received diagnoses of psychosis or schizophrenia. FIs and their implementation seemed under-researched in general. However, there was even less research into FIs for individuals who could be described as having experienced a first episode of psychosis. I was interested in what factors made it difficult to carry out the intervention following training. It seemed that there must be barriers to the implementation of this approach. I talked with a number of people with expertise in the field. Following a review of the literature I felt that a research project in this area was viable.

I realised that I wanted to talk to family workers about their experiences. However, without experience in conducting qualitative research, I set out to understand what approaches were available and what epistemological position I held. I was immediately drawn to Interpretative Phenomenological analysis (IPA; Smith et al., 2009). I wanted to find out what the experience of delivering the intervention was. I read that this was an
approach which provided rich data about the individual. This approach fitted best with my research question. It was also logistically viable given the timeframe available to me. I had been warned at peer review that finding participants would be like “hunting for leopards without spots”. I also gave consideration to grounded theory (Glaser & Strauss, 1967). However, I felt that the theoretical sampling required might pose some difficulties. I was also more interested in developing an understanding of the lived experience of participants than generating a theory.

I considered my epistemological position in relation to the research. I found that this was a difficult task. I learnt that I was neither a positivist nor a constructionist. Although I agreed with elements of each of these positions, I did not feel true to either of them. The critical realist position (Bhaskar, 1975) made sense to me. It offered the ability to take a research position of construing the social world. My interpretations could be open to future revisions. The research that I produced could be deemed to have some explanatory power, but it wasn’t reliant on the creation of an absolute truth.

I contacted the Meriden family programme and was able to book onto the Behavioural Family therapy (BFT) course for early intervention. This necessitated extended travel between Leicester, Birmingham and Cambridge over a five week period. However, it provided an insight into the practical training methods employed. I trained with a number of teams from Birmingham and individuals from other parts of the UK. I had the opportunity for many formal and informal discussions with the trainees about how to use the approach within their service and any challenges that they could foresee.

**Ethical considerations**

I felt that the opportunity for distress to be caused from the interviews was minimal. However, in discussions with my supervisor we considered that the focus on working with families might cause people to reflect upon their own family relationships. The research study was approved by the University of Leicester Psychology Research Ethics Sub-committee. I found the process to receive approval from the local NHS trust research and development departments took more time than I had initially anticipated. I originally planned to conduct the research across five trust sites, but I scaled this back.
to two based upon promising early discussions with prominent staff members in EIP teams within these trusts.

Recruitment

The recruitment process was more challenging than I expected it to be. I planned to recruit through clinical psychologists, team leaders and family work supervisors at the various sites. There were delays and difficulties in identifying and making contact with appropriate individuals at some of the trusts that I had planned to work with. Within the trusts where I had received approval I was able to either arrange to present my research at a family work supervision session or to have details of interested parties forwarded to me. When I presented, I spoke for a short time about my research, fielded questions and asked interested parties to provide their details. I found that a large proportion of the staff trained in family work decided to meet with me. When I conducted the interviews I found that approximately half of the EIP staff who had initially booked to talk with me were unable to attend the interview. This necessitated multiple trips to the trust site which was difficult to accommodate. Having completed a placement within EIP services I was aware of the time pressures of the staff. I was immensely grateful for the time that was afforded me.

Interviews

The development of a qualitative research group which met regularly at University was of great benefit to me. A number of the researchers within this group had attended an IPA workshop and were able to share their experiences and knowledge. There was space to discuss semi-structured interviews and consider these as a group. As we were all at different stages in the research process I was able to gain some great insights from individuals who had already completed some research interviews and this was invaluable in preparing for them.

I found that I was not worried about talking to people about their experiences. I felt that I had developed as a clinician due to my training in clinical psychology. I felt comfortable talking to people. Developing rapport is an important aspect of any interaction and I was
confident in my ability to do this. What concerned me most was making sure I conducted a research interview rather than a therapy session. In my clinical practice I have quite a humanistic approach and tend to reflect and summarise throughout sessions. I was very aware that I could easily fall into this style when conducting the research interviews. However, my experience of interviewing was that it felt quite natural. I did reflect back points to the participants, but I found that this allowed for further comment on areas that were of interest. I think that the main difficulty was retaining too much structure during the original interviews. In the later interviews I was more confident to embark on conversations which moved away from the semi-structured interview. This made the interviews feel much more natural and conversational. When I completed my first interview within this novel approach I felt comforted by the structure. I felt overwhelmed by the multiple processes that I was attending to. I was considering the answers of the participant and attempting to phrase further questions. Having completed the research, I am struck by the similarities that the experience that being a beginner researcher has in common with being a beginner family worker.

Upon reflection I consider that the structure and the ‘interview guide’ have had a bearing on what was accessed from the participants. However, I was really struck by the divergence between participants. Asking the same question could result in different experiences being described. It seemed that the family workers had their own story to tell. Despite the imposition of the structure, they were able to describe their experiences in their own way.

I considered how my position as a trainee clinical psychologist may have influenced the responses which were given. Clinical psychologists often lead the delivery of psychosocial and therapeutic approaches within teams. I considered that profession might have influenced the responses that I received. As a clinical psychologist I am more aligned to non-medical approaches to treatment. I wondered whether this influenced the participants. Did they want to appease me and my professional viewpoint? Was I positioned as being aligned with the approach?

I felt very strongly when conducting the interviews that the participants were very adept at deflecting questions which considered their personal feelings. I repeatedly asked
about how particular situations made the participants feel. I believed that participants responded by talking about the clients and families that they had worked with. Initially I wondered whether this was protective. However, when I conducted the analysis I realised that there were statements that reflected the different feelings of the participants. This led me to consider that I was actively seeking out participants’ feelings. I wonder if this led to an imposition on the participants. Perhaps I was more energetic in my pursuit of answers in this area.

**Analysis**

I chose to transcribe the research interviews personally. This was a considerable commitment. However, it was important to become immersed in the data. I felt that this was an opportunity to become very familiar with the accounts. Listening to the audio enabled me to remain close to the original accounts.

I remember reading an extract from Smith et al. (2009 p96) which stated “this level of analysis is not prescriptive and the analyst is encouraged to explore and innovate”. I felt annoyed by this statement and wanted a very prescriptive step-by-step account of what to do. I later found that my own natural style of analysis emerged. I think that analysing data within an IPA framework needs an overarching structure, but the method employed within this is personal and to each researcher.

The procedure for analysis felt particularly demanding. When I analysed the data from the original transcript I could not attend to the descriptive, linguistic and conceptual ideas at once. This necessitated further readings of the transcript following the familiarisation process. My fears of missing important aspects in the data meant that I began by being over-inclusive, particularly when drawing out the descriptive aspects of the data. However, I very much enjoyed the linguistic analysis. As suggested by Smith et al. (2009), I replayed the audio whilst conducting this part of the analysis. When I came upon metaphors within the transcripts I took time to check definitions. I think that my understanding grew from doing so. I found that drawing out conceptual ideas was difficult. I was really aware that this was the start of the interpretation. I was unsure of how much of myself to give to this process. It felt that too little would end with a bland
A descriptive account and too much would result in my analysis not being grounded enough in the data. This is the tightrope that I walked throughout the analysis. I feel that experience could have made this less difficult for me. However, it may always be important to hold this dilemma in mind when conducting IPA.

I did not completely bracket off prior knowledge. I am unsure if this is truly possible. I felt that I used ‘the self’ as a tool. I felt that some aspects of my personal identity and experience made it possible to consider the position of the participants. Completing a DClinPsy meant that I had been receiving professional training in therapeutic approaches. There were occasions when I felt that my own experiences mirrored that of the participants. This led me to consider that I had a depth of understanding, but had to be careful not to impose my experiences on the analysis.

I later reflected on the breadth of information that was collected within the interview. Many complex processes were discussed and at times when conducting the analysis I wondered whether I should have designed my topic guide to focus more on one particular area. However, as this was the first exploration of family workers’ experiences it was important to be open and reactive to the participants’ perceptions.

I was motivated to get the analysis right. I had never conducted qualitative analysis before and was aware of my own preconceptions. I felt that it was difficult to blend my scientific leanings with the IPA approach. Perhaps this is reflected in my epistemological stance. I feel that I am still in the process of understanding my own evolving position. My clinical work has been influenced most by constructionist approaches. This has led me to question my previous interpretations of truth.

I felt comfortable when working on one transcript and creating tables of themes. I spent a lot of time moving and renaming themes. When I started consolidating the data I started to feel conflicted. I felt that this was a definitive stage and I was moving further from the original data. Bringing the themes together from different transcripts meant more changes. I think the most difficult element of IPA is generating rich data and realising that you cannot possibly communicate it all. I began to feel attached to the data and all of the analysis.
Overall reflections

I have developed hugely as a researcher from completing this thesis within a DClinPsy. I believe that the experiences will help me throughout my career. It will give me a greater understanding of research, and also enable me to cast a critical eye over it. I have developed as a clinician and I have already used my knowledge of family interventions within my clinical work.

I have found the process of the research difficult. It has been a challenge to attend to multiple demands. It has impacted both my emotional health and my relationships. I have developed my self-care skills and used mindfulness to cope with feelings of being overwhelmed.

I initially stopped all social and recreational activities to increase the time I had to work on the thesis. I later found myself adding exercise, walks and enjoyable activities back into my life, as this was unsustainable. I found that having a family impacted on my ability to complete the research. I had no children when completing my BSc and MSc and I spent large blocks of time completing assignments. I have had to modify my approach to research. It has been difficult to manage different responsibilities. Feelings of guilt have emerged when either spending time with family or spending time on the research.

The support of the cohort of trainees has been of huge personal benefit. Reflective practice has been a normalising and restorative experience. The support of others who have experienced the same feelings has made it possible to complete the research.
3.1 References


*Lancet*, 12, 588-590.


### Appendix A: Table of database searches

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| AND |
| "relapse" or "hospitali*" or "readmission" or "psychotic episode*" or "hospital admission" or "psychotic recurrence*" or "remission" or "rehospitalisation" or "hospital admission" or "days in hospital" or "clinical outcome" or "psychotic symptoms" or "burden" or "global assessment of functioning"
| CINAHL         |
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*Limited to: English language, Peer reviewed journal.*
Appendix B: Diagrammatic process tree of article selection

Articles identified from electronic database search
N = 3,924

Excluded on the basis of title
N = 3,744

Abstracts retrieved
N = 180

Duplicate articles removed
N = 51

Abstract articles reviewed
N = 129

Excluded
N = 84

Full articles retrieved
N = 45

Excluded
N = 26

Relevant studies identified from search of references and forward citations
N = 2

Quality appraisal process
N = 15

Follow-up reports of studies included in the review
N = 6
Appendix C: Tables of exclusion of articles

Reasons for exclusion of articles from review: Abstract

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Appendix D: Data extraction proforma

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<td>Outcomes and Measures: (What outcomes are being measured? What measurements are used? Are measures validated? At what time points are measures completed? Self report or clinician rated?)</td>
</tr>
<tr>
<td>Intervention: (Type of intervention? Control group comparable? Format of the intervention? Staff delivering it?)</td>
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<tr>
<td>Analysis: (What statistical methods were used? Was power calculated? Intention-to-treat?)</td>
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<tr>
<td>Findings:</td>
</tr>
<tr>
<td>Controls/Validity/Reliability:</td>
</tr>
<tr>
<td>Conclusions: (What do the findings mean? Generalisability? Implications &amp; Recommendations?)</td>
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<td>Additional Comments</td>
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</table>
### Appendix E: Quality Appraisal

<table>
<thead>
<tr>
<th>Study</th>
<th>Internal Validity - Confounding Bias (7)</th>
<th>Internal Validity - Bias (7)</th>
<th>Total Score (32)</th>
<th>Power (1)</th>
<th>Quality Rating</th>
<th>Removed</th>
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<tr>
<td>Calvó (2014)</td>
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<td>6</td>
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<td>Craig (2004)</td>
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<td>1</td>
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<td>Gleeson (2009)</td>
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<td>0</td>
<td>Good</td>
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<td>Grave (2006)</td>
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<td>Linsen (1996)</td>
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<td>Peterson (2005)</td>
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<td>18</td>
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<td>Rosenbaum (2005)</td>
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<td>18</td>
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<tr>
<td>Rossberg (2010)</td>
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<td>Zhang (2007)</td>
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</table>
# Appendix F: Shortlisted papers for Inclusion/Exclusion against criteria

<table>
<thead>
<tr>
<th>Author (Date)</th>
<th>Title</th>
<th>Inclusion/Exclusion</th>
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</table>
| Agius, M., et al. (2007) | An early intervention for psychosis service as compared with treatment as usual for first psychotic episodes in a standard community mental health team | Excluded  
Did not reach quality criteria  
No statistical analysis of relapse and rehospitalisation. |
| Bertelson, M., et al. (2008) | Five-year follow-up of a randomized multicenter trial of intensive early intervention versus standard treatment for patients with a first episode of psychotic illness: The OPUS Trial | Included  
Follow-up of OPUS trial |
| Calvo, A., et al. (2014) | Intervention for Adolescents With Early-Onset Psychosis and Their Families: A Randomized Controlled Trial | Included (PIENSA program) |
| Cullberg, J., et al. (2002) | One-year outcome in first episode psychosis patients in the Swedish Parachute project | Included |
| Cullberg, J., et al. (2006) | Treatment costs and clinical outcome for first episode schizophrenia patients: a 3-year follow-up of the Swedish Parachute Project and Two Comparison Groups | Included  
Follow-up of Parachute project |
Did not reach quality criteria  
Retrospective matched control group. No particular intervention protocol or specific training for Fls. |
| Gleeson, J.F.M, et al. (2013) | A Randomized Controlled Trial of Relapse Prevention Therapy for First-Episode Psychosis Patients: Outcome at 30-Month Follow-up | Included  
Follow-up of Episode II trial |
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Inclusion/Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grawe, R.W., et al.</td>
<td>Two years of continued early treatment for recent-onset schizophrenia: A randomised controlled study</td>
<td>Included (Optimal treatment project)</td>
</tr>
<tr>
<td>Leavey, G., et al.</td>
<td>A randomized controlled trial of a brief intervention for families of patients with a first-episode of psychosis</td>
<td>Included</td>
</tr>
<tr>
<td>Lenoir, M.E., et al.</td>
<td>Social functioning and the course of early-onset schizophrenia: Five-year follow-up of a psychosocial intervention</td>
<td>Included</td>
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<td></td>
<td>Follow-up of Amsterdam relapse prevention study</td>
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<tr>
<td>Linszen, D.H., et al.</td>
<td>Treatment, expressed emotion and relapse in recent onset schizophrenic disorders</td>
<td>Included (Amsterdam relapse prevention study)</td>
</tr>
<tr>
<td>Peterson, L., et al.</td>
<td>A randomised multicentre trial of integrated versus standard treatment for patients with a first episode of psychotic illness</td>
<td>Included (OPUS)</td>
</tr>
<tr>
<td></td>
<td>Did not reach quality criteria</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selection bias due to part-randomisation. Confounding factors not controlled for.</td>
<td></td>
</tr>
<tr>
<td>Rossberg, J.I., et al.</td>
<td>Are multi family groups appropriate for patients with first episode psychosis? A 5-year naturalistic follow-up study</td>
<td>Excluded</td>
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<tr>
<td></td>
<td>Did not reach quality criteria</td>
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</tr>
<tr>
<td></td>
<td>Longitudinal naturalistic cohort follow-up study with unmatched control groups (treatment refusers and treatment not offered).</td>
<td></td>
</tr>
<tr>
<td>Ruggeri, M., et al.</td>
<td>Feasibility and Effectiveness of a Multi-Element Psychosocial Intervention for First-Episode Psychosis: Results From the Cluster-Randomized Controlled GET UP PIANO Trial in a Catchment Area of 10 Million Inhabitants</td>
<td>Included (GET UP PIANO TRIAL)</td>
</tr>
<tr>
<td>Author (Date)</td>
<td>Title</td>
<td>Inclusion/Exclusion</td>
</tr>
<tr>
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<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
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</tbody>
</table>
Did not reach quality criteria  
Historical control group with confounding factors |
| Secher, R.G. et al. (2015) | Ten-Year Follow-up of the OPUS Specialized Early Intervention Trial for Patients With a First Episode of Psychosis | Included  
Follow-up of OPUS trial |
| Sigrunarson, V., et al. (2013) | Integrated treatment vs. treatment-as-usual for recent onset schizophrenia; 12 year follow-up on a randomized controlled trial | Included  
Follow-up of Optimal treatment project |
| Zhang, M., et al. (1994) | Randomised-control trial of family intervention for 78 first-episode male schizophrenic patients: An 18-month study in Suzhou, Jiangsu | Included |
Appendix G: Statement of epistemological position

The researcher adopted a critical realist position (Bhaskar, 1975). This position asserts that researchers are involved in construing the social world, rather than constructing it. Scientific research produces interpretations, which are open to future revisions. Meanings are deemed to be related to both the circumstances and practical contexts in which communication takes place (Sayer, 2000). Interpretations are transitive, and explanations may be modified by future knowledge. Conflicting perspectives do not invalidate knowledge which has been produced (Finlay, 2006). Truth is a relative concept, however, potential explanations may be judged as having better explanatory power. The production of knowledge is a social process, and language is deeply embedded in this process (Lopez & Potter, 2001). Knowledge produced through the process of scientific research is culturally and historically situated. The position is a subjectivist view of knowledge and holds that the world cannot be known absolutely. The accumulation of knowledge and scientific progress is assumed, though not guaranteed.

Critical realism holds that the world is characterized by emergence. The combination of two of more items gives rise to new phenomena. In this particular context there is a two-way movement between the researcher and the researched participant.

There is a coherence between IPA and critical realism, as IPA is rooted in ‘minimal hermeneutic realism’ (Larkin et al., 2006). The methodology emphasizes that any research exercise is dynamic and the researcher is not passive. The insider perspective is accessed and complicated by the researchers own ideas, conceptions and life view. A double hermeneutic is involved. The participant in the research is attempting to make sense of their world and the researcher is striving to make sense of them, trying to make sense of their world. Realist ontology suggests that the truth of things does not lie on the surface and the focus should be a detailed analysis of underlying structures (Lopez & Potter, 2001).

The researcher was a male in his mid-thirties. He was a trainee clinical psychologist. The role of a trainee clinical psychologist incorporates direct therapeutic work with both
individuals and families. The research participants were describing their experience of delivering a particular therapeutic approach. The perceived role of both therapist and clinician may have influenced the research interaction and the information that was shared in the interviews. The researcher had six months previous experience of working within an Early Intervention for Psychosis (EIP) service and had completed the Behavioural Family Therapy (BFT) five day training course with the Meriden Family Programme in Birmingham.

Personal interests, beliefs, values, thoughts and feelings all impact on the research process. The researcher’s personal interest in the topic have led to a number of beliefs. One strong underlying belief was that mental health is not an individual concept and is dependent upon the contexts which people are engaged in. The researcher felt that family was an extremely important context and that indirect work with families had the potential to be helpful. The researcher believed that family work for psychosis was an important, effective and useful intervention. He also believed that the intervention was under-utilised and felt that organisations may not have supported its implementation. He had no direct experience of using the approach, however following training in the approach he began to think that the intervention was more complex to deliver than initially considered. He had no definitive thoughts on what the impact of the research might be, but wanted it to be useful for clinicians, rather than simply adding to a research base. He hoped that the interviews would offer clinicians a space to be open and honest about their experiences of using the approach and hoped that individuals would feel comfortable enough to divulge their own personal frustrations, difficulties and successes.

The researcher’s experiences working both in third-sector organisations and as part of the NHS may have also influenced his beliefs. He had worked alongside community psychiatric nurses and care coordinators for a number of years and had found many to be insightful, reflective and skilled. He had also developed the belief that they were often incredibly busy and received minimal clinical supervision. This may have led to a
desire to protect their professional integrity and to taking a more supportive stance during interviews.

References:


Finlay, L. (2006). Mapping Methodology. In L. Finlay & C. Ballinger (Eds.) Qualitative Research for Allied Health Professionals: Challenging Choices (pp. 9-29). West Sussex: John Wiley & Sons Ltd


PARTICIPANT INFORMATION

You are being invited to take part in a research study. In order to help you decide whether you would like to participate or not, please take time to read the following information carefully.

Exploring the delivery of family interventions to people facing recent-onset psychotic symptoms: The experience of navigating the family system.

What is the purpose of the study?
Family interventions for psychosis have demonstrated significant effects on reducing relapse of psychosis and readmission to hospital. However the provision and uptake of family interventions in the UK has been limited. This study aims to explore the way in which frontline mental health workers describe the experience of delivering family work with individuals with first-onset psychosis and their families. The study is being conducted as part of the researcher’s Doctoral Degree in Clinical Psychology at the University of Leicester.

Why have I been invited to take part?
You have been approached to take part in the study, as you are a mental health professional who routinely works in the NHS who has been trained to deliver family interventions to individuals with psychosis and their family members. We are interested in hearing about the experiences of currently practicing professionals who have had direct contact with people experiencing psychosis and their families whilst conducting family interventions in the past 24 months.

Do I have to take part?
Study participation is voluntary. It is your decision whether or not you would like to take part. If you do agree to take part, you can withdraw at any time prior to and during the interview. There is also a time-limited right to withdraw (up to one month following the interview). You will not be asked to provide a reason for your withdrawal from the study and can do so without any disadvantage to yourself.

What are the disadvantages and the benefits?
It is possible, though not likely, that the issues talked about in the interview may be emotional for you, and it is possible that you will think about or even re-experience difficult events that have happened to you in the past. Every precaution will be taken to minimise this distress. There will be no financial cost to taking part in the study, and any travel expenses will be reimbursed by the researcher.
The findings of this research will help to provide a valuable detailed description of what it is like to deliver family interventions. The research findings will broaden the existing research base for psychosis and family interventions. The research might also shape family intervention training, supervision, organisational policy and the future experiences of individuals with psychosis and their families presenting to services.

What is involved?
If you choose to take part in the study you will be asked to read and sign a consent form stating that you agree to participate. Subsequent to this, you will be invited to attend a one-to-one, confidential interview at a time and place convenient for yourself. The researcher will ask questions about your experiences of providing family interventions. The interview will last between 60-90 minutes. The interview will be digitally recorded and the transcription completed by the researcher.

What if there is a problem?
It is possible that the subject area being discussed may be upsetting for you. In order to mitigate this possibility the interview questions have been carefully considered. During the interview you are free to leave at any time and are also able to take a break from the interview and return when you feel able to. Following the interview the researcher will be available if you feel you need some time to talk about some of the issues raised. In the event that a subject area has been emotionally distressing, the investigator will give you contact details for further support.

What happens to the information?
The researcher will ask you to provide some basic information about yourself at the interview such as professional background and date of family intervention training, method of training, location of training and date of last family intervention completed.

Anonymity will be assured by assigning participants a numerical code. The codes and consent forms will be held in a locked cabinet separate to the recording and transcription of the interview. The researcher will transcribe the interviews. Any identifiable information will be anonymised in a manner which protects the integrity of the data. Only the researcher, research supervisor and examiners will have access to the transcriptions. Pseudonyms will be produced for each participant, to be used in the analysis and interpretation of the data. Digital data will be accessed via a password-protected computer. The recordings and transcriptions will be erased within 5 years.

Small extracts in the form of anonymised quotes will be used in the final write-up of the project, participants will be asked to provide initial consent for this. Confidentiality will be discussed prior to commencing the interview. Confidentiality will only be broken in the unlikely event that there are serious concerns about your safety or the safety of others. The researcher will discuss breaking confidentiality before they do so, if possible.

Who has reviewed the study?
121
Research conducted within the NHS is reviewed by an independent panel, called a Research Ethics Committee. The current study was reviewed by from the University of Leicester Psychology Research Ethics Sub-committee.

Contact details
Thank you for taking the time to read this leaflet. The contact details of the researcher are included below.

Principal researcher
David Haggarty (Trainee Clinical Psychologist)
Email: dh216@le.ac.uk
Phone: 07934846953

Research supervisor
Dr Gerald Burgess (Senior Teaching Fellow)
Email: gb222@le.ac.uk
Phone: 0116 223 1639
Appendix I: Recruitment poster

Experiences of delivering ‘Behavioural Family Therapy’ to individuals with recent-onset psychosis and their families

Do you work in early intervention for psychosis? Did you receive training to deliver BFT to families? Have you carried out an intervention in the past 24 months?

If you answered YES to the above questions we would like to talk to you about your experiences?

Contact David on or email to be part of this important research study.

Principal investigator: David Haggarty
Research Supervisor: Dr Gerald Burgess

This study was approved by the University of Leicester Psychology Research Ethics Sub-committee.

University of Leicester
Appendix J: Recruitment email

Title: Help improve the delivery of family interventions to people experiencing recent-onset psychotic symptoms.

Dear .....,

Your team leader/family interventions supervisor ..... has provided me with your details. I would like to invite you to participate in a research project. The project is interested in talking to care coordinators and frontline staff who have been trained to deliver ‘Behavioural Family Therapy’ (BFT) and have completed an intervention in the past two years with individuals who have recent-onset psychosis and their families.

The research would require sixty to ninety minutes of your time. The interview can be scheduled at your work base or at the University of Leicester. The aim is to increase understanding of the experiences of delivering BFT. One particular goal is to influence organisational systems to best support clinicians to provide interventions to clients and their families.

Please contact me on [redacted] if you are interested in receiving more information about this important research project.

Many thanks,

Dave
CONSENT FORM

Title of study:
Exploring the delivery of family interventions to people facing recent-onset psychotic symptoms: The experience of navigating the family system.

Identification Number:

Please initial box

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<tbody>
<tr>
<td>1</td>
<td>I confirm that I have read and understand the information sheet relating to this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.</td>
</tr>
<tr>
<td>2</td>
<td>I understand that my participation is voluntary and that I have a time-limited right to withdraw, up to one month following the interview, without giving any reason for doing so.</td>
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<tr>
<td>3</td>
<td>I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Confidentiality will only be broken in the unlikely event that there are serious concerns about your safety or the safety of others. The researcher will discuss breaking confidentiality before they do so, if possible. Only the researcher and their research supervisor will have access to the data. I understand that anonymised extracts of the interview may be published.</td>
</tr>
<tr>
<td>4</td>
<td>I agree to take part in the above study.</td>
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</tbody>
</table>

Name of participant: ___________________________  Name of researcher: ___________________________
Signature: ___________________________  Signature: ___________________________
Date: ___________________________  Date: ___________________________
Appendix L: Semi-structured interview guide

*Topic guide*

Can you tell me your experience of delivering family interventions to people with psychosis and their families?

What is your experience of providing interventions to a whole 'family unit' rather than an individual?

Prompts:

- How do you find working with families and carers?
- What is your experience of engaging and motivating family members?
- What is the experience of 'just being' with the family?

Family interventions seem to require considerable investment? Could you tell me more about that?

Prompt: time, skill, and commitment.

How do you find working to improve the relationship between individuals with psychosis and their families?

How do you usually feel after providing family intervention sessions?

Prompt: physically, emotionally, and mentally.

Can you describe whether anything outside of your experience in sessions either helped or didn't help the delivery of family interventions?

Prompt: supervision, flexible working, organisational support, out of hours working.

How do you view family interventions since you have been involved in providing them to people experiencing psychosis and their families?

Prompt:

- Has your thoughts/feelings about them changed?

How do you feel about the number of interventions you have provided since training in family interventions?

Have you noticed any changes in your professional identity after being trained in and providing family interventions?
Appendix M: Example of analytic process

Step 1: Adding line numbers to the transcript and placing in table

### Exploring the delivery of family interventions to people with recent-onset psychosis

**Participant 1 – Recording 1 – Chris**

| 1 | INTERVIEWER: So Chris I'm quite interested in family interventions, *erm* and I was just wondering when, or what the reason was maybe for for training in the family interventions that, that you've, that you've done. |
| 2 | CHRIS: I think we've benefitted from a formal and formalised approach to working with families, I think we have always tried to do our best to engage with families and offer support. But having the structure to approach that has been really helpful. Especially the modules within the, the BFT approach, *erm* and whether we've actually done that within a formalised BFT setting or not, there's been elements I've been able to take from that to add to my practice more widely so for example feeding back a problem to a family and asking for their solutions rather than looking to me as the expert to provide the answer has been, has been helpful for my practice. |
| 3 | INTERVIEWER: So *erm*, so kind of taking bits out of the approach and and using it that way, and *erm* mitigating that with particular families. |
| 4 | CHRIS: Yeah, very much. |
| 5 | INTERVIEWER: And I was just thinking when *did you*, when did you train in family intervention? |
| 6 | CHRIS: It was in September 14 so last autumn and I have been working with families since that time. *Erm* you might, we might come on to specific families but *erm* I've yet to work with a family where I've been able to follow the model quite closely, it's *it's* been, we've had to be more flexible than that. |
| 7 | INTERVIEWER: Yeah, Yeah, so you trained about a year ago and, but following the model flexibly, can you tell me a little bit more about that? |

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Step 2: Descriptive, linguistic and conceptual analysis

### Exploring the delivery of family interventions to people with recent-onset psychosis

**Participant 2 – Chris**

| 1 | I: So Chris I'm quite interested in family interventions, *erm* and I was just wondering when, or what the reason was maybe for training in the family interventions that, that you've, that you've done. |
| 2 | | 3 |
| 4 | F: I think we've benefitted from a formal and formalised approach to working with families, I think we have always tried to do our best (*yeah* yeah) to engage with families and offer support. But having the structure to approach that has been really helpful (*uhm*). Especially the modules within the, the BFT approach (*I* *yeah*), *erm* and whether we've actually done that within a formalised BFT setting or not, there's been elements I've been able to take from that to add to my practice more widely (*I* *yeah*). So for example feeding back a problem to a family and asking for their solutions rather than looking to me as the expert to provide the answer has been, has been helpful for my practice. |
| 5 | INTERVIEWER: *So*, *erm*, so kind of taking bits out of the approach and and using it that way, and *erm* mitigating that with particular families. |
| 6 | CHRIS: Yeah, very much. |
| 7 | F: *Yeah*, *very much*. |
| 8 | I: And I was just thinking when *did you*, when did you train in family intervention? |
| 9 | F: It was in September 14, so last autumn (*I* *yeah*), and I have been working with families since that time. *Erm* you might, we might come on to specific families but *erm* I've yet to work with a family where I've been able to follow the model quite closely, it's *it's* been, we've had to be more flexible than that. |
| 10 | INTERVIEWER: Yeah, Yeah, so you trained about a year ago and, but following the model flexibly, can you tell me a little bit more about that? |
| 11 | F: Yeah, well for example the first family I worked with was *ah*, *ah*, less, a more atypical family (*Uhm*), if I can put it that way, so it was a pair of foster parents, a man and woman (*Uhm*), and our client, a female |
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Step 3: Emergent themes

Exploring the delivery of family interventions to people with recent-onset psychosis

Participant 2 – Chris

Step 4: Tabling themes and extracts

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<th>Transcript 1 – tabled themes</th>
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<tr>
<th>Supports</th>
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<th>1.4. &quot;benefitted from a formal and formalised approach to working with families&quot;</th>
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</thead>
</table>
| 1.4.6 Session notes | 1.4.6. "I think writing up the...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...no...n
Step 5: Combining, reducing and organising themes

Step 6: Table of superordinate themes for participant 1
### Step 7: Master table of themes for all participants

#### A) External supports to delivering family work

**A.1 The beauty of team working**
- Chris – "you have that other perspective"
- Elizabeth – "It's a comfortable thing to do with someone else"
- Alex – "Doing pair work made me feel a bit better"
- Lesley – "The beauty" of team working
- Hannah – A supportive team

**A.2 Supervision is helpful**
- Chris – "Supervision is helpful"
- Alex – "Supervision really helps"
- Lesley – "Supervision is immensely helpful"

**A.3 The benefits of the framework**
- Chris – "Benefitted from a formal approach"
- Elizabeth – "Framework is helpful"
- Alex – "I quite like having structure"
- Lesley – "A valuable and practical approach"
- Hannah – "Helpful framework"

#### B) Balancing the care coordinator and family worker roles

**B.1 Integrating family work**
- Chris – Augmenting CC with family work
- Lesley – The benefits and costs of the CC relationship to family work
- Elizabeth – Enriching my practice
- Hannah – "Weighing up" different roles

**B.2 Avoiding the expert position**
- Chris – Family as experts
- Elizabeth – Avoiding the expert position
- Lesley – "This is your family, you're the experts"
- Alex – "There's not always anything we can do about it"
- Hannah – "Stepping back"

#### C) Barriers to engaging families

**C.1 Readiness for change**
- Chris – readiness for change
- Elizabeth – "It’s not like giving restrained patients a depot"
- Alex – obstacles to engagement
- Lesley – motivated families
- Hannah – "they didn’t prioritise family meetings"

**C.2 The need for flexibility**
- Lesley – "Families aren’t in neat little boxes"
- Chris – "Offer it like a menu"
- Hannah – "Experience of the reality"
### Appendix N: Table demonstrating recurrent themes

<table>
<thead>
<tr>
<th>Theme (shading denotes subordinate theme)</th>
<th>Chris</th>
<th>Elizabeth</th>
<th>Alex</th>
<th>Lesley</th>
<th>Hannah</th>
<th>Present in over half of sample?</th>
</tr>
</thead>
<tbody>
<tr>
<td>External support to delivering family work</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>The beauty of teamworking</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Supervision is helpful</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>The benefits of the framework</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Balancing the CC and family worker roles</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Integrating family work</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Avoiding the expert position</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Barriers to engaging families</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Readiness for change</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>The need for flexibility</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Work pressures</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>The internal world of the family worker</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Feeling daunted and anxious</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Like coming out of an exam</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Rewarding experiences</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Bringing the self</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Family communication and relationships</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Family, work, is unifying</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Understanding the family in context</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Working with the emotion in the room</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>
Appendix O: Research ethics correspondence

University of Leicester Ethics Review Sign Off Document

To: David Haggerty

Subject: Ethical Application Ref: dl:216-71f

(Please quote this ref on all correspondence)

06/02/2015 10:54:02

Psychology

Project Title: Exploring the delivery of family interventions to people facing recent-onset psychotic symptoms: The experience of navigating the family system.

Thank you for submitting your application which has been considered.

This study has been given ethical approval, subject to any conditions quoted in the attached notes.

Any significant departure from the programme of research as outlined in the application for research ethics approval (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be reported to your Departmental Research Ethics Officer.

Approval is given on the understanding that the University Research Ethics Code of Practice and other research ethics guidelines and protocols will be compiled with

- http://www2.le.ac.uk/institution/committees/research-ethics/code-of-practice
- http://www.le.ac.uk/safety/
8th September 2015

David Haggarty
Trainee Clinical Psychologist

Dear Mr Haggarty,

I am pleased to confirm that with effect from the date of this letter, the above study now has Trust Research & Development permission. You can now commence your research activities in Northamptonshire Healthcare NHS Foundation Trust in accordance to the agreed protocol and the Research Governance Framework.

<table>
<thead>
<tr>
<th>Title</th>
<th>Exploring the delivery of family interventions to people facing recent-onset psychotic symptoms: The experience of navigating the family system</th>
</tr>
</thead>
<tbody>
<tr>
<td>REC Ref:</td>
<td>N/A</td>
</tr>
<tr>
<td>Start date</td>
<td>08/09/15</td>
</tr>
</tbody>
</table>

As part of our monitoring requirements you are required to submit a six months progress report to the R&D Office and to the Research Ethics Committee from the start date. We ask you for a summary report of your study findings upon completion of your research as we would like to disseminate in within the Trust.
If you have any questions regarding this, or other research you wish to undertake in the Trust, please contact this office. We wish you every success with your research.

*Please be aware that any changes after approval may constitute an amendment. The process of approval for amendments should be followed. Failure to do so may invalidate the approval of the study at this trust*

Yours sincerely

Leanne Holman
Research and Development Manager

**Approved documents received:**

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocol</td>
<td>4.0</td>
<td>08/09/15</td>
</tr>
<tr>
<td>Consent form</td>
<td>2.0</td>
<td>May 2015</td>
</tr>
<tr>
<td>CV Field supervisor</td>
<td>NA</td>
<td>08/09/15</td>
</tr>
<tr>
<td>Information sheet</td>
<td>3.0</td>
<td>September 2015</td>
</tr>
<tr>
<td>Support letter from University</td>
<td>NA</td>
<td>08/09/15</td>
</tr>
<tr>
<td>Insurance indemnity</td>
<td>NA</td>
<td>01/04/15</td>
</tr>
<tr>
<td>Pre engagement checks</td>
<td>NA</td>
<td>08/09/15</td>
</tr>
<tr>
<td>David Haggarty CV</td>
<td>NA</td>
<td>08/09/15</td>
</tr>
<tr>
<td>Research poster</td>
<td>NA</td>
<td>08/09/15</td>
</tr>
<tr>
<td>Supervisor CV</td>
<td>NA</td>
<td>08/09/15</td>
</tr>
<tr>
<td>Sample email</td>
<td>NA</td>
<td>08/09/15</td>
</tr>
<tr>
<td>SSI form</td>
<td>NA</td>
<td>12/08/15</td>
</tr>
<tr>
<td>Topic guide</td>
<td>2.0</td>
<td>May 2015</td>
</tr>
</tbody>
</table>
Dear David

Study title: Exploring the delivery of family interventions to people facing recent-onset psychotic symptoms: the experience of navigating the family system
Sponsor: University of Leicester
IRAS/REC ID: Not applicable

Thank you for submitting your project to the Nottinghamshire Healthcare NHS Foundation Trust's R&D Department. The project has now been given NHS permission by:

Dr Julie Hankin: R & D Director, on behalf of Nottinghamshire Healthcare NHS Foundation Trust

NHS permission for the above research has been granted on the basis described in the application form, study protocol and supporting documentation. The following documents were reviewed:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
</tr>
</thead>
</table>

135
Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available at http://www.nottinghamshirehealthcare.nhs.uk/contact-us/freedom-of-information/policies-and-procedures/.

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

Shirley Mitchell
Head of Research and Innovation

cc.
Sponsor
Appendix P: Chronology of research process

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>September – December 2013</td>
<td>Development of research idea</td>
</tr>
<tr>
<td>January 2014 – February 2014</td>
<td>Research proposal preference completed and research supervisor allocation</td>
</tr>
<tr>
<td>March 2014 – May 2014</td>
<td>Draft research proposal submitted for review</td>
</tr>
<tr>
<td>June 2014</td>
<td>Research proposal review</td>
</tr>
<tr>
<td>July 2014 – October 2014</td>
<td>Redrafting research proposal and submission of lay summary for the service user review</td>
</tr>
<tr>
<td>November 2014</td>
<td>Research proposal submitted for peer review</td>
</tr>
<tr>
<td>December 2014</td>
<td>Preparation and submission to University of Leicester ethics submission</td>
</tr>
<tr>
<td>January – February 2015</td>
<td>Re-submission to University ethics for minor amendments. Full approval received.</td>
</tr>
<tr>
<td>March – April 2015</td>
<td>Completion of behavioural family course over five weeks</td>
</tr>
<tr>
<td>May – August 2015</td>
<td>Completion of IRAS form and preparation for local R&amp;D submissions</td>
</tr>
<tr>
<td>May – August 2015</td>
<td>Literature review</td>
</tr>
<tr>
<td>September – October 2015</td>
<td>Liaison with R&amp;D. Full approval granted</td>
</tr>
<tr>
<td>November 2015 – March 2016</td>
<td>Recruitment and interview of participants</td>
</tr>
<tr>
<td>January – April 2016</td>
<td>Analysis</td>
</tr>
<tr>
<td>March – May 2016</td>
<td>Write-up</td>
</tr>
<tr>
<td>May 2016</td>
<td>Submission of thesis</td>
</tr>
<tr>
<td>May - July 2016</td>
<td>Viva preparation</td>
</tr>
<tr>
<td>July – September 2016</td>
<td>Preparation for poster presentation and publication. Draft and send short research reports to participants.</td>
</tr>
</tbody>
</table>
Appendix Q: Guidelines for target journal

Journal of Family Therapy

© The Association of Family Therapy and Systemic Practice

Edited By: Reenee Singh

Impact Factor: 1.151

ISI Journal Citation Reports © Ranking: 2014: 21/40 (Family Studies); 81/119 (Psychology Clinical)

Online ISSN: 1467-6427

Author Guidelines

Manuscript submission

Papers submitted for publication should be original work not previously published in English and not currently submitted elsewhere for consideration. If accepted for publication, a paper cannot be published elsewhere in any language without the consent of both Editor and publisher. It is a condition of acceptance that the Association for Family Therapy and Systemic Practice automatically acquires the copyright throughout the world.

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A cover letter should be submitted with your manuscript and must include a statement that the data have not been published, and is not under consideration for publication elsewhere. It will be presumed that all listed authors of a manuscript have agreed to the listing and have seen and approved the manuscript. The cover letter should include a statement outlining what is new, impact making and original about the paper and why it should be considered for publication.
Please also include a paragraph detailing the Authorship contribution detailing the Author(s) responsible each of the following:

- designing the work
- acquiring the data
- interpreting the data
- drafting the work/ revising the work critically for intellectual content

A statement from the authors agreeing to be held accountable for all aspects of the work and any questions relating to the accuracy or integrity of the work should also be included.

**Manuscript Format**

1. Manuscripts should allow for 'blind/anonymised' refereeing and **must not** contain author names or any identifiable data.
2. Manuscripts **must** be typed in double spacing throughout, including quotation, notes and references in the following order:
   
   - **Title Page**: to contain the title of the paper, word count, suggested running head (short title for your paper), key words, author names, affiliations and contact details for the corresponding author.
   - **Abstract**: on a separate sheet, the title to be repeated followed by a summary of not more than 150 words. The suggested running head should also be present. *For tips on optimizing your abstract for search engines please click [here](#).*
   - **Practitioner Points**: two to six bullet points of no more than 180 characters each (including spaces), up to a total of 480 characters.
   - **Organisation of the text**: see copy of Journal for the format currently in use.
   - **Figures, tables, etc.**: All figures and tables should be numbered with consecutive arabic numerals, have descriptive captions and be mentioned in the text. They should be kept separate from the text but an approximate position for them should be indicated. These will need to be uploaded separately. Please supply figures in the format in which they were created, if possible.
   - **References (in text)**: These should be indicated by the name and date e.g. 'Carr (2009)'. If more than two authors are listed, cite the reference as 'McHugh et al. (2010)'. Quotations should include page numbers. Websites should also be cited in this way, with a full reference appearing in the References section (see below). Please check all websites are live and the links are correct at time of submission.
   - **References**: Should be listed at the end of the paper in alphabetical order according to the first author and be complete in all details following the APA style of referencing.


For further details, please see the APA Style website: (http://www.apastyle.org/learn/tutorials/basics-tutorial.aspx)

3. The word limit, excluding abstract and practitioner points will vary depending on the type of paper you are submitting. Please refer to the ‘Advice to Authors’ section below.

4. **Style**: Whilst *Journal style* is generally formal, originality in presentation does not necessarily preclude publication if clarity and readability is thereby enhanced. Sexist language forms are unacceptable.

Your manuscript will be returned to you if you fail to conform to these requirements.

**Case material and Confidentiality**

*Journal of Family Therapy* readers particularly welcome papers which link theory and practice, and such papers are often enhanced by case material.

The Author takes responsibility for anonymising material in order to protect client confidentiality. All possible identifying information must be altered. Another way of protecting confidentiality is by presenting composite case material, made up of different aspects from a number of similar cases.

Do not identify any participants without consent or write about them in any way that identifies them to the public or other participants without consent.

**Every paper that contains case material must be accompanied by:**

- A statement in the letter to the Editor from the Author(s) specifying whether the material presented is disguised/generic/composite; or
- A statement in the letter to the Editor that the Author has gained signed consent from patients/clients or teachers/students authorizing publication of the material.
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ADVICE TO AUTHORS

Writing is a very enjoyable and satisfying way of being involved in the world of family therapy. The exchange of ideas and experience is important both for the development of our chosen field and for the development of the individual practitioner. We intellectually sustain ourselves by creating a healthy and vibrant literature. Family therapy needs to develop authors and The Journal of Family Therapy wants to hear from you.

These are the types of papers that are regularly submitted to the Journal of Family Therapy:
(The word count for all these papers does not include tables and figures.)
Research Presentation (3,000-6,000 words)

A research paper should include:

- An introduction to the principal concepts and theoretical issues relevant to the study
- Previous work
- Description of methodology including participants
- Results/Findings
- Discussion of results, including implications for future research and practice

Systematic reviews (up to 6000 words).

Systematic reviews are welcomed. For systematic reviews and meta-analyses please ensure that you have used the PRISMA checklist and include a flowchart as part of your submission. Please complete and supply AMSTAR for systematic reviews which are narrative reviews not meta-analyses.

Suggested headings for systematic reviews are:

- background or context;
- objective;
- search strategy;
- inclusion criteria;
- data extraction and synthesis;
- main results; discussion and conclusions.

Please ensure that you include the standard points for practice.

You should provide the PROSPERO number in the methods section of the paper, or explain in your covering letter if you have not registered your review with PROSPERO.

Case Study (up to 2,000 words*)

*Longer papers may be considered at the discretion of the Editor if it is felt the manuscript fulfils the role of a full paper.

The Journal of Family Therapy welcomes case studies. A case study paper should include the following:

- Theoretical/Research Basis

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• Introduction of the case including presenting issues
• Relevant background information
• Systemic case conceptualisation
• Self-reflexivity
• Description of intervention/ treatment
• Outcomes and follow up
• Implications/contributions to the field

For anonymised case studies informed consent to publish must be obtained from all participants in the treatment and/or all family members before submission.

CONSENT TO PUBLISH MUST ALWAYS BE OBTAINED FROM CLIENTS/FAMILIES BEFORE SUBMISSION

Theoretical Discussions or Controversial Theoretical Papers (4,000-6,000 words)

We welcome the submission of articles of this nature. A paper of this type would include:

• A brief general introduction
• A review of previous statements of the issues
• A definition of problems and solutions
• A development of an argument (Research based work which was undertaken for a thesis may be referenced)
• Relation of theory to practice
• Issues to be resolved

Often we will ask one of the reviewers to write a commentary on the paper to stimulate debate through the Journal pages.

Literature Review (3,000–5,000 words)

These are much sought after by the readership. Such a paper would have:

• A brief general introduction
• A description of the way in which the themes in the literature are organised by the author for review. This may include conceptual and definition problems.
• The review
• An overview of the review process including gaps in existing knowledge
Future directions

**Teaching and Learning** (up to 2,000 words*)

*Longer papers may be considered at the discretion of the Editor if it is felt the manuscript fulfils the role of a full paper.

These should include:

- Practitioners Points – key ideas for trainers from paper
- Description of context – situation in which teaching event occurred, experience and constitution of participants and trainers, pre and post learning required for this session
- Aims of teaching event – aims and learning outcomes
- Theoretical Description which includes systemic theory / practice and education / learning/ pedagogical theory
- Description of event – pre reading, structure of session, length, didactic, experiential
- Feedback from participants – formal and informal
- Learning as a result of experience – trainers own evaluation, any suggested changes as a result of feedback or experience, suggestions for application in other settings

**Additional Notes to Authors:**

- JFT has an international readership, so spell out details that might be unfamiliar to the non UK field.
- JFT welcomes the linking of previous literature in a substantive, explanatory sense and therefore advises authors to reference other papers where possible.

PAPERS EXCEEDING THE SPECIFIED WORD LIMITS (including references) WILL BE RETURNED TO THE AUTHOR