



School of Psychology

Doctorate in Clinical and Community Psychology

Major Research Project/Paper

Discussing causality with families in a family management and therapy integrated service, a qualitative study with focus groups.

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Abstract

Objective. Family Therapy (FT) and Family Management (FM) approaches to psychosis have been divided by their understanding of causality. FM holds a biological understanding which has been identified as having negative consequences for the person with psychosis. FT, by exploring family interactions has been criticised for blaming families for causing their relations psychosis. These two approaches have now been integrated, but how causality is discussed in an integrated approach has only now been explored.

Design and methods. This qualitative research asked clinicians working in the most established integrated service how they discuss causality. Four focus groups were conducted and a framework approach using thematic analysis was used.

Results. Five themes were explored; uncomfortable discussion; constructing a shared understanding; therapeutic style; limiting exploration; and blame.

Conclusion. Discussing causality with families was identified as uncomfortable. However, through the development of a therapeutic-relationship three identified tools can be used to construct a shared understanding of causality. The therapeutic style of explorative conversation--based in FT, integrated with the stress-vulnerability model--based in FM, was identified as an important aspect of an integrated model that resolved criticisms levied at each individual approach. Factors that limited exploration were identified as major challenges to causality discussions, but techniques to remedy these problems were also identified. The risk of families feeling blamed/blaming themselves and attempts to avoid/reduce blame made up a dominant theme of the research. The research concludes by challenging the need to avoid/reduce blame, arguing that blame should be openly explored within family interventions.

Introduction

Working with families affected by psychosis is a field which has struggled to find ways of dealing with the issue of causality¹ and blame², and therapeutic approaches can be considered to fall within two broad camps – family therapy (FT³) and family management (FM⁴) (Burbach, 1996). An overarching theme of FT is that clinicians base their work on communication/interactional models of psychosis (Burbach, 1996). Many services that work from a FM framework begin with the premise that *“within some FT approaches an individual’s symptoms of illness are seen as manifestations of dysfunction within the family system”* (Smith, Gregory & Higgs, 2007. P.31). Thus the conclusion presented by many FM services is that FT blames families for causing psychosis (Hatfield, 1986). Clinicians working within FM can be defined by their acceptance of a disease/biological formulation of psychosis (Burbach, 1996). Emphasising a biological cause leads to its own problems, the individual with psychosis is perceived as dangerous and unpredictable (Read, Haslam, Sayce & Davies, 2006) and there is a more pessimistic outlook towards recovery (Angermeyer & Matshinger, 1996).

There is however a third model emerging in which FM and FT are integrated (Meddings, Gordon & Owen, 2010; Lobban, Barrowclough & Jones, 2005; Burbach & Stanbridge, 1998, 2006). Burbach, Carter, Carter and Carter. (2007) argue that integrating FM and FT hold an advantage over a pure model. However as the two

¹ The focus of this paper is on what originally caused the psychosis and not on what causes relapse.

² *Many other areas of mental health have also struggled with this, however given the limited space available psychosis was focused upon.*

³ *Although FT is referred to as if it were one approach it is not easy to say what FT is, as there are many differing schools of thought (Rivett & Street, 2003).*

⁴ *FM is also referred to in the literature as family interventions and family work (Smith, Gregory, & Higgs 2007).*

models have been divided by their understanding of causality it is unclear how causality is conceptualised within an integrated model. Thus this is important to research.

Families' feelings about causality

Corrigan and Miller (2004) found family members related to a person with psychosis reported feeling blamed for the onset of their family member's disorder, felt responsible for relapses, and felt they were themselves incompetent family members. Gonzalez-Torres, et al. (2006) found parents blamed themselves for causing psychosis and sometimes felt blamed by clinicians. Jones (2002) and Askey, et al. (2009) found siblings felt their parents were to blame for their brother/sisters' mental health problem. However, contrary to Corrigan and Miller and Gonzalez-Torres et al.'s findings, no parents blamed themselves. Despite this difference families seem to apportion blame in some way for causing psychosis within the unit itself. Stratton (2003) argues that families come to therapy seeking an expert opinion on whom or what is to blame. Stancombe and White (2005) argue that families are attuned to hear blame within the therapist's talk.

Family therapy

The hypothesis that families are causative in generating or maintaining symptoms provided much of the impetus for starting the field of FT (Wynne, et al. 1992). FT has gone through transformations in thinking, and many writers have characterised this as arriving in three distinct phases (Dallos & Draper, 2005). In the first phase the idea that some families were pathogenic was clearly stated (Haley, 1959). The theory of cybernetics was applied to families, with therapists as separate observers

of the system, interested in its interactions and communications (Dallos & Draper, 2005).

The second phase, second-order cybernetics, heralded the idea that therapists were part of the system. With this came the idea that there was no objective truth, only a subjective perception of an observer (Rivett & Street, 2003). There was a movement away from looking for the truth about the cause of psychosis towards generating hypotheses about individual family interactions. By the third phase FT had embraced post-modernism and began to look at the influence of society on the family and therapist (Dallos & Draper, 2005).

Arguably the most contemporary FT approach for psychosis is Open Dialogue (OD) (Seikkula, et al. 2001). Seikkula, et al. (2006) found interventions that claim there is a truth about the cause of psychosis, which they label a '*stuck monologue*' are linked to poorer recovery and higher rates of medication prescribing compared to OD. OD takes a social constructionist approach to causality, in OD all the people involved in the life of the person experiencing psychosis gather together with the aim of moving away from a stuck monologue towards a more deliberate open to all dialogue about the different perspectives on the problem (Seikkula, et al. 2001).

OD views the problem not as psychosis but rather the language that is used to describe it (Seikkula, et al. 2003). In OD people are required to '*tolerate uncertainty*' as different perspectives are heard and discussed (Seikkula, et al. 2006, P. 215). However, Jones (2002) and Smith, et al. (2007) argue that it's uncertainty regarding causality that angers families and can lead them to feeling blamed.

A number of techniques have been developed to reduce/dissolve families' sense of blame. These include offering reassurance that parents' behaviour is understandable

as a way of supporting their offspring (Burbach et al. 2010); constructing circularities rather than linear causalities (Jones & Asen, 2002); and using a social constructionist approach, in which there is no one, single, identifiable truth about causality, only points of view (White & Epston, 1989; Seikkula, et al. 2001). Doan (1998, P.383) argues that a social constructionist view of causality often ignores or downplays the '*genetically likely stories.*' He argues for an integration of social constructionist and biological understanding to provide a more balanced account.

In summary FT takes a social constructionist approach to causality discussions, from a position that there is no one, single, identifiable truth about it. It considers the role of family members within circularities but doesn't make linear causal connections. It has been criticised for accusing families of causing psychosis.

Family management

Whereas the origins of FT were connected to what caused psychosis, FM interested itself with what led to relapse (Johnstone, 2001). Expressed Emotions (EE), a term used to describe hostility, criticism, and emotional intrusiveness, was found to be associated with relapse. However EE is explicitly said not to have a role in the initial cause of psychosis (Smith et al. 2007).

A number of initial sessions are allocated to explore the original cause and relapse triggers of psychosis (Onwumere, et al. 2009). To do this psychoeducation is used which involves the application of Zubin and Spring's (1977) stress-vulnerability model (SVM). This model describes a vulnerability to psychosis being present at birth or soon after. However just because one is vulnerable to psychosis doesn't mean one will develop it, as there needs to also be an exposure to stress. This stress can be acute, in terms of major life events or ambient, which comes from

accumulated day-to-day stressors of life. The use of the SVM is coupled with information which explicitly says there is no evidence to suggest families have a causal role in psychosis but that they can help reduce the risk of relapse.

Although this was an attempt to create a bio-psycho-social model, Read et al. (2006) argues that the biological factor tended to be over-emphasised. Indeed the Knowledge About Psychosis Interview (KAPI) as recommended for use in FM (Smith et al. 2007) offers a response that psychosis is a biological illness to be correct. Emphasizing biology in causality runs the risk of parents drawing a genetics conclusion that something bad was passed on from them to their offspring (Goldacre, 2010). When psychosis is viewed as having a biological cause the individual with psychosis is perceived as dangerous and unpredictable (Read et al. 2006) and there is a more pessimistic outlook towards recovery (Angermeyer & Matshinger, 1996).

In summary FM's biological emphasis has been shown to lead to challenges for causality discussions and there is evidence that FT has led to some families feeling blamed for causing psychosis. There is however a third model emerging in which FM and FT are integrated (Meddings, et al. 2010; Lobban et al. 2005; Burbach & Stanbridge, 1998, 2006). Burbach, et al. (2007) argue that the integration of FM and FT holds advantages over a pure model. They argue that integrating the FT circular view of causality with FM enables a non-blaming means of exploring the family dynamics that may be maintaining the problem. However how this integration works in practice hasn't been researched.

Furthermore, ethically it's felt important to explore whether causality can be discussed without having negative consequences for the family or person with

psychosis. Burbach and Stanbridge's (1998, 2006) model is the most established integrated approach. Therefore it's reasonable to investigate how the clinicians working within this approach discuss causality, turning experiential knowledge into primary evidence.

Aim

To explore how clinicians' discuss the causality of psychosis with families within the Family Support Service (FSS)⁵.

Method⁶

Design

All cited research on blame stemming from ideas about causality has come from qualitative research. A large proportion of the literature on discussing causality with families comes from clinicians/researchers' description. However there is little description available on how clinicians in an integrated service discuss causality. A qualitative approach was felt the most appropriate means of developing this description.

It has been argued that research that uses pre-existing groups elicit more experiential reflections than one-to-one interviews (Palmer et al. 2010). Thus a focus group methodology was used. A framework approach was used to analyse the data. This allows a targeted method for generating results within a tight timeframe by allowing themes to develop from the research questions (a-priori analysis). However,

⁵ The FSS is the family intervention service that uses the Burbach and Stanbridge (1998, 2006) integrated mode. For a detailed explanation of the FSS please see Burbach and Stanbridge (1998, 2006) papers.

⁶ Research consultation was sought from Dr. Janet Smithson (Law research fellow of Exeter University) who has written about conducting and analysing focus group data.

this approach ensures a comprehensive analysis by allowing themes to also develop from participants' narratives (in-vivo analysis) (Rabiee, 2004).

Participants⁷

The recruitment of the FSS was purposive and from that a voluntary sample was drawn. This service has four teams; each team consists of four to six clinicians, with a total of twenty-two in the service. Four hour-long focus groups were held (one with each team) with four to five participants in each group, totalling eighteen participants⁸. The participants were homogenous in that they had all completed the same one-year training program and worked within the FSS. However the participants had different professional backgrounds and some had completed additional psychotherapy training⁹.

Procedure

The researcher attended a meeting of the FSS to introduce the idea of the research. An invitation to participate¹⁰ was e-mailed to each clinician and consent to participate was facilitated through replying to the e-mail. E-mail was used to reduce the risk of peer pressure to participate. With the field collaborator's assistance the researcher arranged to attend each team's meeting to conduct a focus group. Consent forms¹¹ and information sheets¹² were given to participants at the start of the focus group providing a two-stage consent process. Ground rules were drawn up and the semi-

⁷ Ethical approval was granted from the NHS Ethic Committee, appendix Q.

⁸ Despite being a member of the FSS the research collaborator was not invited to take part in the focus groups due to his level of involvement in the research.

⁹ Appendix O provides a table of participant's demographic details.

¹⁰ See appendix A for invitation to participate.

¹¹ See appendix B for consent form.

¹² See appendix C for information sheet.

structured guide¹³ was used with the researcher (AN) acting as facilitator. The focus groups were audio recorded to enable verbatim transcription by AN.

Analysis strategy

The data were thematically analysed by AN using a framework approach (Krueger & Casey, 2009; Rabiee, 2004; Ritchie & Spencer, 1994). The framework approach has the advantage of a clearly laid out procedure of data analysis which allows other researchers to verify the findings and safeguard against selective perception (Rabiee, 2004). This analysis followed five stages: familiarisation, identifying a thematic framework, indexing, charting, mapping and interpretation (Appendix E). Although Appendix E lays out a linear development of analysis, a constant comparative approach was used. The last three stages were repeated in a cyclical way, moving from segments of text to whole transcripts and back to segments (Barbour, 2007). In addition these steps were repeated following peer debriefing and member checks.

Epistemology

Unlike other methods, no one epistemological position is required in framework analysis. Researchers describe a continuum of epistemological positions with essentialist/realist at one end and constructionist at the other (Braun & Clarke, 2006). My own stance sits somewhere between these poles and is akin to critical realism (Bhaskar, 2002). This stance acknowledges that there is a reality out there, but we can never know this reality for certain and the reality we observe is influenced by social processes. Thus there is a reality of how clinician's discuss causality with

¹³ See appendix D for semi-structured focus group interview guide.

families but how this reality is experienced, observed and described is affected by social processes.

Reflexivity

By reviewing the literature I developed views about discussing causality with families, which affected the questions I asked and the themes I identified. My previous training/practice in FM and FT has influenced my involvement and interpretation because I have my own bias and preferences with regards to these models. To attempt to guard against this I undertook a number of steps to improve the credibility of the research, as follow:

1) *Peer debriefing* (Holloway & Wheeler, 2000): The analysis was discussed with my supervisor, field collaborator and in a qualitative analysis group. Half of the transcripts were double coded by my supervisor and field collaborator; 60% of the codes matched and the themes were considered plausible.

2) *Member checks* (Webb & Kevern, 2002): Thematic maps and representative quotes were fed back to the participants in a follow-up focus group. All the participants were invited to this focus group and eleven participants attended. After presenting the data, questions identified by Morgan (1999) were used to structure the participants' feedback¹⁴. They confirmed the plausibility of the identified analysis but suggested some changes¹⁵ to descriptive names.

3) *Audit trail* (Barbour, 2007): The development of a chart¹⁶, map¹⁷, matrix¹⁸ and interpretation sheet¹⁹ for each theme guard against an impressionistic analysis as

¹⁴ See appendix F for the questions used to structure the feedback focus group.

¹⁵ See appendix G for summary of the feedback focus group

¹⁶ See appendix H for an excerpt from a theme chart.

¹⁷ See appendix I for an example thematic map.

¹⁸ See appendix J for an example theme matrix.

the grouping of codes into themes is transparent (Barbour, 2007). A section of indexed transcript²⁰ and a section of the researcher's diary²¹ are also presented to further the transparency of analysis.

Results²²

Seven themes were identified: 1. Desire for certainty. 2. Uncomfortable discussion. 3. Constructing a shared understanding. 4. Therapeutic skills. 5. Limiting exploration. 6. Blame. 7. Experiencing the self in a group. Themes one and seven aren't discussed in this paper but may be explored in a future paper, although interesting material was generated it wasn't as directly relevant to the research aim as the other themes.

Uncomfortable discussion

Causality appeared to be an uncomfortable discussion to have with families because of factors identified that limited exploration and the role of blame (discussed later). Clinician's felt that there was no prescribed '*right time*' to talk about causality but all the groups said they felt more comfortable talking about it when families specifically ask.

Y4²³ Sometimes they ask for it, don't they, they want to talk about causes (L261-262)
Some groups identified that if not directly asked they touch upon causality throughout the course of the intervention rather than allocating a space to talk about it. Y2 called this '*weaving*' information in.

¹⁹ See appendix K for an example interpretation sheet.

²⁰ See appendix L for an example of indexed transcript.

²¹ See appendix M for an excerpt from the research diary.

²² See appendix N for the theme summary table.

²³ All names have been changed to codes to safe guard anonymity and family names have been changed to stars.

Y2 ... And umm, and weave that information in. Through questions and through exploration rather than as traditionally presenting it...

Y3 I like your analogy about weaving things in, because I mean at the moment I've got three young people on my case...who have recently lost a parent...it's obviously been a significant part of the development of their problems, you know. With two of them we can talk about it now, with the third we can't really yet, we will, but not yet. But I think it's that significance, it's almost that weaving as you say, bringing little bits in (L221-244).

By weaving information in clinicians could be more careful and thus less like to cause offense. Most groups said that once the therapeutic-relationship was established causality was easier to discuss and could be done so more directly.

C4 ...you know building up relationships with people because, I mean there are certain ways which I feel you can be a bit more sometimes direct, once you've got to know someone and they've got to know you and you know they are not just, they are not think(ing) you've been totally presumptuous and being sort of very directive... but that takes time, it takes time to get this knowledge and umm and you know, get to know the family (L760-771).

As captured in this quote, all groups said that time to establish a therapeutic-relationship was helpful when talking about causality.

Following a causality discussion a few groups said they ask the family how they experienced the discussion. It was identified that the thought of talking about causality was worse for the family than the actual discussion.

M4 Well often I'll sort of ask after a session, you know sort of say the words, how, how did you find that? And you can...see the family...sort of feeling visibly relaxed almost, sort of that was ok, that wasn't as bad as I thought

M3 Absolutely that's my experience; it's not as bad as they expected (L865-870).

Constructing a shared understanding

The purpose of causality discussions is to arrive at a shared understanding of what caused the psychosis. A number of tools were described that aided this. The stress-vulnerability model (SVM) was referred to as the most consistently used²⁴.

²⁴Talking about causality is not necessarily different from talking about stress/vulnerability. Stress and vulnerability are simply descriptive terms that can be used. When developing a formulation people tend to use the terms precipitating and predisposing rather than stress and vulnerability but they are very similar concepts.

M5 I find particularly the stress-vulnerability model is the one that crops up most often...I find it's easy to use quite often. (L251-254)

All groups identified positive aspects of the tool, indicating that it can be used visually; it's empowering, gentle/kind, flexible and enables multiple causal factors to be considered in a way that wasn't felt overly confusing.

Some groups spoke about using genograms. They described it as an active approach to constructing a shared understanding that got people involved. Some clinicians referred to it as good at uncovering trauma/genetic factors but others expressed that you needed to be careful when using it.

Y2 ...I wouldn't do a genogram with the family too early on...it might also umm stir up a lot of emotions. So umm you know pacing that and doing it carefully I think is very important. (L361-370)

Interactional cycles²⁵ were discussed in some groups but it was identified that they weren't used to look at causality.

T4 With the interactional cycles which, umm I would guess tend more on the side of what maintains the difficulty rather than what's causal (L273-275).

Formulation was discussed by the groups who didn't discuss genograms. These four tools aren't used in isolation and there is a sense that by combining them clinicians can talk about cause, maintenance and moving on. However formulation was considered to be the only tool that does all three.

T3...we do a formulation which, you know addresses or, these may have been predisposing factors and umm and these are vulnerabilities and this is how it gets played out and I suppose that is causal but then there's moving on to think about protective measures and people wanting help to just manage better (L373-380).

²⁵ *Interactional cycles are similar to circularities but they make cognitions/attributions about family members explicit, see Burbach, et al, (2007) for examples of interactional cycles.*

Therapeutic Style

Therapeutic style was considered the most important factor for causality discussions. This theme was talked about frequently and discussed at length in all groups. All groups spoke of a style of '*matching*' their intervention to the family's needs. For example; Y2 described how some families prefer to look at their family history and others to focus on the future. So clinicians chose techniques and tools that match the family's preference in order to maintain their engagement.

Y2 Some people are... interested in umm hearing about past generations. Some people are very in the present and future and not really, actually have an abhorrence... People will sometimes say I'm not going to talk to you, you know if you keep talking about the past... So it's very important to discuss causes in a context that the family creates for you.

All groups said causality discussions generally took place within a style of '*exploratory conversation*,' a term decided upon in the feedback focus group.

M3 I think that, you know when AN used the words '*techniques*' I think it is mainly about a collaborative therapeutic conversation, most of the ways of introducing these different ideas around causality are mostly conversational.

M2 Because that's rather different than a sort of teacher taught sort of situation.

M3 Yes

M2 I think a collaborative umm is, is, is a sort of, a rather non-expert sort of style of working, isn't it? Where, where it's, you're not the sole source of knowledge and you're not, you're not claiming that at all, you're actually interested in the many perspectives there might be in facilitating something (L574-585).

Some groups spoke of needing to change to a more psychoeducational style at times, particularly when discussing substance misuse. The majority of comments within this theme were in general terms but M3 gave a practical example.

M3... And I think, you know, that family that I mentioned earlier when we were talking about drug use. I think I was quite explicit when I started talking to the siblings about drug use and it could be seen as lecturing but I feel, you know if you, if there's clear drug use, you know similar aged children to, maybe at university and ones got psychosis and has used

drugs, used cannabis for example. I think its information they need to have that they may be at higher risk (L623-632).

However, not everyone agreed that there was a need to change from a style of explorative conversation.

M2 ... I don't think risk outside of the session necessarily alters the way we are with the family...

M5 Yeah (L663-665).

All groups commented that although the focus of the research is on causality, the focus of the intervention is on changing the future. Families attend sessions with the primary aim of improving their and the person experiencing psychosis's life. It was felt that exploratory future orientated conversations gave the family a sense that the future could be different.

M2...I think there are ways in which having conversation can be empowering and have a sense of agency in a situation rather than the feeling that there is something which is signed, sealed and delivered, as it were (L240-243).

Limiting exploration

Although the intervention takes place within the style of exploratory conversation a number of factors were identified that limit exploration. Familial sexual abuse was identified by most groups as one such factor.

M3 ... I think it's a major challenge for family therapists now to sit in a room where there might be somebody in that room a member of the family who might be an abuser, a sexual abuser, someone who has committed a major abuse on maybe the client.(L277-279)

Although not appropriate to explore with the whole family a few groups identified that familial sexual abuse could be explored by seeing different combinations of the family. The abused may not feel comfortable raising the abuse in the presence of

some family members, but might be able to one-to-one or may feel supported by certain family members to raise it.

Seeing different combinations of family members raises the issue of confidentiality. Participants said that family members will often share information about a particular causal factor in one combination of a family meeting but prohibit clinicians from talking about it when other members of the family there. So although these factors may have a causal role they cannot be explored or only explored in a limited way.

M5...I mean we sometimes have a situation in which drug use is clearly an issue possibly with somebody's mental health difficulties but there's a, we're prohibited from discussing drug use with families and that's quite often a confidentiality issue that patients, particularly young patients talk about isn't it? (L167-172).

Some groups indicated that the issue of illicit drug use limited the exploration of causal factors as although clinicians didn't intend to express cultural/societal judgments, clients sometimes experienced their comments in this way. As a result clients often counter-argued, expressing their perception regarding the benefit of drugs. Thus exploratory conversation became experienced as disagreement.

T4 ...you might get the response I smoke cannabis because umm my dad stresses me out telling me not to smoke cannabis,...,and however much evidence you cite about lifestyle choices it can be communicated in the wrong way or it can be received in the wrong way, can't it? However you communicate it as

T3 Yeah, yeah

T4 As another form of oppression but actually "I'm just managing the symptoms and I'd prefer to be out of it" (L518-526).

To guard against exploratory conversation becoming experienced as disagreement participants referred to reflecting counterintuitively, e.g. reflecting on the benefits of illicit drug use. Some groups also said that sensitive causal factors could be reflected on with a colleague in the presence of the family rather than directly discussed with

them. A similar technique of sharing one's own reflections rather than talking directly to the family was identified; both forms of reflection were felt to facilitate exploration, clarify and avoid disagreement.

Some groups spoke holding a care-coordination role for the family, due to service restraints. They described how holding this more '*active doing*' role limited exploratory conversation about causality as the family found it hard to see the clinician outside of their active doing role.

C5 [Care-coordination is] More active

C3 Yeah, yeah, more active role. It's, it's kind of like, I'll sort that out and deal with that as if care-coordinator rather than family role, let's see how we can move the family forward and they couldn't. They couldn't see the difference in roles (L384-388).

Some groups identified client characteristics that meant the client didn't have the capacity to engage in exploratory conversation such as when the client was; in the early stage of psychosis, very psychotic, too focused on their bodily experience and clients who felt very isolated from their family, because in these situations concerns other than causality were more pressing to them

Most groups identified specific family characteristics that limited/prevented the exploration of causal factors. It was particularly challenging when families didn't want family interventions, or didn't want to talk as the intervention requires the family to engage in conversation. Similarly families that wanted to divest themselves of their trauma and families with a biological focus were challenging as they weren't open to hearing other perspectives. However, over time and through the development of a therapeutic-relationship these challenges could be overcome. There was however, a sense that some families were too complex to ever engage in exploratory conversation about causality, as some families find it impossible to

communicate/function together and are unable to be together with a focus on them.

This last point seemed an uncomfortable idea and M1 voiced how this sounded blaming.

M1 ...you know how possibly families, families that perhaps find it so difficult to function that it actually maybe actually is just too impossible, it's, it's impossible to be all in the same room together. In in a, in a looking at them kind of way, I don't know. But then that's quite blaming to sort of say that (*laugh*), it's because they're all messed up (*laugh*)... (L785-792).

Blame

The Role of Blame

Blame had a major role in shaping causality discussions. All groups discussed people blaming themselves both explicitly and implicitly, as well as family members blaming each other for causing psychosis. Clinicians said that although it wasn't their intention, family members sometimes felt they were blaming them.

T2 It's bringing to mind the conversation we had with *** the other day. That "*if I'm to blame for this then I might as well leave now.*" Do you remember? They were just, weren't going to discuss it. It wasn't that we were implying any blame or anything anyway but that was how they were receiving it (L115-119).

Blame was identified as the major reason family members didn't attend sessions or dropped out of the intervention.

M1 ... we've wondered about somebody who was absent to begin with

M3 Yes

M1...we were wondering whether...that particular person perhaps felt they might be blamed for what, for what has happened (L878-885).

The strongest emotional response in all of the groups came from M1 who expressed his guilt for when interventions went wrong and his difficulty in talking about it.

Although not explicitly linked to blame it was connected to when family members leave the intervention which M1 and T2 linked to blame in the previous quotes.

M1... I'm interested in the times when it doesn't work, ... I think they were some of the ones that I was thinking about but not actually talking about because I wasn't quite sure how to talk about them...you know catastrophic meetings that we've had with people, where somebody has stormed out and one of those, but I still feel guilty about it kind of umpteen years later (L761-768).

Avoiding Blame

A number of techniques and ways of working were primarily used to avoid family members experiencing a sense of blame during causality discussions. The sending out of pre-intervention material was a way to avoid blame before the intervention even started.

T3 ... the literature that we send out is, is quite, address the issue, that this is going to be done in a non-blaming way. It's almost like, I think that message is sent out before people even arrive in the sessions.

Other techniques used to avoid blame included empathy, particularly in the early stages of the intervention and using the families own language. C4 spoke about using '*general terms*' to talk about sensitive issues without blaming and once a formulation was constructed supervision was identified as important to check out if it would be viewed as blaming/offensive to the family.

T2 ... you can bring them (formulations) to supervision so that other members of the team can hear. You know, other members of the team being the sounding board. You know, have we phrased that right? Does it sound harsh? Does that sound critical? (423-429).

Reducing Blame

Some groups talked about ways of intervening if someone felt blamed. These included: looking for exceptions, asking the family how the blamed person might view the situation, encouraging the blamed to attend, encouraging empathy/showing empathy for the blamed. However one group felt that regardless of what you did some people will continue to blame themselves.

T4 [Some people] with help, therapy, and whether that's individual or family can you know, release themselves from the guilt...over a period of time and understand the model and the

way the model is delivered come to agree that their influence wasn't umm, perhaps as significant as they first thought, but some people will blame themselves forever

T2 Yeah

T4 Forever and a day (L345-354).

Discussion

This research aimed to explore how clinicians discuss the causality of psychosis with families within the FSS. Five of the seven themes identified were explored; uncomfortable discussion; constructing a shared understanding; therapeutic style; limiting exploration; blame.

The analysis found that causality was uncomfortable to discuss with families because of factors that limited exploration and the role of blame. Clinicians said that families sometimes ask to talk about causality, this permission giving made for a more comfortable discussion. If not directly asked clinicians still aimed to talk about causality. Rather than addressing it directly in a number of allocated sessions, as is common in FM (Onwumere, et al. 2009) they '*weaved*' the information in, to reduce the risk of offending.

The development of a therapeutic-relationship enabled clinicians to discuss causality more directly as it reduced the risk of family members being offended. It was also identified as essential for engaging families and clients who had characteristics that limited/prevented exploratory conversation, such as when families didn't want to talk and when clients were actively psychotic. This finding supports the strongly established psychotherapy finding that the therapeutic-relationship is the most important factor for therapeutic success (Rivett & Street, 2009; Wampold, 2001). For the first time this analysis suggests the therapeutic-relationship is an important factor

for enabling the discussion of causality because it allows for a more direct and comfortable discussion.

Causality discussions aim to construct a shared understanding of what caused the psychosis. Three tools that are used for this are: the stress-vulnerability model (SVM), genogram, and formulation. The SVM (associated with FM) was identified as the most consistently used tool for constructing a shared understanding. This tool allowed multiple causal factors to be considered in a way that wasn't overly confusing.

Read et al. (2006) criticism that the use of the SVM overemphasizes the biological has been resolved by the FSS using it within the style of '*exploratory conversation*.' In exploratory conversation the clinicians hold a not knowing stance whilst exploring many different perspectives, with no one perspective being seen as true. Thus biology isn't emphasised more than other factors. The style of exploratory conversation is akin to that used in OD and narrative approaches to FT, (White & Epston, 1989; Seikkula, et al. 2001).

Doan, (1998, P. 383) criticised narrative approaches for downplaying the '*genetically likely stories*.' However, by using the SVM this criticism has been tackled, as genetic vulnerability is an explicit part of the model. By integrating FT aspects (exploratory conversation) with a FM tool (SVM) clinicians are able to have causality discussions without over-emphasising or downplaying specific factors. This finding has clinical application for those aiming for a balanced discussion about causality with families.

Causality is discussed in terms of linear rather than circular connections, most commonly using the SVM. Although interactional cycles (circular connections) were identified in the analysis they were used to construct a shared understanding about

what maintained the psychosis rather than what was causal. However, the focus of the intervention goes beyond causality to moving the family forward. Interactional cycles by exploring what maintains psychosis can be used to empower families to change future interactional patterns. The advantage of integrating interactional cycles had previously been cited by Burbach, et al. (2007) and is further supported by this research. Future research could investigate if the integration of the SVM with exploratory conversation to explore causality and the utilisation of circular connections to explore maintenance fits with other services, interventions and disorders.

Formulation is another means of constructing a shared understanding that combines causality, maintenance and moving forward but formulation enables this to be done within one tool. Formulation has an additional advantage, by exploring protective factors it can identify strengths rather than solely focusing on problems. Stickley and Matsterson (2003) argue that interventions that identify strengths are more empowering because they explore what is good and can be built upon compared to just focusing on what needs to change. However, there was a risk of offending families connected to formulation. Clinician's spoke of constructing a formulation without the family, checking it out in supervision to ensure it wasn't likely to cause offense and then sharing it. Thus families aren't actively involved in constructing formulations.

Genogram, the other tool identified was considered to be particularly good at getting families actively involved but it only explores causality. Dallos and Stedman's (2006) suggestion of integrating the family's genogram into their formulation may be a way of bringing together the family involving advantage of genogram with the ability to explore maintenance and moving forward inherent in formulation.

When the constructing a shared understanding matrix was looked at, it could be seen that the two teams that had psychologists discussed formulation. Formulation is a tool that is strongly based in the field of clinical psychology (Bentall, 2004) and rarely used in approaches to working with families (Dallos & Stedman, 2006). This is perhaps why it wasn't discussed in the teams without psychologists. Similarly the two teams that had family therapists discussed genograms perhaps because genograms are a more significant part of their practice compared to other professionals. This highlights the effect of professional backgrounds on causality discussions. Family interventions are commonly delivered by clinicians with different professional backgrounds (Rivett & Street, 2009) but how this effects the intervention hasn't been discussed until now. Future research into the effect of professional background on family intervention would be interesting.

All the groups identified that the therapeutic style of matching the intervention to the family was important, as it maintained engagement. Every group identified that causality discussions generally took place within the style of exploratory conversation. As previously discussed this style of approaching causality from a not knowing stance ensured no one causal factor was over-emphasised. The flexibility to switch to a psychoeducational style akin to FM was valued by some clinicians. There was a sense that in certain situations, such as when substance misuse is discussed, a psychoeducational style by informing family members can help prevent relapse and or prevent family members from developing psychosis. However, some clinicians felt that there was no need to switch to a psychoeducational style to discuss causal factors

This may indicate a dilemma in integrating these two differing styles. Rivett and Street (2009) suggest that a therapeutic stance of not knowing, which in part

describes exploratory conversation, is difficult to learn and comes with experience because the family have an expectation that the clinician is expert and the clinician experiences this as pressure to present themselves as expert. Thus the option of using a psychoeducational style is an important choice for those clinicians who feel uncomfortable with not knowing.

Clinician's spoke about finding it difficult to explore causality when they acted as care-coordinator, because the family wanted the more '*active doing*' role of care-coordination which seemed at odds with exploratory conversation. In the current economic climate where health providers are looking to save money, this research highlights the clinical importance of having a separate care-coordinator.

Familial sexual abuse limited exploration because it didn't feel appropriate to explore. Research has suggested that familial sexual abuse is one of the major causal factors in the development of psychosis (Read & Gumley, 2008). If not explored the family's understanding of causality won't be complete. Beyond this the recovery of the person experiencing psychosis will be limited and the abuse may continue (Read & Gumley, 2008). One way identified that enabled familial sexual abuse to be explored was by bring together only the family members that the abused felt comfortable to discuss their experience with.

By seeing different combinations of family members the issue of confidentiality was raised. The analysis identified that family members will often share information about a particular causal factor (such as illicit drug use) in one combination of a family meeting but prohibit clinicians from talking about it when other members of the family are present. Larner (2000) argues that it's the process of saying the unsaid that is healing for families. It's argued that in time it's important to raise the unspoken

causal factor with the whole family. The analysis identified the development of the therapeutic-relationship as one of the main means of making causality discussions more comfortable. Rivett and Street (2009) argue that it's the clinician's ability to contain that allows the unspoken to be spoken and containment is developed in part through establishing the therapeutic-relationship (Wampold, 2001).

Some groups indicated that illicit drug use limited the exploration of causal factors because exploratory conversation could become experienced as disagreement. Rivett and Street (2009) identify that reflection allows the clinicians' experience to be communicated to families without them feeling the need to argue against it and the analysis supports this assertion.

Blame had a major role in shaping causality discussions. Jones (2002) and Askey, et al.'s (2009) finding that family members blamed each other is supported by clinicians' experience. However clinicians felt family members also blamed themselves, which wasn't found in the aforementioned research but does support the research done by Gonzalez-Torres et al. (2006) and Corrigan and Miller (2004). The same researchers' finding that some families felt blamed by professionals was supported by the current research.

Blame was identified as a major reason people disengaged from the intervention and there was a strong expression of guilt from M1 about when things went wrong and people '*stormed out.*' T3 commented that the pre-intervention literature sent out communicated a message that the FSS was non-blaming. However, upon reviewing the literature this message wasn't borne out. It's hypothesised that clinicians' aim to be non-blaming influenced their recollection of what was in the pre-intervention literature.

A number of techniques that were used during causality discussion had a primary function of avoiding blame. The introduction had identified that clinicians/researchers felt conversations in which there is no one, single, identifiable truth about causality, only points of view (White & Epston, 1989; Seikkula, et al. 2001) was non-blamed. Exploratory conversation that shares this aim was identified in the analysis as non-blaming, thus supporting this assertion.

Constructing circularities rather than linear connections had been suggested as a way of discussing causality without blame (Jones & Asen, 2002). However, this research found interactional cycles that draw circular connections were used to discuss maintenance not causality. This research also identified using empathy, using the families own language, talking in '*general terms*' and using supervision to checkout formulations were ways of avoiding blame whilst constructing linear causal connection.

Blame wasn't always successfully avoided and when experienced clinician's described actively trying to reduce/resolve it. One technique used to do this was expressing empathy for the blamed which has previously been described by Burbach, et al. (2010). Other techniques that were described are generally associated with FT (Dallos & Draper, 2005): looking for exceptions and asking the family how an absent member would view the situation. However, until now these techniques haven't been explicitly identified as means of reducing/resolving family member's sense of blame. However, regardless of what clinicians do, some people continue to blame themselves.

There seems to be a preconceived idea or as contended by Cecchin, et al. (2003) a prejudice against blame. They recommend that clinicians' prejudices be named and

explored within therapy. If this isn't done they argue that open explorative thinking is not modelled. Thus families are less able to share/explore their own prejudices which they suggest are at the heart of families' problems. The findings in the present research appear to identify a prejudice that: *'No one in the family should feel blamed for the cause of psychosis.'* Indeed the researcher now believes that his goal of finding a way to *'discuss causality without negative consequences'* was influenced by this issue.

Martindale (2008) describes blame as a precursor to guilt. He argues that guilt can be helpful as it can increase motivation to find a way of assisting the person experiencing psychosis; psychodynamically this is called *'reparative guilt'* (P.39) He argues that to attempt to reduce/resolve this guilt would lessen motivation to help. Thus it follows that if clinicians hold a prejudice against blame then the opportunity for family members to experience reparative guilt is reduced and with it the motivation to help.

Martindale (2008) also argues that guilt that is too unbearable may be projected onto another person within the family; this is observed as one member blaming another. Attempts to avoid/reduce this blaming won't help the person projecting to integrate this split off part of themselves. Martindale and others working psychodynamically advocate exploring the blaming process and in so doing bring the dynamics of blame to the families' consciousness. It may be that some people continue to blame themselves regardless of the FSS's efforts because clinicians' attempt to avoid/reduce blame rather than explore it.

This research proposes that the psychodynamic literature on reparative and projected guilt be utilised to further develop family interventions. It's proposed that

clinical psychologists who through their training are experienced in drawing upon different psychotherapy models to deliver interventions (including psychodynamics) may be best placed to lead this development.

Focus group dynamics

The majority of comments were in general terms and even when directly asked for practical examples participants found it difficult to provide them. Participants identified talking in '*general terms*' as a technique they use with families to avoid blame, perhaps they used this technique in the focus groups to avoid being seen as blaming. Indeed M1 appeared uncomfortable when he identified his comments about complex families as blaming (P.21).

Participants often looked for reassurance from other members with the phrase '*you know?*' Reassurance was commonly provided with participants explicitly agreeing. This level of agreement may have occurred because the participants' views have developed together over a period of joint working.

During the few disagreements participants were more likely to use examples from practice. Kingsbury (1987) argues that it's common for clinicians to give examples from practice to support their position. However, by citing ones practice one is risking this practice being criticised, perhaps another reason that practical examples were rarely given. Thus participants self-censored what experience they shared, indeed whilst reflecting on the focus groups the participants said they self-censored, consequently the data available for analysis was affected by this social process.

Finally as a result of taking part in this research the FSS plan to set aside time to focus on other topics of interest using a focus group methodology.

Limitations

Qualitative research doesn't aim to be empirically generalisable. However it's desirable for implications of the research to inform practice. Given the homogeneity of the sample, these findings will have the greatest relevance to clinicians within the FSS. However, it's hoped that these findings will enable clinicians in other services to reflect on their practice.

Three members of the FSS were unable to attend the focus groups and the field collaborator wasn't invited given his involvement in the research. Therefore these clinicians' thoughts/influence didn't contribute to the research. Thus this isn't a complete representation of the views of all FSS clinicians.

This research is dependent on clinicians' views, with families' voices being absent. Asking families how they experienced causality discussions and observing family intervention sessions in which causality was discussed would have improved the robustness and scope of the research. Unfortunately given the time restraints this wasn't possible. However research using such a triangulation of methods into the issue of blame is currently in development.

It's important to highlight that the focus groups were conducted in a limited time frame (one hour) amongst clinicians who knew each other well and that the groups took place on work premises. Thus it may be that participants responded in a more professional manner than they would have done if they had more time, a different setting and they were less familiar with each other. In part this might be why there was little emotion within the majority of comments, there were high levels of agreement and few practical examples given.

This research focused on causality discussions but this only makes up part of family interventions. It was difficult to hold the focus on how clinicians' discuss causality from drifting wider to how they undertake family interventions. It was artificial to focus on causality and a more accurate picture may have been gained by exploring the whole intervention. However, as framework analysis allows for a-prior and in-vivo analysis, the wider scope of family interventions was acknowledged.

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Extended appendices

Appendix A: Invitation to participate

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Appendix V: An example of an interactional cycle

Invitation to participate

Dear

My name is Andrew Newman and I recently attend your family support service team meeting and talked to you about the research we hope to undertake. We plan to run a series of focus groups to gain clinician's experience of discussing causality with families. Thus we are inviting you to take part in a focus group discussion. The focus group will be held after your team meeting in your team base. It will last for up to one hour and be recorded onto audio tape.

If you would like to take part in the research please opt in by respond to this e-mail. An information sheet and consent form are attached.

If you are interested in taking part I will contact you with the focus group dates and details.

Thank you

Andrew Newman (the researcher)

Trainee Clinical Psychologist

Exeter University and Somerset Partnership Trust

Consent form

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: **The experience of clinicians in discussing causality with families in a family management and therapy integrated service.**

Name of Researcher: **Andrew Newman.**

Please initial box.

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and my withdrawal will have no adverse effect upon me.

3. I understand that the focus group will be audio recorded and data collected during the study may be looked at by individuals from Exeter University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to audio recordings of me obtained at the focus group.

4. I agree to take part in the above study and give consent for direct quotes to be taken.

Name of clinician	Date	Signature

Name of person taking consent	Date	Signature

One copy to participant and one copy to researcher

Information sheet

Theories regarding the cause of schizophrenia have divided family management and therapy for over a hundred years. Now as researchers/clinicians attempt to integrate the two approaches the experience of discussing the causes of psychosis with families is important to research. To do this the wealth of knowledge clinicians have about discussing causality with families will be explored.

We plan to run a series of focus groups to gain clinicians' experience of discussing causality with families. Thus we are inviting you to take part in a focus group discussion. The focus group will be held after your team meeting in your team base. It will last for up to one hour and be recorded by audio tape.

Do I have to take part?

It is up to you to decide. We are happy to describe the study and go through this information sheet with you if you want. If you feel like you would like to take part we ask that you reply to an e-mail invitation to take part. You are free to withdraw at any time, without giving a reason. This would not affect you in any way. You will have the opportunity to ask questions on the day of the focus group, and you will be asked to sign a consent form before it begins.

What are the advantages and disadvantages of taking part?

It will take about 60 minutes of your time to take part in the focus group and the focus group may bring up some uncomfortable feelings. However the researcher will make himself available at the end of the focus group to discuss uncomfortable feelings that may arise.

The main advantages will be the creative experience, the potential to explore your practice in a reflective space and the opportunity to add your views to the body of literature.

Will I find out what happens after I've taken part?

In keeping with the commitment to research 'with people rather than on people' the findings will be taken back to the participants to clarify points and secure consensus in a follow up focus group to which all participants will be invited. You will also have the opportunity to request a copy of the research once completed.

What if I have concerns or want to complain about the way I've been treated?

If you have any concerns or wish to complain you can do so by e-mail to Janet Reibstein j.Reibstein@exeter.ac.uk who is supervising this project. Or to Frank Burbach who is my field collaborator by e-mail at frank.Burbach@sompar.nhs.uk.

Will the information be kept confidential?

Names will be changed in the write up. The code, the audio recordings and transcripts will be secured in a locked drawer. Confidentiality and anonymity can only be guaranteed from the researcher's personal perspective, but this cannot be guaranteed on behalf of the co-participants. The only time we may break confidentiality would be if we were concerned about others safety. In this event we would inform you first if possible.

Please feel free to ask us if there is anything that is not clear or if you would like more information. You can contact the researcher by e-mail at an252@exeter.ac.uk.

Take time to decide whether or not you wish to take part. The researcher will contact you by e-mail near the time of the focus group to see if you wish to participate.

Thank you

Andrew Newman

Trainee Clinical Psychologist

Exeter University and Somerset Partnership Trust

Semi-structured focus group interview guide

This semi-structured guide was generated by the researcher following the literature review. It was reviewed by the research supervisor and field collaborator and piloted on a focus group of five trainee clinical psychologists.

What are the clinicians' ideas/hypotheses about causality?

Can you write on the flip chart paper provided what factors you feel have a causative role in psychosis

Do clinicians discuss causality with families?

Which factors wouldn't you discussed with families?

Can you tell me a bit more about these discussions?

If you haven't discussed any causative factors with families why haven't you?

What has been their experience of discussing causality with families?

Can you tell me about when a discussion went well?

Can you tell me about a discussion that didn't go so well?

You mentioned using to discuss the cause of psychosis with a family, can you tell me more about that?

Have you used any other specific techniques to discuss causality?

How do you decide which techniques to use?

What are the clinicians' reflections on talking about these issues within the focus group?

What are your reflections on talking today about issues around causality?

Table 1. Stages of framework analysis (krueger & casey, 2009; rabiee, 2004; ritchie & spencer, 1994).

Framework stages	Description of stages
Familiarisation	Transcribing the data, reading and re-reading the transcripts. The aim to immerse oneself in the detail and get a sense of the data as a whole before the data is broken into parts
Identifying a thematic framework	Writing memos in the margins of the text, in the form of short phrases, ideas or concepts that arise from the text. The aim to begin to categorise the data and develop descriptive statements
Indexing	Identifying portions of the data that correspond to a particular theme and noting the theme in the margin of the text.
Charting	Cutting up the transcript and sorting all the quotes that address a particular question together (deductive). Also allowing themes that were constructed by the participants (inductive) to be collected. Data that is not considered relevant is put to one side. The 'long table' approach. Microsoft word cut and paste function was used to undertake this stage of analysis.
Mapping and Interpreting	Map The codes identified within a theme are mapped.
	Matrix A matrix is developed for each theme. The matrix contains distilled summaries of each theme and allows for the focus groups to be compared in relation to each theme.
	Words Considering the actual words used and their meaning.
	Context Consider the context.
	Internal consistency Consider changes in opinion or position.
	Frequency Consider how often a comment or view is made.

	<p>Intensity of comment Consider the depth of feeling in which comments or feeling are expressed.</p>
	<p>Specificity of response Greater emphasis placed on participants referring to personal experience rather than hypothetical situations.</p>
	<p>Extensiveness The number of participants who express a particular view and deviant cases.</p>
	<p>Big Picture Consider larger trends or concepts that cut across the various discussions, whilst holding an awareness of deviant cases.</p>

Guide for focus group feedback session

Do they recognise the maps?

Are the factors within the maps grouped appropriately?

Are they labelled appropriately?

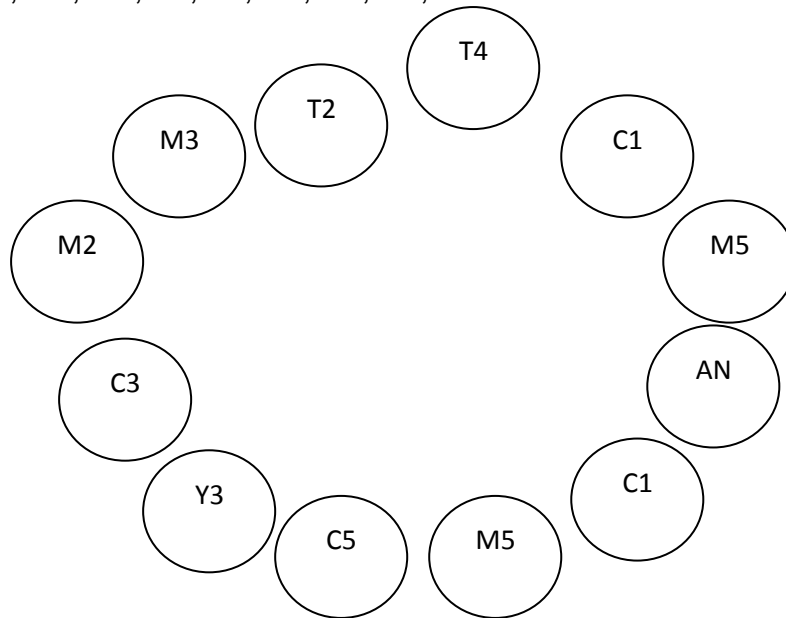
Have I missed anything?

What factors do they think are most important?

Focus group feedback summary

10/02/11

The feedback group lasted for one hour. It included the following people.
M2, M3, M5, T2, T4, C1, C3, C5, Y3



Generally the participants recognised the maps and my descriptions and they reflected that they were true accounts of their practice. They highlighted that discussions about causality begin amongst themselves before family interventions, with other professionals and in supervision regarding the referral.

They felt it was also important to highlight that it was very rare to have less than two clinicians facilitating sessions. They felt it was important to highlight that there can be contact with members of the family outside the sessions and that family sessions can happen in trust properties and in the family's home.

There was also a discussion about changing the word wondering to reflecting. '*playing the other card*' wasn't recognisable and following a description of the box, the title '*reflecting counterintuitively*' was felt to fit better. Within the '*reflecting*' factor the box titled '*to myself*' was considered confusing as it did not indicate that this reflecting was shared with the family. Therefore the term '*sharing self reflection*' was chosen instead.

It was felt the '*fun*' box linked to Genograms was misleading as genograms are often very emotive. This box was felt to be better described as active.

In closing again the participants commented on how useful the focus group experience was and they said they were going to try and integrate focus groups into their practice.

An excerpt from the therapeutic style chart

Therapeutic Style

Matching

AN So you would do it as a kind of education?

C1 Umm

AN And would you cover all those? (referring to white board)

C5 Umm, yeah. Not necessarily either it is very dependent on the situation and the family, doesn't it? Some families are better at communicating or asking for information, I think it's very dependent and very individually assessed really as to how you manage that. And I don't think you would necessarily cover all that in one particular, it would depend on the session and (L98-106)

- **Y2** Yeah second year or maybe third year even and I might not even go there at all. You know it depends on whether they were future orientated or past orientated

AN Can you say more about that distinction?

Y2 Some people are umm very sort of psychoanalytical in the way they understand the world. And so very interested in umm hearing about past generations. Some people are very in the present and future and not really, actually have an abhorrence sometimes, you know sometimes an embargo is put on what you can talk about. People will sometimes say I'm not going to talk to you, you know if you keep talking about the past, you know I want to put that behind me. So it's very important to discuss causes in a context that the family creates for you. And umm, and weave that information in. Through questions and through exploration rather than as traditionally presenting it, like we're going to do stress vulnerability today, you know. They put that, that can be really good for some families and the kiss of death for others, you know, so (L222-235)

- **M2** that that struck me also about that actually you know, there are a number of tools around, there are a number of things you could use, a number of techniques but which you actually use and how you use them depends upon the family that you're with, what they're seeking, what they're looking for and sometimes there's a sort of matching sort of process I think, about trying to, trying to link

M3 Yes, that's a nice way of putting it matching process, yes. (L562-569)

- **M2** But it's, but it's based upon the sort of, you know you say. I mean it struck me as sort of what do you think, what are the needs of the family at that time

M4 Yeah, exactly, yeah

M2 And if the needs are for something to be more structured, then that's what one provides, if the needs are for something more discursive and then (L616-622)

- **T3** I think inevitably yes. Well sometimes we, well you know, we will say to them, you know a view that, people will come with a view that their psychosis was caused by substances misuse and we look at that and think why the substance misuse, what are they trying to manage. So we, we play the other card sometimes. And it's not fixed, I think whatever we say bearing in mind, you have to contextualise that with the family you are with and the material their bringing and the history of previous meetings. I think it's

AN So it sounds like your approach might be different depending on which family you are with? Each family might be different?

(10 seconds of silence)

T3 Yes and no, there's the element which, you know we're always bringing ourselves aren't we? And how we are, umm but I think we do have to be sensitive to that individual families needs as well. (L545-559)

- **C4** And we work with individual families very, very differently I think. I mean

All Hmm, yeah (L227-229)

- **Y3** I guess really we would talk about whatever is relevant for that family. (L200-201)

Interpretation of: therapeutic skills theme

Words

They spoke of matching their interventions to the family's needs in order to increase the likelihood of the family engaging. They said causality discussions generally took place within a style of '*explorative conversation*.' This term was chosen in the feedback focus group. Some of the focus groups spoke of a need to change to a more psychoeducational style at times, particularly when discussing illicit drugs and alcohol. There was some disagreement about the need to change styles. All the focus groups commented that although the research's focus is on causality the interventions focus is on looking for options to change the future.

Context

The semi-structured interview guide did not have a question about this theme but it was mentioned in every focus group. The majority of comments were in general terms but practical examples were given during the disagreement about the need to change styles.

Internal consistency

There was disagreement about changing styles.

Frequency

This theme was talked about frequently and discussed at length in all focus groups.

Intensity of comments

The conversations were generally reflective and there was little emotion within the conversations.

Specificity of response

The majority of comments were in general terms but practical examples were given during the disagreement about the need to change styles.

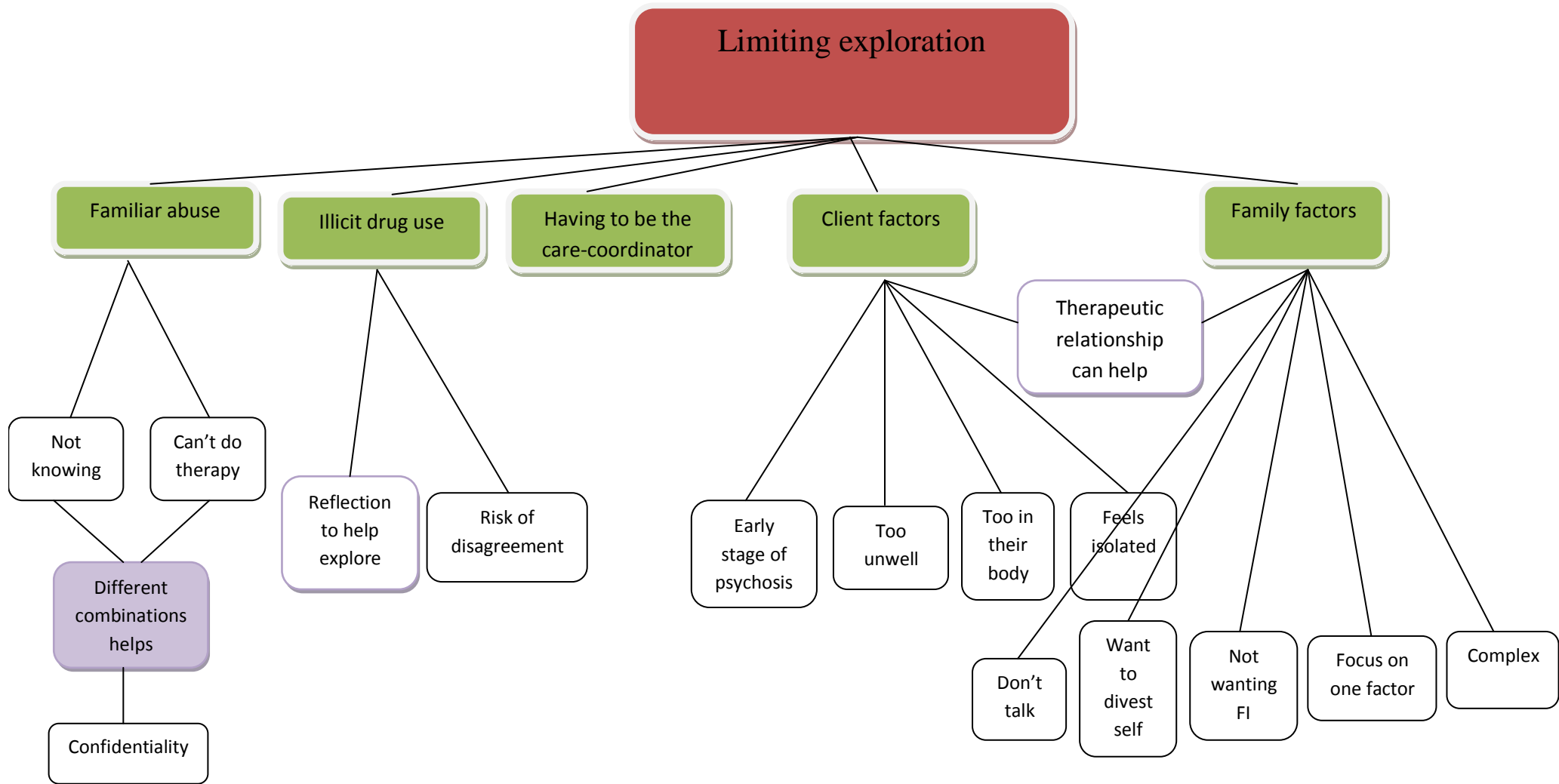
Extensiveness

Every focus group mentioned all of these factors.

Big picture

The factors within this theme were considered the most important for successful discussions about causality to take place. There was an important point made that the interventions focus is not on causality but on options to change the future. This theme captured some disagreement around changing style, perhaps this tension comes from the challenge of integrating FT and FM.

Limiting exploration



Constructing a shared understanding

	Stress Vulnerability model	Genogram	Formulation	Interactional cycles
M	<ul style="list-style-type: none"> S-V model used a lot, as individual. Question what is stress and vulnerability. <p>Positives</p> <ul style="list-style-type: none"> Takes blame out of the equation. Can draw a graph. Empowering. Reduces fait accompli. 	<ul style="list-style-type: none"> Uncovers trauma and genetic factors. Get's people involved. 		<ul style="list-style-type: none"> Combining S-V model and interactional cycles. S-V model for causality and interactional cycles for how it gets played out. Blame doesn't get centred on one person. Someone felt blamed following drawing out the interactional cycle.
T	<ul style="list-style-type: none"> S-V model used a lot, mentioned in nearly every session. <p>Positives</p> <ul style="list-style-type: none"> Non-blaming. It is a gentle and kind model. It is easy to understand. Good for introducing causality If people ask about causality it is good. It is flexible Can be visual Can draw a graph Covers all factors. <p>Negative</p> <ul style="list-style-type: none"> But people can still feel blamed, doesn't wash it away. 		<ul style="list-style-type: none"> Looks at what caused it, how it gets played out and how people can move on. Formulations written outside sessions, pulling together the conversations. People can change it and something's may be left out. Validating. Empowering. Powerful. Objective. Gives a new understanding You need supervision as very sensitive. Use the formulation to set goals. 	<ul style="list-style-type: none"> Use interaction cycles. The participant spoke about drug use in an interactional cycle way. Look at maintenance rather than causality. People can feel blamed following the drawing out of the interactional cycle.
C	<ul style="list-style-type: none"> I'd discuss causality using the S-V model. <p>Positives</p> <ul style="list-style-type: none"> It is easy to understand. Can work even if no psychosis. <p>Negative</p> <ul style="list-style-type: none"> People who want medical find it to woolly. 		<ul style="list-style-type: none"> We share the formulation with the family. 	
Y	<p>Positives</p> <ul style="list-style-type: none"> It is flexible. Can be visual Tidiness and chaos can both be stressors. Complicated but achievable. <p>Negative</p> <ul style="list-style-type: none"> People may not appreciate the jargon. Used to attack person with psychosis. 	<ul style="list-style-type: none"> Good for getting to know people. Uncovers trauma and genetic factors. But need to be careful. Conflict around do it early on or later. Get's people involved. It's an active tool. 		

T focus group 09/11/10 10:00-10:50

242 **T4** But, but part of the mental illness

243 **T1** Yes

244 **T4** And delusional, and not true

245 **T1** Yes, yes definitely. Because he, this client had quite a few,
246 umm distressing beliefs about different family members. That, that
247 didn't seem to have any reality, so it, it was talked about as. But
248 it's something that the client has always come back to, and its
249 all, yes, just never going to know really, whether there's truth to it
250 or not.

Familial
sexual
abuse
challenging
re: Not
knowing.

251 **AN** It sounds like that came very much from the client wanting to
252 talk about it?

253 **T1** Yes, yes

254 **AN** How would you normally decide when to talk about
255 causality?

256 **T1** Umm, yeah, when the family wants to talk about it, usually, isn't
257 it? Quiet often it's one of the first things they want to talk about
258 and the client to so, maybe more the family than the client.
259 Particularly parents I think. It's often one of the first things they
260 want to talk about. Because often they do feel, come with lots of
261 feelings of guilt and blame. What could we have done
262 differently?

Families
ask to
talk about
causality

Families blame
themselves.

263 **T4** This doesn't need any direct accusation from umm, the, the
264 client or any perceived blame for the therapists, or you know
265 that, umm. It's just in the room. Parents can come to sessions with
266 having already built up a fair bank of guilt about things that
267 could have been done differently. And genuine questions about
268 understanding what has happened.

families blame
themselves

269 **AN** And you talked about using the stress-vulnerability model
270 before that. Is there anything else you would do to explore that?

271 **T2** We put up the interactional cycles quiet often. We look at
272 those.

273 **T4** With the interactional cycles which, umm I would guess tend
274 more on the side of what maintains the difficulty rather than
275 what's causal. Umm the thing my, if I'm reflecting on my practice

Maintaining
not
causal.

Research diary excerpt

09/11/10

B focus group

The stress-vulnerability model came up again and formulation also did. There was a very strong emphasis on the therapeutic-relationship. I was interested to hear about the importance of not being the care-coordinator. It was interesting that care-coordination seems a more '*active doing*' role. There was talk about talking differently with staff compared to families. The conversation seemed to go more off topic for this group. We covered a bit about bringing in people who hadn't been at a previous session but this was a little off topic. It will be interesting when I'm listening back to see how much is usable and how much was off topic. I'm not sure why we went off topic, maybe because it was the third group? Maybe the people in the group played a factor in this? It may be that when I listen back that it wasn't as off topic as it felt. Even reflecting upon it now it seems like lots of relevant material was aired. I defiantly think I am building on information and certainly getting a fuller idea of how clinicians tackle the subject of causality. Yeah generally a good day. One focus group to go.....

Table 2. Theme summary table

Themes	Factors that made up the theme		
Uncomfortable discussion	<ul style="list-style-type: none"> • Discussions more comfortable when families asked to talk about causality. • Discussions more comfortable if causality 'weaved' in. • Discussions more comfortable if therapeutic-relationship established. 		
Constructing a shared understanding	<ul style="list-style-type: none"> • Can use the Stress-Vulnerability Model • Can use Genograms • Can use Formulation • Interactional cycles identified but to explore maintenance not causality. 		
Therapeutic skills	<ul style="list-style-type: none"> • Matching the intervention to the family's preferences. • Using a therapeutic style of exploratory conversation. • The flexibility to use a psychoeducational style • Therapeutic focus on changing the future 		
Limiting exploration	<ul style="list-style-type: none"> • Suspecting familiar sexual abuse. Resolved by seeing different combinations of family members • Confidentiality puts blocks on what can be discussed. • Discussions about illicit drug use lead to disagreement. Resolved by using reflection. • Care-coordinator role is more active than family role, so hard to hold both. • Client specific factors and family specific factors. Resolved by establishing a therapeutic-relationship. 		
Blame	Role of blame	Avoiding blame	Reducing Blame
	<ul style="list-style-type: none"> • People blaming themselves. • Family members blaming each other. • Family members feeling blamed by clinicians. • Blame is the main reason people don't attend or drop out. • Clinicians express guilt about when it goes wrong. 	<ul style="list-style-type: none"> • Pre-intervention material. • Using the families own language. • Talking in general terms. • Using supervision to check out formulations. 	<ul style="list-style-type: none"> • Looking for exceptions. • Psychologically bring the blamed into the room. • Encouraging the blamed to attend. • Showing empathy for the blamed. • Sometimes cannot reduce blame.

Participant demographic information table

Focus group	Gender	Profession	Additional psychotherapy qualifications	Length of Service	Time in FSS
M	Female	Social Worker	Psychodynamic Therapy	21	8
M	Male	Art Psychotherapist	Family Therapy	40	13
M	Male	Family Therapist	None	10	9
M	Male	Registered Mental Health Nurse (RMN)	None	7	5
M	Female	Registered Mental Health Nurse (RMN)	Family Therapy	19	13
M summary	2 female and 3 male	1 Art Psychotherapist, 2 RMNs, 1 Family Therapist and 1 Social Worker	2 additionally trained in family therapy, and 1 has done psychodynamic therapy	Mean length of service 19 years Length of service range 7-40 years	Mean time in FSS 10 years Time in FSS range 5-13 years
C	Male	Did not provide details	Declined to provide details	Declined to provide details	Declined to provide details
C	Female	Did not provide details	Did not provide details	Did not provide details	Did not provide details
C	Male	Registered Mental Health Nurse (RMN)	Cognitive Behavioural Therapy	21	11
C	Female	Social worker	None	16	11
C	Female	Social Worker	Psychodynamic Therapy	8	5
C Summary	3 female and 2 male	1 RMN, 2 social workers and 2 clinician's did not provide details	1 additionally trained in Cognitive Behavioural Therapy, 1 in psychodynamic therapy and 2 did not provide details.	Mean length of service 15 years Length of service	Mean time in FSS 9 years Time in FSS range 5-11 years

				range 8-21 years	
T	Female	Occupational Therapist	Cognitive Behavioural Therapy	20	10
T	Female	Registered Mental Health Nurse (RMN)	None	7	4
T	Male	Did not provide details	Did not provide details	Did not provide details	Did not provide details
T	Male	Social Worker	None	15	6
T Summary	2 female and 2 male	1 Occupational Therapist, 1 RMN, 1 Social worker and 1 did not provide details	1 additionally trained in cognitive Behavioural Therapy and 1 did not provide details.	Mean length of service 14 years Length of service range 7-20 years	Mean time in FSS 7 years Time in FSS range 4-10 years
Y	Female	Did not provide details	Did not provide details	Did not provide details	Did not provide details
Y	Male	Registered Mental Health Nurse (RMN)	Family Therapy	31	13
Y	Female	Registered Mental Health Nurse (RMN)	Family Therapy and Cognitive Behavioural Therapy	33	9
Y	Female	Did not provide details	Did not provide details	Did not provide details	Did not provide details
Y Summary	3 female and 1 male	2 RMNs and 2 did not provide details	2 additionally trained in family therapy, 1 in cognitive behavioural Therapy and 2 did not provide details	Mean length of service 32 years Length of service range 31-33 years	Mean time in FSS 11 years Time in FSS range 9-13 years

Total summary	8 males and 10 females	1 Family Therapist, 1 Occupational Therapist, 1 Art Psychotherapist, 4 Social workers, 6 RMNs and 5 did not provide details	2 additionally trained in psychodynamic therapy, 3 in cognitive behavioural therapy, 4 in family therapy and 5 did not provide details.	Mean length of service 19 years Length of service range 7-40 years	Mean time in FSS 9 years Time in FSS range 4-13 years
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The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

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- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

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The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

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Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

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23 July 2010

Mr Andrew Newman

Trainee Clinical Psychologist

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EX4 4QG

Dear Andy

Study Title: **The experience of clinicians in discussing causality with families in a family management and therapy integrated service**

REC reference number: **10/H0107/42**

Thank you for your letter of 17 July 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research (“R&D approval”) should be obtained from the relevant care organisation(s) in accordance with NHS research

governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation’s involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>	
Investigator CV		03 June 2010	
Protocol	3	22 March 2010	
Supervisor CV			
REC application			
Covering Letter		03 June 2010	
Covering Letter			

Summary/Synopsis	1	03 June 2010	
Letter from Sponsor		27 May 2010	
Interview Schedules/Topic Guides	2	22 March 2010	
Letter of invitation to participant	1	22 March 2010	
Participant Information Sheet	3	17 July 2010	
Response to Request for Further Information			
Participant Consent Form	4	17 July 2010	
Public Liability		22 July 2009	
Field Collaborator Cv		03 June 2010	
Major Risk Matrix	3	03 June 2010	
Evidence of insurance or indemnity		17 August 2009	
Referees or other scientific critique report		20 April 2010	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National

Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H0107/42

Please quote this number on all correspondence

Yours sincerely

Dr Mike Shere

Chair

Email: Anthony.Sack@nbt.nhs.uk

Enclosures: "After ethical review – guidance for researchers" [SL-AR2](#)

Copy to: *Andy Richards, Exeter University*

Dissemination strategy

As the finding from this research will have the greatest relevance to clinicians within the FSS this paper will be sent to every member of the service once finalised. A reflective space will be offered to the service to provide them with the opportunity to reflect upon the paper and identify points they wish to take forward.

As this research will be of direct relevance to clinicians practicing family interventions within Early Intervention in Psychosis services a poster will be submitted to the UK and South West Early Intervention in Psychosis annual conference/meetings.

The target journal for this research is the '*British Journal of Clinical Psychology*' as among other research this journal publishes studies of psychological interventions with families. The journal's target audience of clinical psychologists is well suited to this paper as it argues that they are the best placed to further develop family interventions for psychosis. The journal is also read by other mental health professionals and has a worldwide audience. Finally the journal has a proven record of publishing qualitative research.

Glossary of Terms

“Circularity: *The situation where what happens is in some way determined by some precursor event and has also had some effect on that first event, where it is not possible to determine ‘which came first, the chicken or the egg’. This way of viewing the world grew out of biology and ecology. It is consistent with a linear conception if the latter is seen as treating just one small segment of a larger interrelated whole”* (Dalos & Draper, 2005, P 305). (See appendix T for an example)

Exploratory conversation: Are conversations in which clinician’s take a non-expert position and hold a stance that there is no one, single, identifiable truth about causality, only points of view. They invite member’s of the family to share their views and facilitate an atmosphere in which uncertainty/not knowing is encouraged.

Formulation: A formulation describes the problem (psychosis), the predisposing (causal) factors, perpetuating (maintaining) factors and the protective (things that the family can do more of) factors. Formulations as used by the FSS are constructed by the clinicians and then shared with the family.

Genogram: A genogram is a pictorial representation of the people in a person’s family. In clinical practice additional lines are added to demonstrate the strength of a relationship with straight lines representing a strong relationship and wave lines representing a conflictual relationship (see appendix U for an example).

Interactional cycles: Interactional cycles are similar to circularities in that they are interested in the large interrelated whole, but interactional cycles also make cognitions/attributions about family members explicit, see Burbach, et al, (2007) for examples of interactional cycles (see appendix V for an example).

Psychoeducation: Psychoeducation is a style of intervention in which traditionally information on 'what is known' about a psychologically related topic is presented to a client and or family by a clinician/clinicians from an expert position.

Stress-vulnerability model (SVM): This model was purposed by Zubin and Spring (1977) and describes a vulnerability to psychosis being present at birth or soon after. However just because one is vulnerable to psychosis does not mean one will develop it, as there needs to also be an exposure to stress. This stress can be acute, in terms of major life events or ambient, which comes from accumulated day-to-day stressors of life.

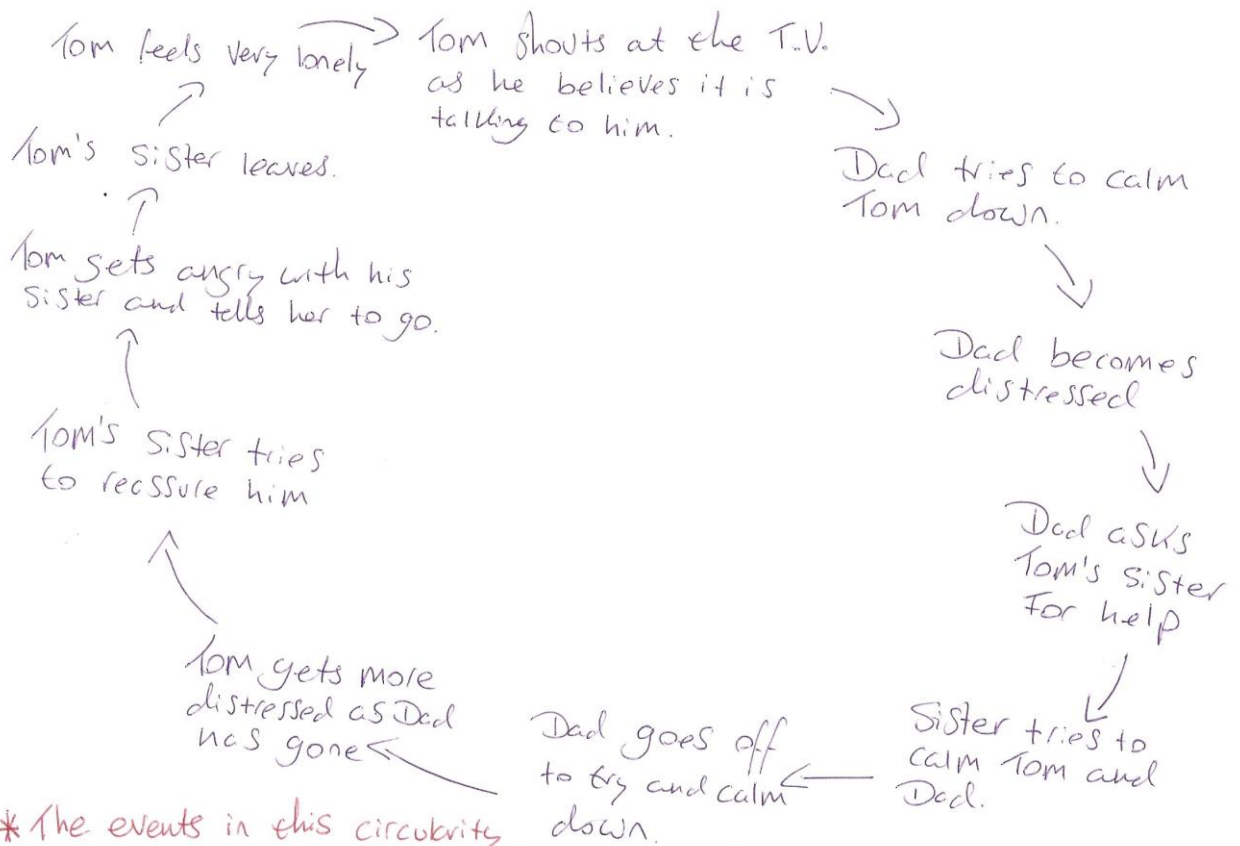
References

Burbach, F., Carter, J., Carter, J., & Carter, M. (2007). Assertive Outreach and Family Work. In: Velleman, R., Davis, E., Smith, G., & Drage, M. (Eds.) *Changing Outcomes in Psychosis, Collaborative Cases from Practitioners, Users and Carers*. Oxford, BPS Blackwell.

Dallos, R. & Draper, R. (2005). *An Introduction to Family Therapy, systemic theory and practice, (2nd edn)*. Maidenhead, Berkshire, Open University Press.

Zubin, J. & Spring, B (1977). Vulnerability: A new view of schizophrenia. *Journal of Abnormal Psychology* **86**, 103-126.

An example of a circularity



* The events in this circularity have been made up to provide an example.

An example of a genogram

Key

□ = Male

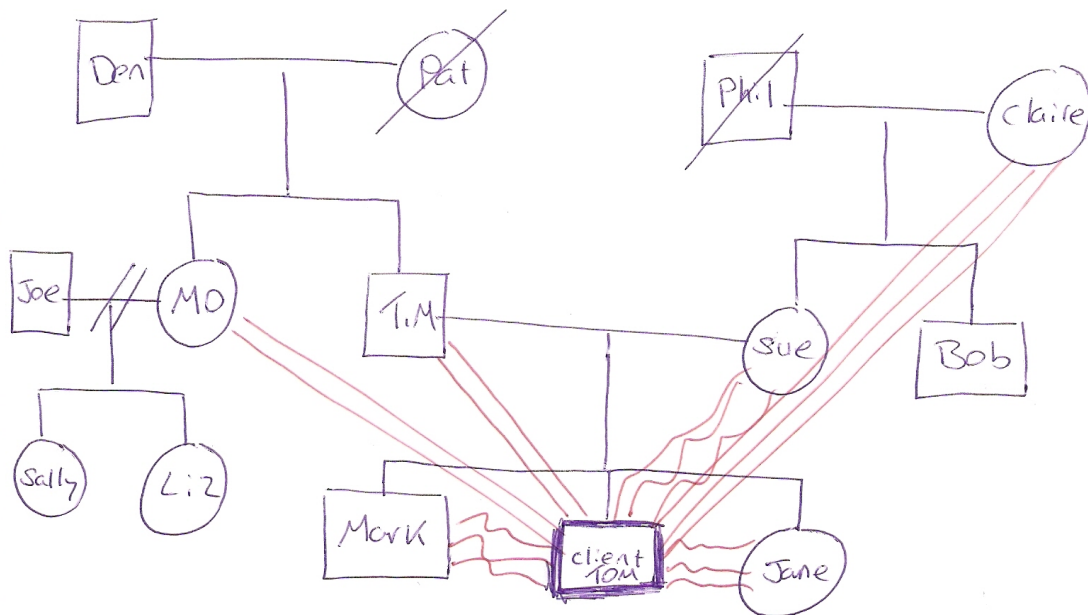
○ = Female

∅ = Has died

= Divorced

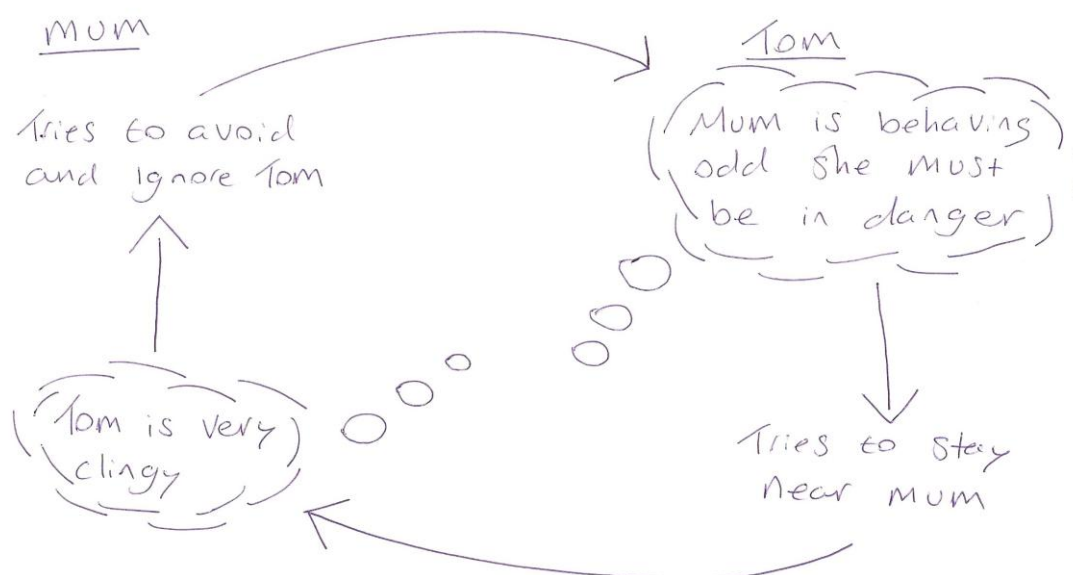
~ = conflictual relationship

— = strong relationship



* This genogram has been made up to provide an example.

An example of an interactional cycle



*The events in this interactional cycle have been made up to provide an example.