



SCHOOL OF PSYCHOLOGY  
DOCTORATE IN CLINICAL PSYCHOLOGY  
Major Research Project

**Exploring the process of family interventions in relation to attachment,  
attributions and the maintenance of difficulties. An IPA study**

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in Clinical Psychology

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**Declaration**

I certify that all materials in this dissertation which is not my own work has been identified and properly attributed, and that no material is included for which a degree has previously been conferred upon me.

Signed.....Date.....

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## **Part 1: Literature Review**

### **1. Introduction**

#### **Topic for research**

This review will discuss the literature surrounding the author's research, a study exploring the individual experience of Family Interventions (FI) that are associated with the way a person thinks about their attachment experiences, the attributions they make regarding a relative with psychosis and the way in which family patterns can contribute toward the maintenance of difficulties.

There is an established evidence base which recommends FI for psychosis. This has developed from robust findings that people who have experienced psychosis are more likely to relapse if they are living in a household where the response of a family member is rated as high Expressed Emotion (EE). Developments in this field have started to consider the role of attachment experiences and attribution styles in the development of high EE. However little is known about how exploring these concepts is experienced by the family and what the mechanisms of FI are that help to inform their thinking in these areas.

#### **Structure of review**

This review will provide a summary of the evidence base for FI. Thereafter, research exploring attachment and attributions in relation to EE and psychosis will be discussed and form the rationale for the current study.

## **1.1 Key terms**

### **Psychosis**

Psychosis is a medical term used to describe a state of mind in which a person experiences a distortion or loss of contact with reality. Psychosis is characterised by the presence of delusions, hallucinations and/or thought disorder (BPS, 2000). Psychosis is commonly associated with the controversial psychiatric diagnosis 'schizophrenia' and there is still argument surrounding the reliability and validity of this category (Bentall, 1990, 2003; Boyle 1990 in Carr and McNulty, 2006). As such, both terms tend to be used interchangeably in the literature. This review will refer to the term psychosis.

### **Expressed Emotion**

Lobban, Barrowclough and Jones (2005) describe Expressed Emotion (EE) as a measure of the emotional response of a relative towards a person with a diagnosed health problem. Brown, Monck, and Carstairs, (1962) discovered that the emotional response of a relative toward a person with psychosis was influential in their recovery. The response of a relative is rated as being "high EE" if they express hostility (reject the client), criticism (make negative comments about the behaviour of the client) or emotional over-involvement (EOI) (are over-intrusive and/or show an exaggerated emotional response) (Lobban, et al, 2005; Falloon, 1988).

## **Family interventions**

Systemic/Family therapy (FT) originated from influential movements in the 1950's which offered an alternative approach to pathology, viewing it as interpersonal as opposed to individual. The majority of present-day practice focuses on the central idea that no individual lives in isolation and when two or more people interact they are involved in the joint construction of actions and meanings (Dallos and Draper, 2008). Watzlawick, Weakland and Fisch (1967, 1974) coined the term 'circularities' when describing how one person's actions will influence another and subsequently how each person's behaviour is maintained by the actions of the other. The clinical implication of this is that a circular perspective enables people to see each other in a non-blaming way. All parties are caught up in patterns of interaction (circular causality) rather than one person being the cause of another's difficulties (linear causality).

Over the years, family based approaches to psychosis have moved away from traditional methods, which seemingly blamed families (Goldenberg and Goldenberg, 2000). Two main schools of thought evolved: FT and Family Management (FM). Each focused on different aspects of research into the family characteristics related to relapse (Burbach, 1996). Whilst approaches developed independently of each other, a shared common ground is evident today in comparison studies which have yielded minimal differences in outcome (Burbach, 1996; Stratton, 2005).

NICE (2010) use FI as a generic term to describe a family based therapeutic approach which draws from behavioural, cognitive and systemic

perspectives. Carr (2000) suggested two core elements typify the approach: emphasis is placed on blame reduction; and the positive role which families can play in the recovery process. Although most approaches are based in either FT or FM traditions, there has been increasing interest in developing services which combine aspects of both. Burbach and Stanbridge (1998; 2006) developed an innovative 'Cognitive-Systemic' FI approach that integrates FT and FM, with a particular focus on the interactional nature of interpersonal processes that can maintain problems.

### **Attachment**

Bowlby (1973, 1980, 1982) defined attachment as a type of 'affectional' bond which forms as a result of a child's interactions with caregivers during infancy. Attachment behaviours are triggered by environmental threats, distress, or illness and are defined as any form of behaviour that results in the individual regaining contact with the attachment figure. Bowlby theorised that as a result of these interactions individuals develop working models about themselves which guide attention, interpretation, and predictions about interpersonal relationships. Following observations of infants and their caregivers, Ainsworth, Blehar, Waters, and Wall (1978) proposed that responses made by infants could be related to different working models. They subsequently categorised three major styles of attachment: secure; insecure avoidant; or insecure ambivalent. Main and Solomon (1986) added a fourth dimension –insecure disorganised attachment. Attachment relationships continue to be important throughout the life-cycle however, attachment theory recognises that working models can be revised according to significant

interpersonal experiences (Crowell and Treboux, 1995). Therefore, two major paradigms are proposed in the adult attachment research –attachment anxiety and attachment avoidance (Brannan, Clark and Shaver, 1998).

### **Attributions**

When faced with significant events in life, most people are inclined to try and make sense of what has happened and why such events have occurred. Heider (1985) developed these concepts into an Attribution theory. Weiner (1985) developed this theory to consider the role of attributions on emotions and behaviour. Fosterling (1988) suggested that people use causal attributions to understand, control and master their environment. Causal attributions indicate the beliefs people hold about why a problem has occurred and provide a basis for evaluating options, interpreting reactions, and making inferences about one another's behaviour (Worthington and Atkinson, 1996; Beck, 2000). Attributions tend to be categorised as: stable/unstable; global/specific; internal/ external; personal/ universal; and controllable/uncontrollable (Stratton, 2005).

## 2. Review of the literature

Table 1. Review of data sources

<b>A systematic review of the literature was conducted:</b>			
Database	Time span	No. of results found	
<b>The ISI Web of knowledge</b>	All years		
Family interventions* Psychosis*		230	
Expressed emotion* Psychosis		29	
Attachment* Expressed emotion* Psychosis		8	
Attributions* Expressed emotion* Psychosis		16	
<b>PsychInfo</b>	All years		
Family interventions* Psychosis*	1992 – 2011	48	
Expressed emotion* Psychosis	1993- 2010	13	
Attachment* Expressed emotion* Psychosis	2000-2000	1	
Attributions* Expressed emotion* Psychosis	1968-2012	1100	
<b>Cochrane Library</b>	<b>Cochrane review</b>	<b>Other reviews</b>	<b>Trials</b>
Family interventions* Psychosis*	2	1	15
Family therapy* Schizophrenia*	6	9	187
<b>Inclusion/exclusion criteria:</b>			
Papers retained were considered as being relevant to the research questions on the basis of their titles and abstracts e.g. studies exploring adult attachment styles and psychosis/attribution styles and psychosis and their implications for clinical practice, particularly Family Interventions. Studies that were published in a language other than English, and which were not published in a peer-reviewed publication (e.g. conference abstracts, book chapters, dissertations) were excluded from the review.			

### 2.1 Evidence base for family interventions

There is a vast evidence base supporting the use of FT for a wide range of diagnostic conditions in both adults and children (Asen, 2002, and Carr, 2000). Early reviews by Hazelrigg, Cooper and Short (1987) and

Shadish, Montgomery, Wilson et al (1993) found positive effects for FT compared to alternative interventions. However, Stratton (2005) suggested relying on earlier studies was limited owing to changes in the field over the years and the more rigorous approach now taken to meta-analysis. Furthermore, different approaches in FT are often grouped together posing potential difficulty in conducting thorough evaluations. Therefore recent reviews have focused on the evidence for specific conditions. In the psychosis literature, High EE within the family has become a robust and well-validated predictor of poor outcome for individuals with psychosis (Bebbington and Kuipers, 1994; Butzlaff and Hooley, 1998 in Grice, Kuipers, Bebbington et al, 2009) therefore paving the way for evidence-based FI.

As such FI are now an integral component in the treatment of psychosis (NICE, 2010). A review by Carr (2000) identified that a combination of psycho-educational FI and routine anti psychotic medication reduced relapse rates in families where the response of a relative was categorized as high EE. FI have also been shown to reduce the length of hospital stays and reduce carer burden (Cuijpers, 1999).

A recent Cochrane review (Pharoah, Mari, Rathbone et al, 2010) offered substantial evidence from 43 randomised controlled trials (RCTs) conducted in Europe, Asia and North America that FI decreased the frequency of relapse compared with those in the standard care group, significantly reduced hospital admissions at the one-year-follow up, and improved the general social impairment and levels of EE within the family.

Despite the clinical significance of these findings, caution is paid to the small numbers used in some studies and the possibility of less positive findings which may be unpublished. In addition, some speculate that FI produce positive effects because they promote compliance with medication, which subsequently reduces relapse rates and hospital admissions (Hogarty, 1997 in Pharoah et al, 2010). Whilst the predictive validity of EE is strong (Barrowclough and Hooley, 2003), many aspects of EE and its mechanism in relapse remain poorly understood. Therefore, research continues to investigate what variables may be influential in its development and maintenance. Two recent trends have drawn from the explanations offered by attribution and attachment models.

## **2.2 Theoretical processes involved in EE: Attributions**

Greenley (1986) reanalysed Brown's original data and found that an expression of hostility/criticism/EOI made by relatives was likely to be modified depending on the way they viewed the illness. Those whose behaviours and/or comments were rated high EE were more likely to doubt if the person was genuinely ill, viewed their ill relatives as having control over their symptoms, and tended to blame them for their difficulties, expressing less warmth. Relatives who made fewer negative emotional responses toward the client tended to view the client as suffering from a legitimate illness therefore being more tolerant of disturbed behaviour (Vaughn and Leff, 1981; Brewin, MacCarthy, Duda et al, 1991). These ideas led Hooley (1985, 1987) to propose an attributional model of EE. He hypothesised that controllability attributions assign responsibility and blame to the client rather than the

situation or illness. McNab, Haslam and Burnett (2007) suggested this led to negative affective and behavioural responses such as anger, hostility and criticism in the relative.

In addition, research has found the way in which relatives and clients view each other also has implications for clinical outcome. If clients expected their relatives to see them negatively they were more likely to have a worse outcome (Scott, Fagin and Winter, 1993). In cases where relatives were viewed as affectionate and less controlling, the course of the illness was better (Warner and Atkinson, 1988). These findings imply that the views held of one another within a family could be influential in the maintenance of difficulties.

Barrowclough and Hooley (2003) provided a comprehensive review of 13 studies which examined the relationship between the attributions made by relatives and EE. All published investigations at the time of the review confirmed Hooley's (1985, 1987) attribution theory. This finding has been replicated cross-culturally (see Yang, Phillips, Licht et al, 2003 and Weisman, Lopez, Karno et al, 1993).

Recently, studies have found that reductions in hostility are associated with shifts toward more universal and uncontrollable attributions (Brewin, 1994); relatives who make comments rated as high EE hold a more negative view of psychosis in comparison to the client (Lobban et al, 2005); relatives who make fewer negative responses are more likely to make spontaneous

attributions about positive events (Grice et al, 2009); relatives may believe criticism is a helpful strategy in assisting the client to control their symptoms (McNab et al, 2007); and attributions made by a relative toward a client can also affect the relatives own well-being and impede the recovery of those they care for (Kuipers, Onwumere and Bebbington, 2010).

Most of the methodologies used in these studies used a quantitative approach. These commonly included rating scales where participants were provided with statements and asked to make ratings on causal attributions. Alternatively, attributional statements were extracted and rated from interview transcripts (such as the Camberwell Family Interview, Vaughn and Leff, 1976) using the Leeds Attributional Coding System. The latter is considered a more valid method as it allows the expression of beliefs to occur under more naturalistic conditions (Barrowclough and Hooley, 2003). However, the approach to assessing attributions is not without limitation; Wendal, Miklowitz, Richards et al (2000 in Barrowclough and Hooley, 2003) noted that associations in ratings made between EE and attributions could stem from using the same data source. In addition, assessment can only be made on the attributions presented at that time, therefore, findings cannot be considered wholly representative of the family members' causal belief structure. Further limitations include small sample sizes and the possibility of biased samples owing to the nature of voluntary participation from 'convenient' populations.

Adopting an attribution perspective provides helpful insight into our understanding of EE, consistently identifying links between high EE and

causal attributions. However, Barrowclough and Hooley (2003) stated that conclusions cannot be made about the direction of effect. Whilst some attribution models assume that attributions lead to emotions and subsequent behaviours, it could be argued that the way a person feels may in fact influence their attributions. Nonetheless these studies have clinical implications for family based approaches. Helping families to explore beliefs and develop alternative causal explanations, identifying the interactions in which they occur and developing understanding about the way in which their attributions influence their behaviours, may serve to highlight how difficulties can be maintained. In doing so, unhelpful patterns of interaction could be modified, improving both the course of psychosis and carer wellbeing. Yet there is no research that explores how family members experience these aspects of interventions. Therefore, future research would benefit from adopting a qualitative approach to explore how FI help families to understand how attributions made could maintain difficulties.

### **2.3 Theoretical approaches involved in EE: Attachment**

There is limited research investigating the relevance of attachment theory to psychosis (Dozier, Stovall and Albus, 1999) which is surprising given the prevalence of interpersonal difficulties in this population (Penn, Mueser, Tarrrier et al, 2004; Berry, Barrowclough and Wearden, 2007). Existing research tends to draw from the adult attachment literature. Berry et al (2007) state 'a pre-requisite condition to establishing the relevance of attachment theory to the study of psychosis, is evidence of high levels of insecure attachment in individuals with the diagnosis' (pg. 462). Indeed Mickelson,

Kessler and Shaver (1997) and Dozier (1990) found high levels of insecure and avoidant attachment styles in psychosis samples. Individuals with an insecure attachment are typically characterised by a negative self-image, an overly demanding interpersonal style and a fear of rejection. Avoidant attachment is associated with a negative image of others, interpersonal hostility and social withdrawal (Mikulincer, Shaver and Pereg, 2003).

Research has considered a number of different ways in which attachment experiences might influence psychosis and recovery: MacBeth, Schwannauer and Gumley (2008) proposed that in the absence of a secure attachment, anxiety is heightened serving to increase the potential for paranoid ideation; Drayton, Birchwood and Trower (1998) found that a negative self-image meant that any additional threats to the self, such as a diagnosis of psychosis, were met with inadequate defences to cope; Parker, Fairley, Greenwood et al (1982) found that clients diagnosed with psychosis rated their parents as less caring and their fathers as over-protective; and Warner and Atkinson (1988) found that clients who viewed their parents negatively tended to experience more relapses if they had frequent contact with them.

These findings emphasise the influence of interpersonal relationships on the course of psychosis. It could also be argued that a client's view of their relationship with a relative would have implications in the way they interacted with one another. Indeed, working models of attachment are believed to influence individuals to behave in a way that elicits responses from others

consistent with his or her expectations (Pietromonaco and Feldman Barrett, 2000).

A recent review of the attachment literature by Berry et al (2007) found that the quality of current interpersonal relationships was associated with relapse, recovery and the maintenance of difficulties (Mallinckrodt, 2000; Garety, Kuipers, Fowler et al, 2001; Penn, Corrigan, Bentall et al, 1997 in Berry et al, 2007). They suggested that attachment theory provided a framework for understanding the interactional nature of attachment styles and EE, suggesting that a client's attachment style could elicit different attributions from their caregivers and therefore levels of EE. Barrowclough, Haddock, Lowens et al (2001) suggested that if a client's difficult interpersonal behaviour was understood in terms of attachment, others would be less likely to have critical or hostile attitudes, therefore make fewer negative appraisals.

Early attachment experiences have also been associated with later parenting (Paterson and Moran, 1988; Diamond and Doane, 1994) therefore suggesting that some aspects of EE may be associated with a relative's own childhood experiences (Paley, Shapiro and Worrall-Davies, 2000). This would imply that insecure attachments to parents are influential in the development of critical or over-involved parenting styles with one's own children. Therefore, maladaptive attachment styles and subsequent EE responses could be passed down through family generations.

This concept is similar to Byng-Hall's (1985) theory of family scripts. He suggested that sequences of interactions become embedded in an individual's knowledge of how to function in given situations. Scripts have their origins in each family member's history and become shaped and blended throughout generations. This idea locates models of attachment at the heart of family processes. Therefore, given the interface between both the client and parent's attachment experiences and subsequent attributions, Diamond and Doane (1994) suggested that EE was a means by which attachment patterns become apparent within a family. Indeed, Vetere and Dallos (2008) suggested that attachment styles influence communication patterns: an insecure attachment means feelings and needs become distorted as they cannot be expressed openly. Berry et al (2007) concluded that attachment theory helped to explain the development and maintenance of interpersonal difficulties in psychosis and also offered a framework for understanding the development of different attribution styles and subsequent EE responses.

Therefore FI could be influential in exploring these interpersonal interactions and developing understanding about how current patterns of relating might serve to maintain difficulties. Byng-Hall (1995) also suggested that therapy could offer a temporary secure base from which families could explore problematic interactions, and ways of improving interpersonal relations.

It is necessary to note that studies investigating attachment styles in samples with psychosis have focussed on measuring individuals' expectations

about general rather than specific relationships. Furthermore, methodologies in this area have also tended to use a quantitative, questionnaire-based approach. Berry et al (2007) bring to light the many methodological limitations in this area, including a critique surrounding the Adult Attachment Interview (AAI) in people who are currently or have previously experienced psychosis. Some studies were limited by unrepresentative samples, limiting the generalisability of findings. Furthermore, there is no research which looks at how family members experience approaches in FI which explore patterns of attachment. Therefore, it would be helpful to explore qualitatively how family members' are helped to think about their experiences of being parented, their current interpersonal relationships and how this may inform their thinking about the way they make sense of difficulties and their subsequent interactions with one another.

### **Methodologies available to the research topic**

Most of the research described adopted a quantitative approach and has been influential in developing an evidence base which suggests that attribution and attachment styles are influential in EE. However, there is no qualitative research exploring how family members experience the way these concepts are incorporated in to FI. In particular, talking about their attachment experiences, the attributions made and how they are helped to develop their understanding of the interactional nature in which difficulties can be maintained.

Byrne and Morrison (2010) used Grounded Theory (GT) to explore communication and interpersonal relationships in young people at risk of psychosis. They concluded that difficulties with interpersonal relationships contributed to difficulties in communicating. GT involves the progressive identification and integration of categories to generate new theories that are 'grounded' in the participant's perspective. However, it does not specifically examine discourse therefore; this approach could potentially lose the meaning of individual experience in its attempt to produce an overarching theory.

Budd and Hughes (1997) used semi structured interviews with family members to explore what they had found helpful about FI. This study used a coding approach to analyse transcript data. Categories identified included improvements in communication and an increased understanding and tolerance of behaviour. This could suggest FI are influential in developing understanding in relatives, therefore influencing attributions and EE. However, the rigorous approach taken to coding this data implies a descriptive representation and the richness of participants' individual experiences' were lost.

Stanbridge, Burbach, Lucas et al (2003) explored family satisfaction of FI services. A thematic analysis identified families' thought the sessions had helped them develop new perspectives and deal more effectively with problems and relative's symptoms. However, what aspects had enabled these alternative styles of thinking were unclear owing to the process of identifying and grouping common themes.

Newman, Reibstein and Burbach (2011) used focus groups to explore how clinicians working in a FI service discussed causality with families. They found that the stress-vulnerability model, Genogram, interactional cycles and formulation were used to construct a shared understanding of causality. This study provides insight into the tools that are helpful in facilitating conversations about causality. However, this study only provided the views of the clinicians and focus groups have been criticised as being limited in their potential for understanding individual thoughts, feelings and experiences.

Pitt, Kilbride, Nothard et al (2007) used Interpretive Phenomenological Analysis (IPA) in their study which looked at recovery from psychosis. They identified that rebuilding the self and having hope for the future was important in recovery. Using IPA enabled a detailed exploration of what recovery meant and how it was experienced by each individual service user.

Another recent study by Allen, Burbach and Reibstien (2012) used IPA to explore individual's experience of FI and the way they contributed to recovery. They found that the family sessions provided the setting for the development of new points of view and enabled change in patterns of relating. This study confirms that FI can be influential in facilitating change in these areas. The methodological approach used also allowed for an emphasis on individual lived experience. A limitation of these findings was that only individuals who had experienced psychosis were interviewed.

The present study is interested in exploring the individual experiences of family members who have received a FI. A thematic analysis was excluded as it did not allow for the deeper level of interpretation consistent with IPA. Grounded Theory (GT) is often considered the main alternative to IPA and overlap between the approaches is acknowledged, in particular, both take an inductivist approach to enquiry allowing findings to be discussed in light of existing psychological theories (Brocki and Wearden, 2007). However, Smith, Flowers and Larkin (2009) state that GT is likely to 'push toward a more conceptual explanatory level' (pg. 202) and individual accounts are used to illustrate theoretical claims. By contrast, IPA is focused on a detailed and nuanced analysis of particular phenomena and seeks to understand personal experiences rather than social processes (Smith et al 2009; Willig, 2001). Given the aim of the current study to capture and explore the meaning individuals give to their experience of FI, particularly the way they make sense of their attachment experiences and attributions made, IPA is considered the most suitable methodology.

### **Closing summary**

The literature presented here highlights the evidence base for FI in psychosis and reports developments in the field of EE. Quantitative research suggests that attachment experiences are influential in forming attributions and makes links between attribution styles and high EE presentations. These findings point toward clinical implications for FI, suggesting their role in helping family members to make sense of their relationship experiences and develop understanding about the way beliefs are formed and manifest

themselves in behaviours. Qualitative research has tended to focus on more general aspects of FI and has demonstrated that family members value FI in helping them to develop alternative perspectives, improve communication, and patterns of relating. However, there is no published research which brings each of these concepts together and explores how interventions may influence families thinking about their own attachment experiences, attribution styles and how they are helped to develop their understanding of the interactional nature in which problems can be maintained. Therefore, this study aims to explore these phenomena from the lived experience of family members who have received a FI.

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## **Part 2: Major Research Project**

### **Abstract**

Family Interventions (FI) are recommended in the treatment of psychosis. This is based on the robust finding that a high rating of Expressed Emotion (EE) is predictive of poor outcome. Research has looked to attachment and attribution theories to further develop our understanding of EE.

This study sought to understand how the experience of FI helped family members to develop their thinking about their attachment experiences and the appraisals made about a relative, and how these discussions helped to inform their understanding about the interactional way in which difficulties could be maintained.

Six master themes were identified: 'the significance of the therapeutic relationship', 'understanding relationships with significant others', 'developing a sense of agency', 'making sense of psychosis/difficulties', 'exploring and understanding unhelpful patterns of interaction in the family', and the 'mechanisms of therapy that were helpful'.

The FI was experienced as helpful in bringing about changes in the way family members construed each other and psychosis. This influenced patterns of relating which allowed for an emotional climate within the family that promoted a sense of agency and was experienced as healing.

## **Introduction**

There is an established evidence base recommending FI for the treatment of psychosis (Pharoah, Mari, Rathbone, and Wong, 2010; NICE, 2010; Stratton, 2005; Carr, 2000). This has developed from robust findings that people who have experienced psychosis are more likely to relapse if they are living in a household where the response of a family member is rated as critical, hostile or emotionally over-involved (EOI); -or high EE (Brown, Monck, and Carstairs, 1962; Vaughn and Leff, 1976). Given that EE is a predictor of poor outcome in psychosis (Bebbington and Kuipers, 1994; Butzlaff and Hooley, 1998) research has continued to investigate what variables may be influential in its development and maintenance.

Hooley (1985, 1987) proposed an attributional model of EE and hypothesised that controllability attributions (regarding psychosis symptoms) assigned responsibility and blame to the person rather than to the situation or illness. A literature review by Barrowclough and Hooley (2003) found that where the behaviour of relatives was rated high EE, the attributions made were consistently different to those rated as low EE. More recent studies have found that in high EE presentations, relatives often hold a more negative view of the illness than the client (Lobban, Barrowclough and Jones, 2005); that criticism may be considered a helpful strategy in assisting their relative to control their symptoms (McNab, Haslam, and Burnett, 2007; Greenley, 1986); and fewer spontaneous attributions are made about positive events compared to low EE presentations (Grice, Kuipers, Bebbington et al, 2009).

Research also highlights the influence of family members' construal of each other, and their relative's situation, on levels of distress and EE (Scazufca and Kuipers, 1996; Cuipers, 1999; Kuipers, Onwumere, and Bebbington, 2010; Warner and Atkinson, 1988; Scott, Fagin and Winter, 1993). In particular, EOI has been linked with feelings of loss, self blame and guilt about being responsible for a person's illness (Patterson, Birchwood and Cochrane, 2000; Watson, Garety, Weinman et al, 2006).

Therefore, exploring attribution styles is indicated in FI. Indeed, qualitative studies have reported that the process of therapy helped to develop new perspectives in both carers and clients (Stanbridge, Burbach, Lucas, and Carter, 2003; Allen, Burbach and Reibstein, 2012; Dilks, Tasker and Wren, 2010), improved communication (Budd and Hughes, 1997), and that a shift in attributions reduced hostility in family members (Brewin, 1994). Newman, Burbach and Reibstein (2011) identified a number of therapeutic tools that clinicians found helpful when discussing causality with families.

Another recent development in the EE arena has been considering the role of adult attachment styles. Research suggests that disrupted social bonds and difficulties in forming meaningful relationships are hallmarks of people with psychosis. Indeed, high levels of insecure and avoidant attachment styles are typically found in this population (Penn, Mueser, Tarrier, et al, 2004; Berry, Barrowclough and Wearden, 2007; Mickelson, Kessler, and Shaver, 1997;

Dozier, 1990). A literature review by Berry et al (2007) identified the interactional nature of EE, suggesting that a client's attachment style could provoke a high EE response from a relative. This is consistent with the idea that working models of attachment influence individuals to behave in a way that elicits responses from others that are consistent with their expectations (Pietromonaco and Feldman Barrett, 2000).

Research also indicates that a relative's own childhood experiences could be influential in subsequent negative affective interactions with their offspring (Diamond and Doane, 1994; Paley, Shapiro and Worrall-Davies, 2000; Berry et al, 2007). This would imply that maladaptive attachment styles and subsequent EE responses could be passed down through family generations, a concept similar to Byng-Hall's (1985) theory of family scripts. Vetere and Dallos (2008) suggest that attachment styles influence communication patterns, pointing toward a different way in which patterns of relating contribute towards EE.

These findings suggest that the exploration of interpersonal interactions is a significant mechanism within FI. Both attribution models of EE and the emerging research into attachment and EE point to the importance of interpersonal construal when working with families; that is, the way family members see each other is crucial in the way they relate to one another and what explanations are given about psychosis. This is supported by the suggestion that attachment theory may help to explain the development and

maintenance of attribution styles, interpersonal difficulties and subsequent EE responses in psychosis (Berry et al, 2007).

Byrne and Morrison (2010) found that difficulties in interpersonal relationships led to problems communicating with others, whilst Allen et al (2012) found that FI enabled changes in patterns of relating between family members. Byng-Hall (1995) suggested that therapy was a safe-base from which to explore difficulties, and Dilks, Tasker, and Wren (2008) identified the role of therapy in linking the client's social and internal world.

Despite the growing evidence base indicating the influence of attachment and attribution styles in EE there is no published research which brings together these concepts and explores the mechanisms of FI which help to facilitate the development of family members' thinking in these areas. Therefore, this research aimed to explore how family members experienced FI and how FI might help them to think about (I) their experience of attachment and how this might influence their relationship with a relative with psychosis, (II) how they make sense of the symptoms and behaviours of psychosis and the attributions made about one another, and (III) how these processes might serve to maintain difficulties.

## **Methodology**

### **Design**

Ten individuals who had attended an integrative FI participated in one-to-one interviews. Interviews were analysed using Interpretive Phenomenological Analysis (IPA). IPA is considered a process of discovery (Willig, 2001) and was considered the most suitable methodology for this study as it allowed a detailed and in-depth exploration of personal experience. This study sought to investigate how family members made sense of what happened during the FI and the meaning they gave to those experiences and these are considered fundamental aspects of IPA (Smith, Flowers and Larkin, 2009). Furthermore, IPA has become an increasingly recognised technique in attempting to understand the experience of both individuals with psychosis and experiences of systemic therapy (Allen et al, 2012; Pitt, Kilbride, Nothard et al, 2007; Newton, Larkin, Melhuish and Wykes, 2007; Lloyd and Dallos, 2008).

### **Measures**

A semi-structured interview was developed to gain an in-depth account of the individuals' experience of FI. Three areas of questioning were covered: family relationships, past and present; the explanations given for the symptoms and behaviours of psychosis; and interactional patterns which contributed toward the maintenance of difficulties<sup>1</sup>.

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<sup>1</sup> See appendix 5 for the interview schedule

<sup>2</sup> See appendix 7 for information on the FI service.

## Participants

Participants were recruited from an integrative FI service (Burbach and Stanbridge, 1998, 2006) from the South of England <sup>2</sup>. All participants were British Caucasian and ages ranged from 20-65 years old. Table 1 provides further participant information.

**Table 1: Participant information**

Family	Participant	Relationship to client	No. family sessions
1	John	Father	18
	Angela	Mother	18
	Reece	Client	18
	Mary	Sibling	6
2	Susan	Mother	15
	Richard	Father	15
3	Brian	Father	10
	Anna	Mother	10
4	Debbie	Mother	96
5	Andrew	Husband/Client	26
*Names have been changed to ensure anonymity			

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<sup>1</sup> See appendix 5 for the interview schedule

<sup>2</sup> See appendix 7 for information on the FI service.

## Procedure

Ethical approval was granted by NHS National Research Ethics Committee, Taunton and Somerset Research and Development Consortium and the University of Exeter<sup>3</sup>.

## Qualitative analysis

IPA was used to analyse the interview transcripts, following the structure suggested by Smith et al, (2009) detailed in the table below.

**Table 2: Analysis procedure**

Step 1	Reading and re-reading the transcripts
Step 2	Initial noting
Step 3	Developing emergent themes
Step 4	Searching for connections across emergent themes
Step 5	Moving to the next case
Step 6	Looking for patterns across cases

The individual transcripts were read and re-read several times in order to familiarise the researcher with the participant's account. During this process initial notes were kept relating to anything in the text that seemed significant. Following this, the transcripts were examined again and conceptual themes were created which seemed to capture the essence of the participant's account. These emergent themes were listed and connecting themes identified. Those which appeared related were clustered under appropriate super-ordinate headings. This process was repeated for each transcript. Lastly, patterns were looked for across cases and themes identified. Once the analysis was completed, a summary of the themes was sent to the

<sup>3</sup> See appendix 2 for ethical approval documents.

<sup>4</sup> See appendix 12 for a summary of participant feedback.

participants to gain their feedback on the emergent themes and to ensure they reflected a true account of the discussions held<sup>4</sup>.

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<sup>3</sup> See appendix 2 for ethical approval documents.

<sup>4</sup> See appendix 12 for a summary of participant feedback.

## Results

An in-depth analysis of the transcripts revealed six master themes.

Table 3 provides a breakdown of the themes.

**Table 3: Table of master themes**

<b>Master themes</b> (Developed from the research questions)	<b>Sub-themes</b> (Emerging from the process of interpretation)
<b>1.0 Significance of the therapeutic relationship</b>	<b>1.1</b> Bond with the therapist <b>1.2</b> Role of the therapist
<b>2.0 Understanding relationships with significant others</b>	<b>2.1</b> How I understand my experience of being a parent/partner/sibling/son/daughter <b>2.2</b> How I make sense of my own experiences of being parented <b>2.3</b> Developing a sense of family cohesion
<b>3.0 Making sense of psychosis/difficulties</b>	<b>3.1</b> Developing a shared understanding of psychosis
<b>4.0 Developing a sense of agency</b>	<b>4.1</b> Storying of experience
<b>5.0 Exploring and understanding unhelpful patterns of interaction in the family</b>	<b>5.1</b> Developing an understanding of the influence of behaviours on each other
<b>6.0 Mechanisms of therapy that were helpful</b>	

### **1.0 The significance of the therapeutic relationship**

The therapeutic relationship was an influential aspect of FI. Therapists were considered in a position of positive influence, enabled by the bond family members experienced with their therapist. This created a safe space where ideas regarding attachment, attributions, and the maintenance of difficulties could be explored.

Debbie described the value she placed on this relationship:

*“One in particular became almost a family friend (...) at one point he was the only person (...) that Marc trusted. He certainly helped me too (...) and he has been absolutely wonderful.”*

Angela emphasised how the relationship with individuals in the family helped to develop understanding of each other and new perspectives:

*“The way they treated us individually, although we were all in a group (...) they would explain say to my husband, actually Reece was doing that because of how their relationship was (...), not criticise in any way, but (...) if you think of it from Reece’s point of view...”*

### **1.1 Bond with the therapist**

The therapeutic relationship was often referred to as a friendship, implying the importance given to the connection made:

John: *“They became real friends...”*

Brian: *“He was ever such a nice guy and really relaxing. They were almost like talking to a qualified friend.”*

Reece: *“They were just very positive in a different way and they were very human, even though they were there as watching over, you almost felt like they did care but you could relate to them as people.....They were genuine but they knew their stuff as well...”*

The qualities illustrated enabled a reflective space in which honest conversations were held, allowing for the exploration of difficult experiences:

John: *"It was quite reflective. Yeah. And quite honest, candid, because they were honest brokers if you like."*

Mary felt that without the opportunity to have these difficult conversations, issues would have been left unsaid and continued to be *"carried in the house"*. Angela described how each member of the family was given time and space to talk about their own thoughts and feelings:

*"...there was an awful lot going round the room"*.

This allowed for the difficult emotions experienced by family members to be revealed and understood within a safe space and perhaps modelled a helpful way of relating.

## **1.2 Role of the therapist**

Therapists were viewed in a position of authority and someone from whom family members could seek guidance and validation. Furthermore, the therapeutic relationship provided containment and reassurance. These processes were seemingly enabled via the bond created between the family and therapist:

John *"...of course I felt that they understood the problems much better than we did and were able to explain what was going on..."*

Susan: *"We didn't know what to do (...) it was reassuring that what we had done in interventions was actually ok and the right thing to do and have somebody else say, yes that was a good thing to do"*

Susan said that the therapeutic relationship offered them support - *“something for us”*. Similarly, Richard said the relationship enabled them to *“share the problem”*, in essence, an opportunity to share the burden of caring and for their distress to be acknowledged and validated by *“someone outside the family”* (Susan):

Richard: *“I mean it was just nice to be able to have somebody to talk to at that particular crisis time. I mean it got us through (...) it certainly kept us going through having somebody independent but still a friendly face to see.”*

Indeed, Debbie said that had it not been for the sessions she too would have experienced mental health difficulties:

*“Particularly for me I would have been inside there alongside Marc if it hadn’t been for family support...”*

Therefore, it seemed a reason people valued the therapeutic relationship was because it allowed family members as well as clients’ to benefit from the sessions.

## **2.0 Understanding relationships with significant others**

The therapeutic relationship developed in FI created a forum in which each person could reflect upon and explore their own relationship experiences within the family. This was true of both current and past relationships:

Mary: *“It was more between my father and Reece and that was like the battle of the older stag and the younger stag...”*

John: *“It did make us look back at our own families in much more detail, more critically if you like, and realise that there might have been problems with siblings, you know, at the time that were just brushed aside, but we now appreciate much more what they may have gone through”*

It seemed FI enabled conversations about ways of relating to each other and the opportunity to reflect upon the influence of previous relationship experiences. This was significant in developing mutual understanding and insight into their difficulties, as highlighted by Reece: *“...the family really understood each other better from it”*. These areas are discussed further in the following emergent themes:

### **2.1 How I understand my experience of being a parent/partner/sibling/son/daughter**

Most spoke about the way exploring interpersonal relationships helped them to reflect upon their role within the family. This allowed each member of the family to share their views regarding their position within the family and to consider how this was experienced by others;

John: *“...to listen to how they perceived (...) they perceived us, you know, I assume they have a temper and all this sort of thing that I didn't recognise. It made me recognise quite a lot of personal traits which I might not of otherwise”*

Angela: *"I was able to say, just a little bit, how I had been and it also made my husband see how it had been for me which he could never comprehend what is wrong with me and actually had no time for me feeling the way I was..."*

Mary: *"It allowed us to talk about it in the unit and for Dad to talk about, you know, that isn't how it always feels it was just the way I approach things, and to break down some kind of assumptions..."*

This seemed to enable a greater understanding of each other, serving to develop empathy and helping to influence the appraisals made about each other.

Susan and Anna described the distress they experienced when caring for a relative with psychosis and how it was difficult to judge the 'right' amount of parenting:

*"At the time we didn't feel that we could do anything, go anywhere, you know, we couldn't have gone away for the weekend and just left him (...)you kind of want to lead your own life and you want them to lead their own lives, but you see you can't"*

*"Give a sum of my feelings or whatever feeling resentful or trapped (...) at different points of Sally being ill."*

*"...being told it is alright to feel how you are feeling, but you have got to stand back and respect and allow him to develop and grow"*

This would imply that FI helped parents to acknowledge and validate the dilemma between closeness and distance to their relative which was a experienced as significant part of the intervention.

## **2.2 How I make sense of my own experiences of being parented**

Family members also spoke about the way FI helped them to make sense of past relationship experiences which enabled them to begin to observe patterns in the way they managed difficulties:

John: *“Actually it has certainly made me understand a problem that one of my younger brothers had had, perhaps quite similar in fact to Reece”; “... it explains one or two things that again you just brushed aside”*

Angela, Susan and Richard described how they were helped to identify similarities between their own experiences of being parented and the way they parented:

*“I can remember I suppose about the age of 15 saying something to my mother and she obviously couldn’t handle it and she just turned her back on me. Now Reece claims that there was something he said to me (...) and he said you just turned your back on me”*

*“I have always tried to be a lot more laid back than my parents were.”*

*“...it was just my mother but she was always a very open sort of person, prepared to discuss whatever and listen and I suppose that is what I tried to do with Christopher...”*

It seemed exploring these patterns were influential in helping family members to identify family traits which allowed understanding to be developed about how their beliefs were formed and the way these influenced their behaviours and patterns of relating:

Susan: *“I think they would have been absolutely horrified and therefore I (...) was trying to not to be like one’s family, but you could see where my traits perhaps of being horrified by it all would come from.”*

Debbie: *“In my own family my dad was a Victorian (...) and work was a very, very strong ethic (...) so work in me was a very strong ethic as well and I found it quite difficult when he didn’t knuckle down...”*

### **2.3 Developing a sense of family cohesion**

Many spoke of how exploring their relationships with significant others over the course of the FI illuminated how the difficulties associated with psychosis had caused a rupture within the family. Debbie described *“a wedge”* that had been driven between her and her husband, and how their children *“hated Marc”*. Angela said that *“a bond had been broken”* between father and son and believed FI helped to *“build bridges”*, uniting the family again. Others also described a similar experience:

John: *“We are all going along together with it and we had a much better understanding. I think it is the understanding of the problems that help so much.”*

Reece: *“I mean sometimes the sessions might not end positively between the family and we learnt from that as well (...) but the family really understood each other better from it and we kind of grew together as a family and we understood each other more.”*

It appeared that FI increased family members understanding of psychosis and each other. This seemed significant in developing mutual empathy and restoring emotional connectedness between family members. This is considered in more detail in the next theme:

### **3.0 Making sense of psychosis/difficulties**

The FI was experienced as helpful in making sense of the symptoms and behaviours of psychosis and helping families to develop new explanations:

Angela: *"...sometimes you think oh, somebody is just being lazy and slothful."*

Debbie: *"Yeah I didn't really realise it was something to do with being a negative symptom at the beginning I just thought it was him being a pain!"*

The multiple perspectives offered by both family members and therapists' were described as an influential factor in developing new ways of thinking about difficulties and helping to *"shift the stubbornness"* (Angela):

Angela: *"And my daughter also came to a few of them (...) she also gave another side as a sister (...) and I was sort of thinking oh my gosh that is another dimension, I hadn't thought of that to do with his illness".*

Richard: *"I think we just realised there are different ways to, probably common sense really, but different ways to approach the situation and to present with the alternatives"*

Letter: *“Until Family Therapy, Marc’s siblings did not appreciate the problems which he had...although we as parents had told them I do not think it registered at all”.*

This would suggest that in helping families to make sense of difficulties; FI was influential in changing the attributions held about relative’s symptoms. This process of change was enabled by the development of a shared understanding and exploring the role of diagnosis:

### **3.1 Developing a shared understanding of psychosis**

In discussing difficulties as a family, each member was able to offer their own view and together with the support of the therapists, develop a shared understanding of psychosis:

John: *“Each of us would have come in originally with totally different perceptions of what the issues were and how we reacted to them in the past and we found that by sharing those experiences we realised we had differences and (...) we had a much better common understanding at the end of it.”*

Developing a shared understanding helped to normalise difficulties and to separate ‘illness’ related from ‘normal’ behaviour:

John: *“I think that we were not the first people to be going through this experience. That is was quite normal in fact in this abnormality and the experience of the support showed that everything that we thought was exceptional was not... normalised the whole thing...”*

Reece: *“I was trying to get them to understand was that it could be me behaving from the psychosis. It was never black and white, it could be the psychosis or could be normal for just me (...) and it got them to understand and look at things differently. Maybe a bit more outside the box and more open to it.”*

This appeared to increase empathy toward each other, therefore it could be assumed helped to improve relationships within the family.

### **3.3 Role of diagnosis**

The way psychosis was made sense of seemed to be influenced by the way family members interpreted diagnosis. Mary felt the diagnosis was damaging to her brother’s sense of self:

*“He was still battling with the terminology of what he had been diagnosed with...”; “... it becomes a solid matter and then that in itself can really cascade and feed into the (...) whole weightiness of the sensitivity...”.*

Angela was concerned about how others would react to her son and the negative connotations associated with psychosis:

*“You just have to say that word to anybody and they go ahhhh”*

In comparison, Debbie spoke of her relief when her son was given a diagnosis, allowing her to research it and help others in the family to understand his symptoms:

*“Well, to me it was so wonderful that they actually said the word, it was something that we suspected for ages and then we could do our research on that, understanding where he came from.”*

Susan also described diagnosis as helpful. Knowing that her son’s difficulties stemmed from a *“chemical imbalance”* seemed to provide clarity on his difficulties, and hope for its management:

*“Then when he has become well by proper drug treatment...”*

The way family members made sense of difficulties and diagnosis varied; some found diagnosis helpful whilst others experienced it as damaging to a sense of self. Indeed it seemed the way diagnosis/difficulties were viewed was influential in the development of agency. This is explored in the next theme:

#### **4.0 Developing a sense of agency**

This theme describes the way FI seemed helpful in exploring how interpersonal relationships and appraisals made influenced the client’s sense of agency. Mary described the way her mother would *“do everything”* for her brother which she felt prevented him from developing autonomy:

*“...I used to get quite angry (...) that he was being protected in that way because it was almost not allowing him to open up into his adulthood”*

Mary also observed the difficulties her mother faced in *“severing the umbilical cord”* to her brother, and how over the course of the FI he was

*“...able to step into his power in the family.”* Indeed Angela spoke about the way FI supported her in changing her position from seeing her son in a ‘sick role’ to encouraging his recovery:

*“...when somebody is so ill with mental health, they cannot cope for themselves (...) I had to learn that I had to stand back and give him space (...) being told it is alright to feel how you are feeling, but you have got to stand back and respect and allow him to develop and grow...”*

Similarly Reece found FI helped his parents to notice his recovery: *“...a lot of the sessions were focused on the change within myself and how that affected me with the family”*. This seemed to help him separate his selfhood from psychosis. Richard, Anna and Brian also described how FI helped them to recognise progress, acknowledge the development of agency in their relative and provide hope for the future:

*“They could see the progress he was making whereas we couldn’t...”*

*“I mean she herself is sort of learning to kind of see and know what the triggers are and to access support when she needs it...”*

*“So, she has obviously taken great strides and made great progress...”*

#### **4.1 Storying of experience**

The opportunity provided in FI for family members to tell their own story seemed an influential factor in developing this sense of agency and was described by Angela as *“healing”*. Angela, John and Anna found describing

their narratives enabled them to reflect upon and take ownership of their own difficulties:

*“It was through all the talking etc that I began to think, gosh this is healing me as well”*

*“...I regret that I hadn’t been supportive enough to Angela...”*

*“...when Sally started getting better actually, I was depressed...”*

Story telling allowed families to become more aware of each other’s lives and belief systems, and the way these influenced ways of coping and family functioning:

John: *“...again you just brushed aside (mental health difficulties) and I think what came out of it from my point of view is how I had the distraction and release all the time at work (...) As long as they are all sitting round the table eating everything was okay...”*

Mary: *“... in the family there is so much going on so many stories so many different perceptions you may not be aware of at all. As soon as that is brought into the room and unveiled then so many sort of pennies drop for people.”*

This process of hearing and telling each others’ stories allowed identities to be re-constructed and further contributed to a sense of agency. Debbie spoke of her need to grieve for the son she had lost whilst also discovering the new person he had become:

*“...it’s quite a bereavement process (...) but it’s more about discovery of the person and seeing all the great assets that that person brings rather than ever thinking he is going to go back...”*

Whilst Mary described how FI helped her brother to externalise his illness, enabling him to take ownership of his recovery:

*“...the healing process of separating himself from the title and name of it to seeing himself as a whole being”.*

Lastly it seemed FI encouraged acceptance and helped relatives to develop realistic expectations regarding recovery. This appeared to enable them to encourage a sense of agency in the client:

Brian: *“OK let’s accept that she is anxious, how do we cope with that and how does Sally cope with that”*

Richard: *“I think we came to realise that it was going to be a slow process that he perhaps might never return to quite the sort of level of normality before all this blew up. I think it gave us the feeling that we could deal with him and help encourage him to move on as best he could...”*

## **5.0 Exploring and understanding unhelpful patterns of interaction in the family**

Family members described the way FI helped them to explore unhelpful patterns of interaction within the family and recognise how these interactional processes could serve to maintain difficulties:

Anna: *“I think the most valuable thing that I have learnt is really that every relationship that you have is completely interactive and so however one person behaves is partly dependent on the how the other person is behaving...”*

Reece and Angela illustrated how exploring family patterns allowed them to become aware of the unhelpful cycle in which they had become stuck:

*“Back then my mother would say I wish you would get up earlier, this and that, and really nagging me (...) and I would really get annoyed (...), it was silly things like that from mother to son (...) and it was good to get that out and a release to talk about that it was frustrating at times.”*

*“One of the things with myself is my son was wanting me to back off, but I was concerned that he was taking his medication etc, things like that, because when people are so ill they do not keep, they are not well enough to think, have I taken my medication today?...”*

Holding these conversations seemed to help family members reflect upon what factors might be influencing their behaviours. Both Angela (above) and Mary described how this process made them aware that their attempts to help their relative often contributed to the maintenance of these unhelpful patterns of interaction:

*“...I thought you know I am just really helpful because I was helping him through this journey and suggesting very helpful things but then actually realising my role oh well it's not so helpful to sometimes be really bossy and now to allow him to find his way.”*

## **5.1 Developing an understanding of the influence of behaviours on each other**

Indeed it seemed unpicking interactions in this way was fundamental in developing insight into why a person might respond in the way they had, developing empathy and acknowledging the way that difficulties could escalate and serve as a perpetuating factor:

Brian: *“The way we react to her also has an effect on her and can either help or make worse what she is feeling or how she is feeling”.*

Susan and Brian described how noticing these unhelpful patterns of behaviour opened up the possibility for change:

*“...you feel yourself slipping into the same pattern of almost sort of saying ‘oh Christopher, you shouldn’t do this or shouldn’t do that’ you know...It helps you reflect on actually, well maybe we should just stand back”.*

*“Sally is extremely dependent on Anna’s approval (...) and a lot of the time she will phone up and say (...) is mummy mad at me (...) and Anna also gets quite upset if Sally is in danger or is unhappy... So, we did discuss (...) Anna’s reaction to Sally phoning (...) and Anna’s reaction to that feeding back into Sally’s anxiety, and (...) how Anna should react or could react differently to try and stop that circle.”*

Furthermore, Mary identified how the views of each other held by family members could also interact in an unhelpful way, and how noticing these patterns bought about change: *“...seeing our dynamics with him and changing our dynamics with him and him changing his dynamics with us to*

*respect us as well not seeing us as in a certain way for us not to see him in a certain way just changing and opening our perspective of the thing.”*

Therefore, identifying unhelpful patterns and exploring the nature of those interactions, in particular, the appraisals made of each other and/or an attempt to help, appeared a significant part of FI in making changes in patterns of relating.

### **6.0 Mechanisms of therapy that were helpful**

It seemed that each of the themes described previously were made possible by a number of therapeutic mechanisms. Families spoke about a number of tools they found helpful which included: psychoeducation; -*“I now understand that schizophrenia is brought on by stress...”* (Debbie), genograms; -*“I can remember doing a genogram which I suppose was a bit of a bonding experience and knowing if there was anything in the background”* (Debbie), improving communication; -*“... the contracts and the communication were the main things...”* (Debbie), and learning about the course of psychosis; -*“You know it is teaching people about the time scale...”* (Angela).

It could be surmised that each of these mechanisms had significant influence in facilitating conversations about attachment experiences, attributions, and how an interaction of these processes might influence behaviours and contribute to the maintenance of difficulties.

## **Discussion**

### **Summary**

This study showed that FI helped to increase family members' understanding of their relationships with one another, helped to develop a shared explanation of psychosis, and how these elements influenced their interpersonal interactions. These processes were influential in developing the client and relative's sense of agency. These themes were made possible by a number of mechanisms of therapy, in particular, the therapeutic relationship.

### **Relating findings to the current literature**

The way in which family members spoke about their relationships with each other and reflected upon their relationships with their own parents and siblings pointed toward how FI had tentatively explored attachment experiences. In developing greater understanding of their relationships with significant others, insight was gained into what influenced their beliefs and coping styles, and the way this persuaded their thinking and behaviour toward others, particularly a relative with psychosis. These findings echo Byng-Hall's (1985) concept of family scripts where sequences of interaction are blended and shaped throughout generations providing a template of how to function in a given situation.

Penn et al (2004) suggested that psychosis was often associated with disrupted meaningful relationships. In this study family members spoke about relationships which had become segmented and how FI were helpful in

developing a sense of family cohesion. Parents often reported feeling 'horrified' and 'frustrated' by their relative's symptoms and the process of exploring significant relationships helped them to make links between these reactions and their own childhood experiences. These findings offer support to the literature which suggests that early attachment experiences are influential in later parenting and EE, as displayed in the negative affective responses identified by these families (Diamond and Doane, 1994; Paley et al, 2000).

Research in the EE and attribution arena has tended to focus on relatives who are rated as making hostile or critical comments toward their relative. However, the current study found EOI was a more pertinent factor. Family members frequently spoke about their need to 'take over' and do things for their relative. It is suggested that criticism and EOI are coping strategies motivated by relatives' perception of loss and changes in attachment relationships following the onset of psychosis. These strategies are often desperate attempts by distressed parents to control their relative's symptoms, which they consider helpful (Patterson et al, 2000; McNab et al, 2006). These suggestions underpin findings from the current study where relatives' well-intentioned attempts to help became problematic, serving to maintain difficulties. Family members valued the FI helping them to recognise these patterns and 'stand back'. In developing understanding about the way in which previous relationship experiences could elicit unhelpful interactional processes in current relationships, this research supports the conjecture that

attachment styles provide a framework in which to understand the influence of interpersonal experiences on the development of EE and subsequent attributions made (Berry et al, 2007).

The theme, 'making sense of psychosis', highlighted the significance of family members' experience of talking about the development and maintenance of psychosis. A combination of providing information and offering alternative points of view enabled a shared understanding of the difficulties. Hooley's (1985;1987) attribution model of EE identified that where a relative's behaviours are considered undesirable and changeable they become likely targets for criticism. This theme highlights how developing a shared understanding of psychosis was a powerful mechanism in shifting attributions. We saw how relatives were helped to develop their thinking from internal and controllable attributions, such as attributing behaviour to laziness, to external attributions –the behaviour became a negative symptom of psychosis. These findings echo previous studies, in that negotiating shared understandings helps to develop new perspectives, making available new possibilities for thinking and acting in relation to areas of difficulty (Dilks et al, 2008 and 2010; Allen et al, 2012).

Dilks et al (2008) suggested that it is the client's interpretation of the difficulties that is important rather than the explanation per se, and this research develops this idea, highlighting the importance of the family's interpretation. This supports Stanbridge et al (2003) suggestion that family

members' construal of their situation was imperative in interactional processes. We can also relate these findings to research which suggested that relatives' appraisal of the client's situation are determinants of carer distress and EE responses (Kuipers, et al, 2010; Patterson et al, 2000; Watson et al, 2006; Scazufca and Kuipers, 1996). Greenley (1986) suggested that the more anxious and fearful the relative is about psychosis, the more likely they are to initiate unhelpful coping behaviours. Findings from this research indicated that relatives felt distressed and tended to be overly involved. Therefore, making sense of psychosis served to develop new ways of thinking about difficulties and subsequently each other. This alleviated distress, decreased unhelpful patterns of interaction and improved the emotional climate.

The process of understanding significant relationships and making sense of psychosis enabled families to explore and understand unhelpful patterns of interaction. This theme develops Barrowclough and Hooley's (2003) suggestion that FI are influential in exploring how relatives' beliefs regarding mental illness relate to the way in which they respond to aspects of a patient's behaviour. FI helped relatives to understand the way in which the attributions made toward a relative with psychosis and/or patterns of relating served to maintain difficulties.

Research also indicates that where relatives make different appraisals about psychosis compared to the patient this will cause difficulties in the

relationship (Lobban et al, 2005). These factors are evident in this theme. We saw the way a mother, believing that psychosis rendered her son incapable of caring for himself, became overly involved and controlling. The son reported feeling frustrated by his mother's actions and withdrew. His actions then inadvertently reinforced his mother's view, which served to perpetuate the cycle. However, by exploring this cycle, they were able to share the effect these behaviours had on each another, challenge their beliefs and identify the unhelpful patterns in which they had become stuck. This interactional process underpins the integrated FI approach developed in Somerset (Burbach and Stanbridge, 2006). Similarly, Newman et al (2011) identified that using interactional cycles helped to develop a shared understanding of the way psychosis could be maintained, which served to empower families to change patterns of interaction. Indeed, accounts from this study highlighted how families were helped to consider, develop and practice new ways of behaving, improving their relationship with each other and the emotional atmosphere.

It has been observed that family members acknowledged their tendency to become over-involved in their relative's care. It could be surmised that this was a significant factor in not only maintaining the symptoms of psychosis but also contributing to the erosion of the patient's sense of self. For some, this was also affected by receiving a diagnosis. Research has drawn attention to the possible negative impact on 'selfhood' of being given a diagnosis (Dilks et al, 2010). However, this study found that how diagnosis

was construed by family members was also influential in the effect it had on agency.

The theme, 'developing a sense of agency', captures the process in which the client developed their sense of self over the course of the sessions, the way the sessions helped relatives' to become aware of and take ownership for their own actions, and how relatives were helped to notice change in the client. These findings echo those of Dilks et al (2010; 2008) who found that clients were engaged in an ongoing process of 'negotiating selfhood'. Other people's appraisals and the way the therapist emphasised the client's qualities and abilities bolstered their sense of agency. These areas are built upon further in the current study by recognising that both the relative and client contribute to the development of a sense of agency during the exploration of current interpersonal relationships and construal. This underlines the reciprocal nature of developing the self. Allen et al (2012) suggested that developing a more robust sense of self was influential in recovery, making possible 'a new positioning in the world' (p10). These findings accentuate how developing a sense of agency within the context of FI enabled both the client and family members to negotiate a new positioning with each other, therefore creating a firm foundation from which to develop their position within the world and navigate their recovery journey. These findings locate the client and family members' experiences of FI within the attachment literature (Bowlby, 1982; Mikulincer et al, 2003; Berry et al, 2007).

A number of therapeutic mechanisms facilitated the processes described in previous themes; one deserving a theme in its own right was the 'significance of the therapeutic relationship'. Both Dilks et al (2008) and Allen et al (2012) made reference to therapy being a shared process between client and therapist, and the confiding context created by the therapist, which was experienced as fair and neutral. Stanbridge et al (2003) indicated the importance to family members of sharing the therapy experience. The findings from the current study enhance these ideas, pointing to the significant role of the therapist in providing guidance and reassurance.

Encapsulated within this theme is the bond that individuals described they felt with their therapists. Family members' experience of feeling understood and validated could infer a level of attunement between individual and therapist and suggest the therapist as a type of attachment figure. This concept is similar to Byng-Hall's (1995) description of therapy as a safe base from which to explore and experiment with change, facilitating exploration of both the internal and external world. Dallos and Vetere (2008) suggested that a secure therapeutic base emphasised the role of trust, soothing and calmness as a context for de-escalating unhelpful patterns of interaction. Dilks et al (2008) referred to this as 'building bridges between different perspectives and the new possibilities for thought, action or feeling allowed by them' (p224). Indeed, engaging the client, family and therapist in a relational process was experienced as influential in modelling helpful interactions and developing new perspectives.

A noteworthy component of this theme was the way family members experienced the therapeutic relationship as a valuable source of support which enabled them to process their own difficult emotional experiences associated with their caring role, thereby enhancing their own well-being. This highlights the multiple purpose of therapy, supporting both the client and family members. There is increasing research which acknowledges the role of carer burden on the relationship between the client and relative, adding to the attribution and mechanisms of EE literature (Kuipers et al, 2010). These findings further point toward the significance of FI in reducing carer distress by validating and normalising feelings, understanding relationships, making sense of psychosis and having a positive effect on family interactions.

Other mechanisms of therapy that were helpful included the presence of alternative points of view, introducing the concept of multiple perspectives, and developing understanding of each others perspective, a finding which resonates with Allen et al (2012). These were made possible by the integrated nature of the FI and the therapeutic tools available within the approach (Burbach and Stanbridge, 2006). The provision of support and advice for the family was also considerable. Allen et al (2012) found that clients were less likely to place salience on receiving practical advice, which was not supported by the present research. Instead, clients and family members often spoke about the value of seeking guidance from their therapists. Stanbridge et al (2003) also found that family members valued the practical advice given, particularly in relation to problem solving and communication strategies.

Lastly, Newman et al (2011) highlighted the tools that therapists found helpful when developing a shared understanding of psychosis with families. It is interesting to observe that family members in the current study made reference to the same tools as influential in helping them to make sense of psychosis and their interpersonal relationships and interactions. This could provide further evidence of the way in which therapists were able to become attuned with families.

### **Implications for practice**

The themes identified in this study point toward a number of implications for clinical practice. In developing insight into their relationship experiences, family members were able to consider how their beliefs were formed and how these beliefs may manifest in their appraisals of a situation and their behaviours toward their relative. By acknowledging these processes, changes in patterns of relating were made possible. Similarly, making sense of psychosis through the development of a shared understanding served to shift attributions regarding a relative's symptoms and raised hope for the future. In addition, understanding the influence of relationship experiences on the way they made sense of difficulties enabled them to identify and change unhelpful patterns of interaction. Each of these components served to decrease the distress of family members and levels of stress experienced by the client, developing an environment more conducive for the recovery of the client and improving carer wellbeing.

Furthermore, the therapeutic relationship was essential in providing a nurturing atmosphere in which therapeutic change could occur. The integrated FI approach provided therapists with the flexibility to draw from a plethora of therapeutic tools that served to meet the needs of families, enabling a collaborative approach.

### **Limitations of the study and directions for future research**

These findings are limited to those that received an integrative FI service in the South of England. In addition, the methodology used in this study limits the generalisability of the findings. No direct assessment was made of attachment or attribution styles therefore the conclusions drawn regarding these mechanisms are inferred from the individual accounts of lived experience. The nature of IPA allows for a rich understanding of how FI were experienced by family members allowing for tentative associations to be made to these theoretical approaches. Future research could incorporate measurements of attachment and attribution styles, collected at the start and end of therapy to make these links more robust and assess the change process. Further research with people receiving FI from other areas is also indicated which will allow a comparison of findings with others services.

This study identified the role of FI in providing a support service for family members. Supporting families is still limited in the broader mental health context with little acknowledgement of carers' services potential effect

on client and carer wellbeing. This study has contributed to this under developed field but further research is called for.

### **Conclusion**

Considering the dynamic nature of the way in which relational experiences interact with the formation of attributions has provided a helpful structure for understanding how difficulties may be maintained. Understanding the way in which families benefited from the exploration of prior relationships (attachment issues) and specific features of FI sessions provides clinicians with a framework to help develop carer wellbeing and promote clients' sense of agency and recovery.

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## Appendix 1: Journal of Family Therapy Author Guidelines

### Manuscript submission

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

Manuscripts should be submitted to the following website:

<http://mc.manuscriptcentral.com/jft>. Full submission instructions can be found on this website.

A cover letter should be submitted with your manuscript and must include a statement that the data have not been published, and is not under consideration for publication elsewhere. It will be presumed that all listed authors of a manuscript have agreed to the listing and have seen and approved the manuscript.

### Format for Manuscripts

1. Manuscripts should allow for 'blind/anonymised' refereeing and **must** not contain author names or any identifiable data.

2. Manuscripts **must** be typed in double spacing throughout, including quotation, notes and references in the following order:

- Title Page: to contain the title of the paper, word count, suggested running head (short title for your paper) and key words.

- Abstract: on a separate sheet, the title to be repeated followed by a summary of not more than 150 words. The suggested running head should also be present.

- Organisation of the text: see copy of Journal for the format currently in use.

- References (in text)

these should be indicated by the name and date e.g. 'Carr (2009)'. If more than two authors are listed, cite the reference as 'McHugh *et al.* (2010)'. Quotations should include page numbers. Web sites should also be cited in this way, with a full reference appearing in the References section (see below).

- Figures, tables, etc.: All figures and tables should be numbered with consecutive arabic numerals, have descriptive captions and be mentioned in the text. They should be kept separate from the text but an approximate position for them should be indicated. These will need to be uploaded separately. Please supply figures in the format in which they were created, if possible.

- References should be listed at the end of the paper in alphabetical order according to the first author and be complete in all details, again following the Journal's existing format.

*Articles:* Larner, G Intergrating Family Therapy in adolescent depression: an ethical stance. *Journal of Family Therapy*, 31: 213-232.

*Chapters:* Woodcock, J. (2009) Love and hate and the oedipal myth: the perfect bridge between the systemic and psychoanalytic. In Flaskas, C. And Pocock, D. (Eds) *Systems and psychoanalysis: contemporary integrations in family therapy*. London: Karnac. Pp 129-146

*Books:* Rivett, M. and Street, E. (2009) *Family therapy: 100 key points and techniques*. London: Routledge.

*Web sties:* Alzheimer's Society (2009) *Counting the cost: caring for people with dementia on hospital wards*, retrieved 11 January 2012 from [http://alzheimers.org.uk/site/scripts/documents\\_info.php?documentID=1199](http://alzheimers.org.uk/site/scripts/documents_info.php?documentID=1199).

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

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

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

#### **Patient Consent Form**

Authors using case material must also sign the appropriate form to confirm that patients/families have given their informed consent for their details to be included in publication.

#### **Pre-submission English-language editing**

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at [http://authorservices.wiley.com/bauthor/english\\_language.asp](http://authorservices.wiley.com/bauthor/english_language.asp). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

#### **Evaluation of Manuscripts**

The Editorial office will acknowledge receipt of manuscripts. The Editor will arrange for evaluation by at least two assessors. Following receipt of the assessors comments the Editor will advise the authors about the decision concerning the manuscript. This will be done as rapidly as possible with the aim being 12 weeks.

#### **Exclusive License Form**

Authors will be required to sign an Exclusive License Form (ELF) for all

papers accepted for publication. Signature of the ELF is a condition of publication and papers will not be passed to the publisher for production unless a signed form has been received. Please note that signature of the Exclusive License Form does not affect ownership of copyright in the material. (Government employees need to complete the Author Warranty sections, although copyright in such cases does not need to be assigned). After submission authors will retain the right to publish their paper in various media/circumstances (please see the form for further details).

### **Copy Editing**

Following acceptance for publication an article is copy edited for conformity to the style of publication, clarity of presentation, punctuation, standard usage of terms, etc.

### **Proofs**

First-named authors will receive proofs for correction which must be returned within 48 hours of receipt. The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site:

<http://www.adobe.com/products/acrobat/readstep2.html>. Further instructions will be sent with the proof.

### **Early View**

*The Journal of Family Therapy* is part of the Wiley Online Library Early View service. Articles accepted for publication can be accessed on a regular basis online in advance of their appearance in a print issue.

These articles are fully peer reviewed, edited and complete and are considered fully published from the date they first appear online. This date is shown with the article in the online table of contents. The articles are available as full text HTML or PDF and can be cited as references by using their Digital Object Identifier (DOI) numbers. To view all the articles currently available, please visit [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1467-6427/earlyview](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1467-6427/earlyview). On print publication, the article will be removed from the Early View area and will appear instead in the relevant online issue, complete with page numbers and volume/issue details. No other changes will be made.

### **ADVICE TO AUTHORS**

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

These are the types of papers that are regularly submitted to the *Journal of Family Therapy*:

**Research Presentation** (3,000-6,000 words)

A research paper should include:

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

**Case Study** (3,000-6,000 words)

*The Journal of Family Therapy* particularly welcomes case studies. A case study paper should

- Introduce the clinical dilemma posed by the case.
- Review relevant literature.
- Describe the intervention/treatment.
- Discuss the relevance of the intervention for general clinical practice.

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

**Theoretical Discussions or Controversial Theoretical Papers** (4,000-5,000 words)

Again there are few articles of this nature offered for possible publication. A paper of this type would include:

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

- Issues to be resolved.

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

### **Literature Review (3,000-5,000 words)**

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

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

### **PAPERS EXCEEDING 6,000 WORDS (including references) WILL BE RETURNED TO THE AUTHOR**

### **PREPARING THESIS MATERIAL FOR PUBLICATION**

From the outset, it needs to be appreciated that the audience for a thesis is very different to the readership of a Journal. A thesis is prepared to demonstrate candidates' knowledge of an area, their understanding of how theoretical matters link and their ability to use a wide range of sources to develop arguments. In presenting research material, the thesis will provide explanations about the process of deciding on a methodology, the utilisation of that methodology and a critique of its application. A Journal article by contrast seeks to make one or two points clearly and to link these with the current understandings and conceptions in such a way that there is the development of ideas. The Journal reader assumes that the author has a wide range of knowledge of the area and is looking for the author to make a few points well by building on what is already known.

The key to overcoming the difficulties of moving from a thesis to a Journal article is to be aware that one uses the thesis as a source rather than using it as an earlier version of the article. In preparing a Journal article you begin with a blank sheet of paper, a lot of knowledge and previous written material. What is available has the potential of being an article but further work will be necessary.

**A thesis and a Journal article are very different pieces of writing and the process of preparing one for the other is more than just re-wording the title page!**

Many Journal reviewers can easily identify thesis based material by the following common problems that appear:-

**1. The introduction is over long and covers too broad an area.**

Histories of where family therapy came from and descriptions of core elements of systemic practice are not necessary in Journal articles. Only the theoretical point germane to the article's principle aims need to be outlined.

**2. Long explanations as to why particular methodologies are used.**

For a Journal article there is no need to enter into discussions of this nature or to compare different methodologies. The decision was made to undertake the research on one particular methodology and this is what should be present.

**3. Too many quotes from other authors.**

There is a need in a thesis to seek validation from a wide range of sources, but in a Journal article the author's own arguments should be enough with a few selected quotes to emphasise points.

**4. The attempt to write the journal article by following the same structure of the thesis.**

In many cases this is not necessary as the article will demand a different type of structure.

**5. Over long self critique of the work.**

Although self criticism is a necessary part of any public presentation of one's work, it needs to be pertinent to the material presented. There is no need for a full descriptive account of the self reflective process.

**6. De-emphasising the main findings of any research study in an attempt to fit it in with the fuller perspective of the thesis.**

In an article the main findings of the research study need to be emphasised and examined and then linked to broader themes relevant to the issues discussed.

In short, writers of papers prepared from theses often attempt to include as much of their thinking that went into the thesis in the paper. There is a need to overcome the reluctance to cut out elements of the thesis in the preparation of an article to keep the writing solely relevant to the ideas being present.

**Good Marks and Articles**

Because the consumers of theses and papers are different, the potential author needs to be aware that if a thesis is praised it does not necessarily mean it is readily translatable into an article. It simply means a good mark

towards the degree. Similarly, even if a thesis or extended essay just scrapes past the pass mark, it may contain some very useful material that can be worked with for future submissions as an article to a Journal.

### **The Question of Authorship**

In many academic departments there is a tradition that material which is offered for publication which is based on a thesis should be seen as a joint endeavour between the student and the supervisor. The student is seen as being the senior author with the supervisor in a supporting role. Courses and supervisors are quite likely to have different views on this. There are no set rules. However in some situations it may be that by using the thesis material as a source a good quality article could be developed by the student and supervisor working on it jointly. This is a point that should be borne in mind by both students and staff of family therapy courses.

Visit <http://authorservices.wiley.com/bauthor> for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.

## Appendix 2: Ethical approval documents

### 2.1 South West Research Ethics Committee



Miss Estelle Rapsey  
Flat 1, 49 Cheddon Road  
Taunton  
Somerset  
TA2 7BS

South West 4 REC  
Whitefriars  
Level 3, Block B  
Lewin's Mead  
Bristol  
BS1 2NT  
Tel: 0117 342 1328  
Fax: 0117 342 0445

16 March 2011

Dear Miss Rapsey

<b>Study Title:</b>	<b>Exploring the process of family interventions in relation to attachment, attributions, and the maintenance of difficulties. An IPA study.</b>
<b>REC reference number:</b>	<b>11/H0102/12</b>

Thank you for responding to the Committee's request for further information on the above research. The further information was considered by a sub-committee of the REC at a meeting held on 14 March 2011. A list of the sub-committee members is attached.

#### **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, 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:

<b>Document</b>	<b>Version</b>	<b>Date</b>
Protocol	4	15 January 2011
REC application	3.1	20 January 2011
Academic CV		26 January 2011
Interview Schedules/Topic Guides	4	15 January 2011
Evidence of insurance or indemnity		02 August 2010
Evidence of insurance or indemnity	Isur Cert	27 July 2010
Investigator CV	1	17 January 2011
Participant Information Sheet	2	21 February 2011
Participant Consent Form	2	21 February 2011
Covering Letter		15 January 2011

Covering Letter		24 February 2011
Letter from Sponsor		26 November 2010
Major Research Risk Matrix: DClinPsy	4	15 January 2011
Exploring the process of family interventions in relation to attachment, attributions and the maintenance of difficulties. An IPA study.	1	15 January 2011

### 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](mailto:referencegroup@nres.npsa.nhs.uk).

<b>11/H0102/12</b>	<b>Please quote this number on all correspondence</b>
--------------------	---

With the Committee’s best wishes for the success of this project  
Yours sincerely

**Dr David Evans**  
**Chair**

Email: [mindy.kaur@nhs.net](mailto:mindy.kaur@nhs.net)

Copy to: Professor Janet Reibstein

### South West 4 REC

#### Attendance at Sub-Committee of the REC meeting on 14 March 2011 Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr David Evans	Consultant Neonatologist	Yes	
Miss Mumtaz Goolam	NHS LARMS Co-Ordinator - Trustwide, Clinical Risk Department, Nursing, Safety & Patient Standards Di	Yes	

## 2.2 University Research Ethics Committee



Psychology Research Ethics Committee  
Psychology, College of Life & Environmental Sciences  
Washington Singer Laboratories  
Perry Road  
Exeter  
EX4 4QG

Telephone +44 (0)1392 264626  
Fax +44 (0)1392 264623  
Email Marilyn.evans@exeter.ac.uk

To: Estelle Rapsey  
From: Chris Burgess  
CC: Janet Reibstein  
Re: Application 2010/231 Ethics Committee  
Date: August 2, 2012

The School of Psychology Ethics Committee has now discussed your application, **2010/231 – Exploring the process of family interventions in relation to attachment, attributions and the maintenance of difficulties. An IPA study.** The project has been approved in principle for the duration of your study.

The agreement of the Committee is subject to your compliance with the British Psychological Society Code of Conduct and the University of Exeter procedures for data protection (<http://www.ex.ac.uk/admin/academic/datapro/>). In any correspondence with the Ethics Committee about this application, please quote the reference number above.

I wish you every success with your research.

A handwritten signature in black ink, appearing to read "Chris Burgess".

Chris Burgess  
Chair of Psychology Research Ethics Committee

## 2.3 Trust R&D approval

(E. Colgan)

**Somerset Partnership** **NHS**  
NHS Foundation Trust

**Research & Development Team**  
**Somerset Partnership NHS Foundation Trust**  
2<sup>nd</sup> Floor, Mallard Court  
Express Park, Bristol Road  
Bridgwater  
Somerset  
TA6 4RN

Tel: 01278 432033  
Fax: 01278 432099

13<sup>th</sup> September 2011

Our ref: SPT075

Miss Estelle Rapsey  
Washington Singer Building  
Prince of Wales Road  
Exeter  
Devon  
EX4 4SB

Dear Miss Rapsey,

**Title of Study: Exploring the process of family interventions in relation to attachment, attributions, and the maintenance of difficulties. An IPA study.**

**Date of approval: 12/09/2011**

**NREC Number: 11/H0102/12**

#### Approved documents

Document name	Version number
Protocol	4
R&D Form	20/01/2011
Ethics approval letter	16/03/2011
Participant Information Sheet	2
Consent form	2
Interview schedule	4
CV	15/01/2011

Please be aware that if there are any amendments to the above approved documents, these must be sent to Andy Harewood, Research & Development Lead for approval.

I am pleased to inform you that all the required documentation listed above has been received and all the relevant Governance checks have now been completed. I am therefore happy to give



Somerset  
Partnership

If you are interested in community health, mental health or learning disability services or issues and would like to become a member of our Trust, please contact the NHS Foundation Trust Office on 01278 432073 or visit our website on [www.sompar.nhs.uk](http://www.sompar.nhs.uk)

Chairman: Linda Nash Chief Executive: Edward Colgan

approval for the above study on behalf of the Somerset Partnership NHS Foundation Trust ("the Trust") for the site listed below:

**Foundation House, Taunton.**

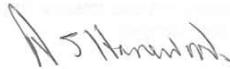
You are reminded that you must report any adverse event or serious incident whether or not you feel it is serious, quoting the study reference number. This requirement is in addition to informing the Chairman of the relevant Research Ethics Committee. You are also required to submit to the Research & Development Lead (Andy Harewood) a final outcome report on completion of your study, and if necessary to provide interim annual reports on progress. Should publications arise, please also send copies to Andy Harewood for inclusion in the study's R & D file.

You must also abide by the research and information governance requirements for any research conducted within the NHS:

- Work must be carried out in line with the Research Governance Framework which details the responsibilities of everyone involved in research.
- You must comply with the Data Protection Act 1998 and where required, have up to date Data Protection Registration with the Information Commissioners Office. Where staff are employed, this includes having robust contracts of employment in place and ensuring that staff are made aware of their obligations through training and similar initiatives.
- You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice:  
([http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4069253](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253))
- You must have appropriate policies and procedures in place covering the security, storage, transfer and disposal of information both personal and sensitive, or corporate sensitive information. Any information security breach must be reported immediately to the Trust.
- Where access is granted to sensitive corporate information, this must not be further disclosed without the explicit consent of the Trust unless there is an override required by law. Where disclosure is required under the Freedom of Information Act 2000, the Trust will assist you in processing the request.

Please note that, as a public authority, the Trust is obligated to comply with the provisions of the Freedom of Information Act 2000, including the potential disclosure of information held by the Trust in connection with this study. Where a request for potential disclosure of personal, corporate sensitive, or contract information is made under the Freedom of Information Act 2000, due regard shall be made to any duty of confidentiality or commercial interest.

Yours sincerely



**Andy Harewood**  
Research and Development Lead

Cc: Frank Burbach

## Appendix 3: Participant information sheet



### **Participant Information Sheet**

**Project title:** Exploring the process of family interventions

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. **The researcher will go through the information sheet with you and answer any questions you have.**

**What is the purpose of the study?** This study will form part of the researcher's Doctorate in Clinical Psychology training. In addition, it hopes to contribute to the research base for Family Interventions.

There has been a lot of research exploring the various approaches involved in the treatment of psychosis. Research findings from Family Interventions have consistently shown them to be helpful in the course of psychosis, for example, decreasing the chances of an individual experiencing a relapse. A number of theories are offered in the literature which suggests a framework for understanding how difficulties can be maintained in families. However, there is a limited amount of research which explores how families experience Family Intervention sessions and the ways these ideas are explored.

**Why have I been invited?** We are interested in finding out from you what your experience of the Family Support Service was like. In particular, we are interested in how the family intervention may have helped you to think about and make sense of your relationships with others and, the explanations given about the symptoms and behaviours of psychosis. We are especially interested in finding out how the sessions may have helped you to think about difficulties and, identify interactions which may serve to maintain difficulties.

**Do I have to take part?** It is up to you to decide to join the study and is entirely voluntary. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of the care you receive.

**What will happen to me if I take part?** You will meet with the researcher who will interview you about your experiences of the Family Support Service. The interview will last for approximately one hour. The interview is not intended to be distressing in any way. The researcher will offer you a debriefing after the interview and you can also talk to your Family Support Service clinician if any issues were to arise. This study is hoping to interview 12 participants in total.

The interviews will be recorded. You will be given a participant number and all transcript data will use this number to ensure anonymity. The information

gathered from each of the participant's interview will be analysed and themes identified. Both the principle researcher and other members of the research team (i.e. academic and, NHS supervisor) will review the transcripts. We will then write to you with a list of themes and ask for your feedback to ensure they are representative of your experience. We will then use the data gathered during the interview to provide a summary overview for all those who took part. The full report, including a summary of the findings will be used in the researcher's doctoral thesis and, submitted for publication in a relevant journal. The findings will be available to you should you request them.

**Will my taking part in the study be kept confidential?** Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. Audiotapes of the interview will be recorded on an encrypted (that is, secure against anyone other than the researcher and her supervisors accessing the interview) digital recorder and kept in a locked filing cabinet in a locked office. When the interviews are transcribed, all information that can be used to identify you, your family or anyone else involved in your case will be removed or changed to ensure anonymity.

If you are being supported by a care coordinator at the time of the study and would like to inform them of your participation, the researcher will do so on your behalf.

**What happens when the study is over?** Once all the interviews have been completed and analysed, a summary of the findings will be included in the researcher's doctoral thesis. This will be submitted in May 2012. Three months after this time, all audiotapes, transcripts and any identifiable information will be destroyed. A shortened version of the study may also be submitted to a relevant journal for publication.

**What if there is a problem?** If you have a concern about any aspect of this study you should speak to the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting The Patient Advice and Liaison Service on 01278 432022 or via email [pals@sompar.nhs.uk](mailto:pals@sompar.nhs.uk) .

**Who is the principle researcher?** Estelle Rapsey (Trainee Clinical Psychologist) is the principle researcher. Estelle is completing this research as part of her training in a Doctorate in Clinical Psychology at Exeter University. She has completed a psychology degree and the foundation level course in family interventions. Before starting the course, she worked in an Early Interventions in Psychosis team and as a research assistant for the family therapy service in the mental health service. Prior to this, she gained experience working as an assistant psychologist for the adult learning disability service and worked in a secondary school.

**Who has reviewed the study?** All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed by the South West 4 Research Ethics Committee.

In addition, this study has been reviewed by the Somerset Partnership NHS Foundation Trust Research and Development committee and Exeter university ethics board.

**Contact details:**

Exeter University

Department of Psychology

Washington Singer Labs

Perry Road

EX4 4QG

## Appendix 4: Participant consent form



### Consent Form

**Participant Number:**

**Project title:** Exploring the process of family interventions

**Name of principle researcher:** Estelle Rapsey

Please initial box

1. I confirm that I have read and understand the information sheet dated 21/02/11 (version 2) for the above study. I have had the opportunity to consider the information and 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, without my care or legal rights being affected.
3. I understand that 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 my records.
4. Where relevant, I agree to my care coordinator being informed of my participation in the study.
5. Where relevant, I understand that my relative may also participate in this study and that all information shared will remain confidential. If I am not happy for my relative to participate I can ask for them not to take part.
6. I agree to take part in the above study.

**Name of participant**

**Date**

**Signature**

**Name of person  
taking consent**

**Date**

**Signature**

## Appendix 5: Interview schedule



### Interview Schedule

**Project title:** Exploring the process of family interventions in relation to attachment, attributions and the maintenance of difficulties. An IPA study

#### **Opening question:**

1. What was your experience of the family sessions?

Prompts: What did you find helpful?

What did you find unhelpful?

#### **Attachment:**

1. I am aware that part of the therapy process can involve exploring family histories, parenting styles and patterns of relating. What was your experience of talking about family relationships in the sessions?

Prompts: What did you find helpful?

What did you find unhelpful?

2. Did the family sessions make you think about the way you are/were parented (prompts e.g. as a child/teenager/now)? If so, how?
3. What did you think about the way you were/are parented and the relationship you had/have with your parents?
4. Did the family sessions make you think about your relationship with your parent/child/sibling/partner? If so, how?
5. Did the family sessions help you to think about the similarities/differences between the way you were parented and the way you parent your child/your relationship with your partner? If so, how?

Prompts: Parenting styles  
Family beliefs/scripts  
Genogram/family history

**Attributions:**

1. I am aware that part of the therapy process can involve thinking about the different possible explanations given for the cause, symptoms and behaviours of psychosis. What was your experience of talking about your/your relative's psychosis in the family sessions?

Prompts: What did you find helpful?  
What did you find unhelpful?

2. Did the family sessions help you to think differently about the cause, symptoms and behaviours of psychosis? If so, how?

Prompts: How symptoms and behaviours are made sense of?  
Experience of the sessions that have been helpful/unhelpful in providing alternative explanations?  
Responsibility/blame/cause of psychosis?

3. How have the sessions helped you to think differently about your relative's possibilities for the future?

**Maintenance of difficulties:**

1. I am aware that part of the therapy process can consider circular patterns of interactions which may serve to maintain difficulties. What was your experience of talking about family issues and patterns?

Prompts: What was helpful?  
What was unhelpful?

2. Did the sessions help you to think differently about the way problems can be maintained? If so, how?

Prompts: Patterns/cycles  
Circular view

Interactional cycles/feedback loops

Interpersonal relationships and attribution style e.g. critical comments/poor relationships/maintenance of symptoms.

3. Is there anything else you would like to say/ask?

**Thank you for taking the time to meet with me today and participate in this study.**

**Appendix 6: Participant feedback form**



Estelle Rapsey  
Foundation House  
Wellsprings Road  
Taunton  
Somerset  
TA2 7PQ

01823 368444

27<sup>th</sup> March 2012

Dear

**Exploring the process of family interventions**

Following my last letter, I have now analysed the interviews and identified six themes across the data set. Please could you consider the themes listed below and tick the box if you feel that they **do** fit with your experience of the family support service sessions. Please also provide any other thoughts and feedback in the space provided.

**1.0 The significance of the therapeutic relationship**

(This relates to the relationship experienced with the therapists' and the space created to discuss sensitive issues)

**2.0 Understanding relationships with significant others**

(This includes considering your relationships with each other

and reflecting upon relationships with other family members  
e.g. parents, siblings)

**3.0 Making sense of difficulties/psychosis**

(This relates to the way the family sessions were helpful in developing a shared understanding of the difficulties faced, including information about psychosis)

**4.0 Developing a sense of agency**

(This theme describes the way the family sessions enabled family members' to talk about their own experiences and their story. It also includes identifying change, hope for the future and re-constructing the self in light of the difficulties experienced.)

**5.0 Exploring and understanding unhelpful patterns of interaction**

(This includes developing understanding of the influence of behaviours on each other and considering ways of changing unhelpful cycles.)

**6.0 Mechanisms of therapy that were helpful**

(This themes describes a number of therapeutic mechanisms that were considered helpful, including the information provided, the forum to talk in a facilitated and safe environment, value of having two therapists' and the support offered for family members.)

**Additional comments:**

.....  
.....  
.....

Many thanks for your ongoing assistance with this research project. I have enclosed a stamp addressed envelope for your convenience. Please contact me if you would like to discuss this or any other issues relating to the research further. I look forward to hearing from you in due course.

Yours sincerely,

## **Appendix 7: Description of research setting**

The Somerset Partnership has an established FI to support families where a member has experienced psychosis. The 'Family Support Service' (FSS) offers an integrated therapeutic approach (Burbach and Stanbridge, 1998, 2006) and is based in four teams across Somerset: Wells, Yeovil, Taunton and Bridgwater. Just over half of the referrals to the service are from the Early Intervention in Psychosis team. However referrals can also be received from other community or inpatient settings.

The FSS consists of a team from multiple professions, including systemic family therapists, clinical psychologists and other mental health clinicians such as nurses and social workers. All staff have completed a one-year training course in family interventions (run in partnership with Plymouth University and accredited by the Association of Family Therapy at foundation level) in addition to their professional qualification. Families are seen by two clinicians for a length of time, which is agreed collaboratively between the family and clinicians.

## **Appendix 8: Reflexivity statement and researcher position**

IPA acknowledges that a researcher's understanding of a participant's experience is influenced by his or hers own ways of thinking, assumptions and conceptions. The researcher in this study acknowledged her role in the construction of the research, the research setting, and the research findings.

The researcher attempted to bring these processes into conscious awareness through consideration of her own position and personal history, a reflective journal, supervision, and thinking through the implications of these factors for the research. The following factors were acknowledged that might influence participants' accounts of their experience and the researcher's interpretation:

- The researcher was aware that participants may not want to express any negative views about the FI service, particularly those still attending sessions. Furthermore, more favourable descriptions may have been offered in light of their knowing that the findings would be published and distributed. It was hoped that emphasising the anonymity and confidentiality of the study would reassure participants to speak as freely as possible about their experiences. In addition, participants were given the choice of interview location. All but one opted to be interviewed at home. Indeed, most commented that they welcomed the opportunity to provide detailed feedback about the service they had received and the researcher felt that balanced accounts were given which included both positive and negative

comments about their experiences. However, it is possible that some may have felt unable to offer a more critical view.

- The researcher also considered the potential power differential between her and the participants, especially given the stigma associated with psychosis and the concept of blame often felt by family members. Furthermore, the participants were aware that the researcher was a health care professional and a trainee clinical psychologist working in the FI service. This may have discouraged them from providing honest accounts and made them wary of expressing difficult feelings. The researcher experienced the participants as friendly and every effort was made to put them at ease. Anonymity and confidentiality were again assured in order to encourage open conversations. The researcher drew from her skills and experience of working with families to help to establish an alliance during the interview and basic therapeutic techniques such as reflection and summarising were used to check understanding of the language used.
- The researcher had conducted an in-depth literature review as part of the requirement for this study and was aware of the potential biasing effect this may have when conducting the interviews and interpreting the data. It was acknowledged that this would have influenced her understanding of the way individual's described their experience. To minimise these effects, the researcher kept a reflective journal and sought supervision throughout the research process. Reference was

made to transcripts repeatedly to check themes and question the influence of previous research findings. In addition, final themes were sent to participants for their comment and feedback.

- The researcher was also aware of how her own experiences of working in both the early intervention in psychosis and the FI service may bias the interpretation. However, whilst attempts were made to minimise this bias, as noted in the previous point, IPA also acknowledges that interpretation is an inter-subjective process of meaning making.
- The researcher is personally interested in systemic approaches and believes locating a person within their broader social system, including their family, is imperative in understanding their situation and promoting their mental well-being. The researcher has also completed a foundation level qualification in systemic approaches. However, the researcher has also worked at an individual level with clients and acknowledges the relative merits of these approaches. Nonetheless, the researcher was aware of her own aspiration to produce results that were favourable to the service. Therefore, regular supervision was sought to explore these assumptions and consider how this position may influence the process of interpretation.

# Appendix 9: Example of transcript coding

**EMERGENT THEMES**

Relationship with therapists

Time

Honesty

Communication facilitate difficult conversations

Containing space?

Normalising grounding altering perceptions

Time

Drawing on expertise of therapists

Developing awareness - changing attributions (time)

shared understanding

Internal attribution

control when things improving?

**Participant number 1**

**Can you tell what your experience was of the family sessions?**

It was a very good experience because first of all we were uncertain as to what we might get out of it. The sessions developed. I think because of the personalities of the care staff, the support staff, they became real friends and things could be said quite candidly and in fact we found it much easier to talk with them than if we did as a family originally. - TIME allowing for developments/progress

**Right. Ok. Excellent. What in particular did you find helpful?**

- I think that we were not the first people to be going through this experience. That is was quite normal in fact in this abnormality and the experience of the support carers showed that everything that we thought was exceptional was not.

**So that helped to normalise**

Normalise the whole thing and of course I felt that they understood the problems much better than we did and were able to explain what was going on and I think each of us would have come in originally with totally different perceptions of what the issues were and how we reacted to them in the past and we found that by sharing those experiences we realised we had differences and it was, we had a much better common understanding at the end of it.

\* Past-time-change? shared.

**Was there anything you found not so helpful?**

There was very little. It was very positive and it lasted for about a year, at least a year probably, roughly once a month. Not quite that as [redacted], my son, might have been away, and by the end of it it seemed a complete change in [redacted] was happening anyway hopefully, but at the end of it we could all leave feeling grateful to what we had had and very, very satisfied with what... we had gone through.

↳ passage of time = change

**Ok. Excellent. Thank you. I am aware that part of the therapy process is sometimes looking at people histories and sometimes this will draw out family**

Descriptive comments: content of what has been said, subject.

Linguistic comments: Exploring specific use of language.

Conceptual comments: Introductory, conceptual level.

**EXPLORATORY COMMENTS**

Positive experience of sessions

- Uncertainty - who is service for?

- candidly - open, honest

↳ forum for talking about issues.

↳ Objective, neutral forum.

Normalisation

↳ Isolated reasoning/comforting

- normalising behaviours attributions toward behaviours?

psychoeducation

Being experts - guided

Multiple perspectives

- sharing, hearing different perspectives

Originally shared understanding

↳ Attributions? change in way of understanding difficulties?

\* Does this imply it facilitated a change in thinking/perspectives? subsequent behaviours i.e. reacted to those experiences

↳ Relief?

- Processed emotions?

- Beginning i.e. end

Mr nor talked about - Pattern of relating - found difficult to talk about?

Making links with the past - Joining up, sense making.

Meaning difficult things - acknowledging plans

changes in cultural society 'A leaving experience'

'A reflective process'

Honesty

Time

Sense making, links

Time

\* 'Brushed aside - family script - how we deal with problems?

- developed / more sophisticated understanding  
making links

trees and things like that, what was your experience of talking about family relations in that way

It did make us look back at our own families, in much more detail, more critically if you like and realise that there might have been problems with siblings, you know, at the time that were just brushed aside, but we now appreciate much more what they may have gone through, but of course things were much less explicit, I am talking 10-15 years ago, and then I think we learnt a lot of what [redacted] had gone through with us not having recognised the symptoms, the problems because he had put on a fairly convincing act and it was quite sad, the truth, is to listen to how they perceived, because my daughter occasionally joined in, she is a bit older, she is in her mid 30's and how both [redacted] and [redacted] perceived their parents very differently. They perceived us, you know, I assume they have a temper and all this sort of thing that I didn't recognise. It made me recognise quite a lot of personal traits which I might not of otherwise

So quite a reflective

It was quite reflective. Yeah. And quite honest, candid, because there was honest brokers if you like.

In those reflections, did it make you think about, perhaps what similarities you might have had to your own, the way that you were parented or the way that you were parenting or could you think of similarities and differences in that way.

Actually it has certainly made me understand a problem that one of my younger brothers had had, perhaps quite similar in fact to [redacted] and I was too busy as a student or whatever to give it much thought. It is an episode that I have hardly ever thought about. -> 'Brushed aside'

So I suppose I am thinking in the sense of, did it make you think any further about your relationship with your parents, sort of going through this experience?

Not very much because it was a long time ago. My mother died when I was in my mid 20's, by which time I was married and had left home and again, I thought they wouldn't live much longer. They live in Scotland. So my wife and I started a new life if you like, more than 40 years ago. There were issues with my parents as a

\* Convent situation - reflecting on past, Making sense of what happened - changing attributions?

Stigma associated with MH.

-> Consider past relations - how shaped behaviour? Noticing differences ie, attitudes / behaviour toward MH.

\* Brushed aside - hidden, disregarded. Perceptions of each other - patterns of relating based on perception of each other?

-> facing / acknowledging plans?

Reflective - developing new awareness of self in relation to family?

Making links with the past - Joining up - sense making

- Always too easy!

- Noticing, becoming aware of problems - guilt, blame? Fulfillive?

Episode - snap shot in time

-> Justice?

Moved away - poor relationship with parents?

## Appendix 10: Emerging themes for each individual

John		
Themes	Sub themes	Extracts
<b>Therapeutic relationship</b>	Friendships developed Candid/honest	"They became real friends and things could be said quite candidly and in fact we found it much easier to talk with them."
<b>Therapeutic space</b>	Normalising Containing Shared experience	"That is was quite normal in fact in this abnormality and the experience of the support showed that everything that we thought was exceptional was not."  "Each of us would have come in originally with totally different perceptions of what the issues were and how we reacted to them in the past and we found that by sharing those experiences we realised we had differences and it was, we had a much better common understanding at the end of it."
<b>Reflecting on own experiences</b>	Making links with the past – joining up  Considering difficulties experienced by family members –siblings/Increasing understanding	"It did make us look back at our own families, in much more detail, more critically if you like and realise that there might have been problems with siblings, you know, at the time that were just brushed aside, but we now appreciate much more what they may have gone through".
<b>Process of therapy</b>	Making sense of/conceptualising difficulties	"We are not quite sure I don't think if it is psychotic mood or whatever, but it turned out that (Son's name) had been bullied at school for some years by his friends. People he was going out with all the time. It wasn't a classic poor little kid in a corner in the playground. Outwardly he

		was popular, but he was being picked on in a certain way and it had got to him in a certain way”.
<b>Processing difficult feelings</b>		<p>“We didn’t realise that there was some level of pain. We just missed it which from his parents’ point of view we feel very guilty of.”</p> <p>“I regret that I hadn’t been supportive enough to (Wife’s name). I hadn’t picked up with (Son’s name).”</p>
<b>Influence of society</b>	Changes in societal approach to mental health difficulties	“Realise that there might have been problems with siblings, you know, at the time that were just brushed aside, but we now appreciate much more what they may have gone through, but of course things were much less explicit, I am talking 10-15 years ago”
<b>Facilitating difficult discussions and developing new perspectives</b>	<p>Hearing other people’s perspective</p> <p>Acknowledging difficulties</p> <p>Developing a shared understanding</p>	<p>“Reflecting ourselves and that was at times uncomfortable, not very uncomfortable, but when 2 out of 3 of the family would say that we think that the other member has your temper or in my case, it was slightly awkward”</p> <p>“We are all going along together with it and we had a much better understanding. I think it is the understanding of the problems that help so much.”</p>
<b>Developing a systemic understanding</b>	Reflecting upon unhelpful patterns of interaction	“I would come home fairly tired and perhaps a little stressed and she would start on me until, so I used to sometimes short circuit and just blow up very quickly, but we all recognise it it wasn’t me just doing it”
<b>Angela</b>		
<b>Process of healing over time</b>	<p>Experiencing the sessions as a journey</p> <p>Experiencing the sessions as</p>	<p>“At first I found it slightly, I suppose, nerve wracking, but then gradually as the weeks went on, I found it extremely comforting and actually given strength”</p> <p>“You sort of knew that what you were doing, you were going in the right direction and I found that</p>

	healing and comforting	comforting.” “And it was through all the talking etc that I began to think, gosh this is healing me as well”
<b>Therapeutic relationship</b>	Bond developed with therapists –friendships Being understood, validated Relationship provided comfort	“When it came to the end, I was really quite sad because you actually make friends with people who come” “I think it was because you were, not patronised, but we were praised and you sort of knew that what you were doing, you were going in the right direction and I found that comforting”
<b>Therapeutic space</b>	Difficult discussions facilitated, safe base from which to explore difficult issues, supervised Healing for the whole family Containing and processing difficult feelings	“And it also I think, talking about the family as a whole, I was able to say, just a little bit, how I had been and it also made my husband see how it had been for me which he could never comprehend what is wrong with me and actually had no time for me feeling the way I was, you know, so there was an awful lot going round the room sort of just gentle, the word that keeps coming up is healing. You know, it was healing in 3 ways.”
<b>Reflecting on past experiences</b>	Sessions facilitated exploration of past experiences and developed insight Different ways of coping – things not talked about in the past Focus on immediate family relations rather than own	“And my older brother had a small period of depression which we never knew about, but also like myself, though I would have talked to somebody if somebody had talked to me about it, we had to keep this a big secret” “I did see a pattern, but it was more between (Son’s name) and I than I can sort of say between parents and my parents and myself”

	attachment experiences	
<b>Multiple perspectives</b>	<p>The opportunity for each person in the family to speak and be heard</p> <p>Hearing the perspectives of others –therapists</p> <p>new perspectives –insight, empathy, changing attributions</p>	<p>“What I found the biggest help was the way, you could say the same thing about each other, but I think it made my husband realise how ill our son was. He is a very strong man and emotions don’t enter into things, you just keep on going and it will help them build bridges because I think sometimes you think oh, somebody is just being lazy and slothful. Get a life which is the most terrible phrase, but that is what bought me comfort was that we could talk and they could talk to each other without shouting”</p> <p>“Because there was two people coming, they saw different sides as well so they bounced ideas off each other and so it just widened and widened and you began to think again, oh I didn’t think of it that way”</p>
<b>Developing a systemic understanding</b>	<p>Exploring and developing an understanding of how interactions influence one another</p> <p>Interactional nature of relationships and the meanings behind behaviours</p> <p>Identifying unhelpful patterns of relating</p> <p>Re-building bridges between members of the family, healing relationships</p>	<p>“With the way they treated us individually, although we were all in a group, there definitely was, they would explain say to my husband, actually (Son’s name) was doing that because of how their relationship was so, you know, not criticise in any way, but they would sort of say that of course if you think of it from (Son’s name) point of view, therefore you, it sort of helped to shift the stubbornness so we would move along that way and you may sort of make me realise, although I was his mum”</p> <p>“I was just so worried and I was trying to find out, between father and son a bond had been broken and it started to come bonding again”</p> <p>“There was a sticky time when he was reapplying to uni and the family support team could see that, but I was having a hard time dealing with that and so she would only think that this is only natural and it doesn’t matter so we would talk through that which you wouldn’t think that that would be a difficult week, but it was. And for him to understand that I was sort of trying to be normal with it, but I expect I was over. It was coming out differently to him. Again we were able to talk about that which I think was just as important to be honest. I had to learn that I had to</p>

		stand back and give him space”
<b>Hope for the future</b>	Being helped to see hope for the future Recognising change, recovery	“When they started talking about his future I realised that that was another, you had come a long, long way and so you know, he has gone back to uni and staying strong”
<b>Reece</b>		
<b>Therapeutic space</b>	Protected time to talk Safe environment – facilitated	“Yeah having two facilitate the actual session was brilliant and the two professionals cos say we were discussing something I don’t understand from my side or my parent’s didn’t understand” “Gave me the opportunity to say it to them in an environment where it wasn’t at a dinner table shouting at each other it was they used the words like not an easy environment but a kind of secret environment where we could discuss it with each other, a safe environment, yeah.”
<b>Therapeutic relationship</b>	Qualities of the therapists Affirming, validating Value of the therapist’s point of view –professional opinion, guidance given, psychoeducation The right amount of information/support –tailoring the approach	“It was good for my parents to hear it coming from them instead of me of what the explanations of this they wanted detail but we had long conversations about it, how it can come about and how it affects me, the family and everyone. It was good it was good to have them say it as well what I was saying or paraphrasing it back to my parents” “My father, hearing it from professionals, my dad is very academic and professional and hearing that from who they were, because they were really good these facilitators” “It was great when they came in and they had that expert, the knowledge training and experience it helped.”
<b>Being given the opportunity to</b>	client, family and therapists Power of talking –release of	“It (the sessions) kind of opened us up as a family, we were more open with each other and

<b>talk</b>	built up frustrations, emotions, Being heard	making difficult or subjects that were you know we discussed it definitely opened things up”  “I mean sometimes the sessions might not end positively between the family and we learnt from that as well and that was the only thing I could think of, the content we are talking about wasn’t always positive, it was quite serious but the family really understood each other better from it and we kind of grew together as a family and we understood each other more.”
<b>Multiple perspectives</b>	Developing new perspectives Understanding each others perspective, developing empathy, seeing each other differently Clarity Shifting attributions, developing a shared understanding	“My sister would put a slightly different perspective on things which was great because it wasn’t a different perspective in terms of oh I saw that differently, it was like how she perceived things but it was still in a good way if you can understand that.”  “I was trying to get them to understand was that it could be me behaving from the psychosis. It was never black and white it could be the psychosis or could be normal for just me and this illness and it was beneficial and it got them to understand and look at things differently. Maybe a bit more outside the box and more open to it.”
<b>Exploring unhelpful interactions</b>	Identifying problematic patterns of relating Developing an understanding about the meaning behind behaviours	“Things that we needed to work on as well and I think when we described relationships how we saw each other”  “It was like ‘come on this is not what I really need’ nagging about what time I wake up cos I am doing things and sorting my life out but it was giving me a break from that and I think that she needed to say something just to get me.. .. In the end it was her caring ...”
<b>Mary</b>		

<b>Storying of experience</b>	<p>Each person telling their story, reflecting on experiences</p> <p>Seeing people in context, developing insight into other peoples lives</p> <p>Unveiling each others narrative</p>	<p>“I felt that the family therapy gave validation to everyone has their perspective of the world and their lives and that we all bring colour and story to our lives in a very unique and individual way and that really was interesting through rather than it just being about one person which has you say has it’s own benefits for sure when it’s brought into the family dynamics as you said if the context if the person is living in the family there is so much going on so many stories so many different perceptions you may not be aware of at all. As soon as that is brought into the room and unveiled then so many sort of pennies drop for people.”</p>
<b>Significance of being heard</b>	<p>Hearing each other, communicating</p> <p>Missing voices, perspectives</p> <p>Everybody having a turn to talk</p>	<p>“It is particularly not helpful if your voice is smaller and not able to be heard whether that’s actually the reality of it or if it was an emotional obstacle, which I saw in (brother’s name) case, his real frustration with not being able to complete a sentence, in a way, and then having that expectation to almost not bothering to try to do that, and then that turned into more anger and resentment, particularly towards certain members of the family. So that was really striking to see everybody being able to talk individually and to be listened to through to the end and have that facilitated”</p>
<b>Multiple perspectives</b>	<p>Facilitating multiple perspectives enabled the development of understanding, shifting attributions and the way the family saw one another</p> <p>Unpacking the problems</p>	<p>“To be able to come up to the foreground and people’s awareness in the session, which perhaps hadn’t even really, really been recognised or not even been thought of as something that was relevant, but that’s just the way we are we just cut down you know ‘don’t be draft’ but actually it was weighty it was more important than that it was much more significant. So that was something that really was really allowed for a great deal expansiveness I felt in the family”</p> <p>“It allowed us to talk about it in the unit and for dad to talk about you know that isn’t how it always feels it was just the way I approach things and to break down some kind of assumptions in a way was very important as well for him to see that we are just people and it’s easy to project onto others and to have a sense of being separate from that.”</p>

<b>The experience of diagnosis</b>	What diagnosis means	<p>“That’s been an absolute pivotal part in turning his perception of who he was around to see it clearly and for him to realise. There is such a danger in being told that you are something because it becomes particularly if your mind becomes fixated if that is a symptom of your condition to become fixated upon something than being told you are something it becomes a solid matter and then that in itself can really cascade and feed into the whole part of the whole weightiness of the sensitivity”</p>
<b>Developing a systemic understanding</b>	<p>Multiple layers of interaction</p> <p>Complexity of family relations/interactions</p> <p>Accepting each person’s role in the maintenance of difficulties</p> <p>Making changes to Interactional processes</p>	<p>“To peel back the layers of the dynamics was really helpful”</p> <p>“To see that particularly for my father and for myself not really realising because I thought you know I am just really helpful because I was helping him through this journey and suggesting very helpful things but then actually realising my role oh well it’s not so helpful to sometimes be really bossy and now to allow him to find his way. So as I mentioned before it was sort of backing down from there and making a conscientious effort at the dinner table to hear him”</p> <p>“It was essential absolutely essential in (brother’s name) healing process and seeing our dynamics with him and changing our dynamics with him and him changing his dynamics with us to respect us as well not seeing us as in a certain way for us not to see him in a certain way just changing and opening our perspective of the thing.”</p>
<b>Patterns of relating</b>	<p>Relationship with attachment figures, protective</p> <p>Difficulties letting go, navigating transitions</p> <p>Observing family dynamics</p>	<p>“It was more between my father and (Brother’s name) and that was like the battle of the older stag and the younger stag was interesting in that way, you know the Alpha male wanting to yeah to sort of stomp down a little bit”</p> <p>“She was his main carer, it was much harder I would say out of all the family you know mum to sever that relationship from the umbilical cord is so strong so I know she found it very positive”</p>
<b>Navigating the recovery</b>	Process of discovery	<p>“And then (Brother’s name) started to enter into oh well it was almost like when he passed</p>

<b>journey</b>	<p>Stages progressed through in therapy</p> <p>Healing journey</p> <p>Accepting loss of self, bereavement process, incorporating new idea of self into being</p> <p>Hope for the future</p>	<p>through that battle field of that battle with the title of psychosis and why had it happened to him and he broke through a boundary through that and he was onto the next part of his journey and he could maybe start to entertain the thought but he would almost separate himself out from the person he sued to be so the person he used to be before this happened could do that whereas the person he was couldn't . That separation was very valid for the family to understand that we talked about the grieving of something he had lost and the person that he wished he had grown into that was really significant and symbolic cos we allowed that grieving to take place, rather than just you dismissing that as something which was that's past. It was really important to call that person into the room you know to recognise that person that he wanted to be and felt very sad that he wasn't. When that happened that was a big shift for everyone actually to see really his perception of who he was who he wanted to be who he thought he should have been and then to try and to complete who he was and carry that forward and that really then broke through this title of psychosis"</p>
<b>Susan</b>		
<b>Therapeutic relationship</b>	<p>Collaborative process</p> <p>Position of neutrality, objective</p> <p>Offering reassurance, guidance, knowledge, support</p> <p>Validating</p> <p>Something for the family</p>	<p>"I think it was being able to have somebody stand back and look at it from outside and perhaps give us. Well initially it was crisis manageable because we were lurching from one crisis to another to another with our son and that was, I think we felt a bit out of control. We didn't know what to do. Or it was reassuring that what we had done in interventions was actually ok and the right thing to do and have somebody else say, yes that was a good thing to do"</p> <p>"When it was offered, something for us, to help us, it was really helpful to have had that and the people that we saw were brilliant, they were very comfortable to talk to and extremely helpful."</p>
<b>Therapeutic space</b>	<p>Containing, safe</p> <p>Being heard</p>	<p>"I mean it was helpful to us so know what the different stages were and therefore so trying to help us think, now do we worry about this. At what level do we need to get the extra help in and what level do we kind of need to really worry rather than just feeling overwhelmed, it gave a bit of structure. We like structure. We like to think, right if it is this that's ok."</p>

	Space for positive risk taking Providing a framework in which to understand difficulties	“The sessions were helpful on the safe risk management because at the time we didn’t feel that we could do anything, go anywhere, you know we couldn’t have gone away for the weekend and just left him at all and that, you kind of want to lead your own life and you want them to lead their own lives, but you see you can’t and it was about having that support about the risk management as he began to get better of being able to withdraw, but be safe.”
<b>Impact of mental health difficulties on family</b>	Feeling out of control Stress and burden of caring Outside skills remit –coping Beyond normal life experience Managing challenges of life alongside mental health difficulties of family member	“He has done this, that and the other and it could be day, night. It was so out of control that we felt out of control and I suppose nothing from your childhood experiences enables you to cope with that.”  “No pre-learning at all on how to deal with things and both of us have been very used to dealing with crisis’ which might have sent people off you know, bereavement counselling. All sorts of things that you have got to deal with. But this was, I think it was being out of control. Maybe both of us were a bit control freaks, I don’t know. We like to be organised, structured and know what we are doing and it was living with the day to day. Never knowing what the day would bring. How he was going to be or what the phone calls are going to be, you know we have picked your son up, he is doing this, that and the other. “
<b>Perception of self/family</b>	Family beliefs, ways of coping	“We are not the sort of people that would have usually accepted that kind of help. We usually manage.”
<b>Patterns of relating/attachment</b>	Influence of past experiences Finding ways to parent without being over protective – stepping back Focus on immediate family	“I have always tried to be a lot more laid back than my parents were. They had very high expectations and, you know, sort of everything had, and I suppose all of us were a bit perfectionist so that was a similar kind of trait, but I suppose the sheer, I suppose if I was honest, the sheer horror of what had happened with the psychosis and how out of kilter our son had got was. Unfortunately both my parents had died by that point. I think they would have been absolutely horrified and therefore I suppose I was trying to come to terms with how you know, how off the rails everything was because.....and the other two kids were doing conventional, normal things, you know jobs and families and those things. It was trying to not to be like one’s

	context	family, but you could see where my traits perhaps of being horrified by it all would come from. “
<b>Exploring patterns of interaction</b>	Identifying unhelpful patterns and changing them  Learning new ways of managing  Developing a systemic understanding	“He kind of, if there is something coming up that you feel yourself slipping into the same pattern of almost sort of saying ‘oh (Son’s name), you shouldn’t do this or shouldn’t do that’ you know, you almost say to each other ‘what would (Therapist’s names) say, they say stand back’ (laughs) so it can kind of. It helps you reflect on actually, well maybe we should just stand back, let him fall over, let him make a mistake about this because it is a safe enough thing to do. You know, what is the worse thing that is going to happen so it is kind of learning a different way of dealing with him now that he is a lot more stable so we are just trying to change our behaviour a bit.”
<b>Multiple perspectives</b>	Hearing alternative perspectives  Differing perspectives which feel blaming, unhelpful  Developing realistic expectations  Developing insight/understanding	“Or it was reassuring that what we had done in interventions was actually ok and the right thing to do and have somebody else say, yes that was a good thing to do or why didn’t you or perhaps you could look at it from this point of view or that point of view”  “A lot of the time they thought it was kind of, you know, his background, his childhood. I found that quite difficult when they were taking that slant, oh well he is like this because of his childhood and you think, well I have got 2 other kids who are perfectly ok and they have all had the same upbringing, literally, you know because they are the same age, and you find of feel quite threatened as a parent I think. Then when he has become well by proper drug treatment, you think then yes it is a chemical imbalance in his brain and why did they just keep on and on and on, oh it is his childhood you know”
<b>Telling the story</b>	Making sense  Identifying stressors and resilience	“I think one could see, one could pick up the life stresses for him – the living on his own, you know he has never done that. We are a close family and strange town, he didn’t know anybody, a strange job, people hostile to him, you know it all added up to too much and it was understanding that he actually can’t manage too much stress.”
<b>Richard</b>		

<b>Therapeutic relationship</b>	Feeling supported, validated Comforting, reassurance Somebody who understands what it is like for the family Sharing the problems Looking after the wellbeing of the family	<p>“We needed somebody to talk to, to share the problem because it was quite a sort of roller coaster nightmare sort of ride with (Son’s name) and we never knew what was going to happen at all and it was just comforting to be able to talk with people”</p> <p>“It was just nice to be able to have somebody to talk to at that particular crisis time. I mean it got us through, I don’t know how long it went on for initially before (Son’s name) finally became more stable but it certainly kept up going through having somebody independent but still a friendly face to see”</p>
<b>Process over time</b>	Identifying change, progress Seeing the positives	<p>“They could see the progress he was making whereas we couldn’t well not so easily because we were right up against it all the time but they could see marked changes at each session when he did start to attend and that was quite comforting to having somebody else observing that and actually reinforcing how far it was for us to see how far he had advanced. So yes, he was I suppose from that previous session”</p>
<b>Developing a shared understanding</b>	Making sense of difficulties, building a picture Considering alternative perspectives and developing alternatives Developing realistic expectations for the future	<p>“It was sort of we were vaguely aware but I think it helped to pull it out. We, had at one stage, wondered whether all this has been triggered off with (Son’s name) being at university and the very, what I would call, arty farty environment and whether it had been triggered off by drugs but if it had been it was a waste of time pursuing that any further because the damage would have been done. I think also it helped to focus on the that (Son’s name) had always been a bit of loner when he was child. He has always been very anxious, never seems to be content with anything but perfect and those sort of things and I think that helps to understand he might build up pressures and stresses in him that might not in other people and I know it can be triggered off by too much stress. So to that extent yes it helped to sort of try and focus our thoughts on that.”</p> <p>“I think we came to realise that it was going to be a slow process that he perhaps might never return to quite the sort of level of normality before all this blew up. I think it gave us the feeling</p>

		that we could deal with him and help encourage him to move on as best he could”
<b>Reflecting on past experiences</b>	Considering own relationship with parents and influence on own parenting style	“I had a slightly odd childhood. My father died when I was 9 so it was just my mother but she was always a very open sort of person, prepared to discuss whatever and listen and I suppose that is what I tried to do with (Son’s name)”
<b>Exploring patterns of relating</b>	Exploring the balance of care, knowing when to intervene and when to back off – challenges of being a parent	“How much do you hold back and let him make mistakes I mean we got the point we didn’t dare hold back and see what the consequence was because we knew damn well the consequences could be pretty dire”
<b>Brian</b>		
<b>Process over time</b>	Journey	“She has obviously taken great strides and made great progress and I think I didn’t realise quite how ill she was during some of those sessions, so I think she has done very well too.”
<b>Exploring patterns of relating</b>	Balance of care, burden of caring, impact of difficulties on self  Learning when to let go, step back –parenting, attachment	“I mean that is something that is very difficult to deal with and I mean any amount of advice from anybody is not necessarily going to help you”  “It was helpful when I mean (Daughter’s name) is extremely dependent on (Wife’s name) approval for a lot of her actions and a lot of the time she will phone up and say we would be discussing something and she will say is mummy mad at me or and things like that, so she is and (Wife’s name) also gets quite upset if (Daughter’s name) is in danger or is unhappy. So, they are very, very, very close in that way because I think they are quite similar emotionally.”
<b>Making sense of difficulties</b>	Attributions made –illness or normal behaviour	“It was more sort of dealing with how she was if you see what I mean rather than trying to analyse what her specific illness was, it’s schizophrenia but it doesn’t really matter if she exhibits certain behaviour.”

	<p>Unpacking the problems</p> <p>Developing understanding, insight</p> <p>Acceptance</p>	<p>“So I think we have come to realise or discuss quite a lot what is (Daughter’s name) problem half of it is not even mental illness. I know she is schizophrenic but sometimes she is just oversensitive to things and that could be anything. So, and because I just don’t think they know so I don’t they have even tried to say well she is schizophrenic because of this or that or she behaves like she is very anxious because of this or that, because I think they much more focused on OK lets accept that she is anxious how do we cope with that and how does (Daughter’s name) cope with that and how can she get round that and are there things that she can do that will help her cope and are there things we can teach you parents to do that will help her cope. Like not overreacting when she does something like losing her key or something you can’t say oh for Christ’s sake (Daughter’s name) why have you done that again.”</p>
<b>Therapeutic relationship</b>	<p>Talking to a qualified friend</p> <p>Influence of a professional’s perspective, guidance</p>	<p>“He (Therapist) was ever such a nice guy and really relaxing. They were almost like talking to a qualified friend.”</p> <p>“They were always gentle with her and I think she believed them too whoever it was that gave her advice which we might have given her the same advice but that it came from the professional she believed it, but also we gained insights too sometimes into how to treat (Daughter’s name) and how to deal with her when she was paranoid”</p>
<b>Developing a systemic understanding</b>	<p>Recognising unhelpful patterns</p> <p>Developing new ways to respond, changing behaviours</p>	<p>“The way we react to her also has an effect on her and can either help or make worse what she is feeling or how she is feeling. So, that’s been at the later stages of the sessions or the later sessions.”</p>
<b>Anna</b>		
<b>Process of therapy</b>	<p>Relief to share problems and seek guidance</p> <p>Bringing family together –</p>	<p>“Also I think it was quite helpful to just have just some basic support really to feel that there was somebody professional there to listen”</p> <p>“The reason that we stopped going was that all the problems that had been talked about already</p>

	getting something out of the sessions as a family	and we were kind of going around in circles so we didn't see any point really in continuing and because we had sort of got as much as we could, as a unit, out of it. "
<b>Making sense of difficulties</b>	<p>Therapist's influence in disentangling problems</p> <p>Offering alternative perspectives</p> <p>Challenging beliefs</p>	<p>"I found that (Therapist's name) actually was much better overall at disentangling the kind of problems and really getting (Daughter's name) to think about ways in which she could solve various problems within. I mean we are a very closely knit family and there was never a problem about kind of you know being loving or concerned it was just her illness was often standing in the way that happened"</p> <p>"I think sort of realising what an effect that that had had on her psychologically and how stressful it was for her. Then of course, because of these problems she was quite badly bullied at secondary school and I think that kind of you know whether that brought on the schizophrenia, I don't know, but it certainly exacerbated her feelings of kind of low self esteem in. Things like that that we you know I think the family support really did help kind of get her to really think about it and for us to really think about it the significance of that period in her life that really added a lot of stress to things and it has actually helped a lot looking at that"</p>
<b>Impact of mental health difficulties on family</b>	<p>Burden of caring, needing to express own feelings but fear of hurting others</p> <p>Fragility of family relations</p> <p>Impact on own wellbeing</p>	<p>"The only thing that I found I would have liked that would have been different would have actually to have had a few independent sessions where I could have said things that I was annoyed with about (Daughter's name) that I perhaps or even about (Husband's name) that I wouldn't have perhaps wanted to say in front of them. And kind of give a sum of my feelings or whatever feeling resentful or trapped or you know at different points of (Daughter's name) being ill. You know with (Daughter's name) illness which I didn't really want to say in front of her. Because I thought it would be hurtful and then I felt I didn't feel that I needed an entirely different sessions you know therapist but it probably would have been helpful perhaps to have a few separate times"</p> <p>"I mean I did go through a course of CBT because when (Daughter's name) started getting better actually, I was depressed which was... and I know I was depressed I just thought I was feeling anxious all the time"</p>

<b>Patterns of relating</b>	Exploring similarities and differences in immediate family context  Family traits	<p>“No, I don’t think we did. No. No. It would come up as a matter of course because we might have some sort of anecdote that we would kind of be talking about to somebody and oh well you know (husband’s name) always behaves like that”</p> <p>“Take over, yeah, the general mother. The mother method! Just do what I say and it will all be fine!”</p> <p>“I tend to be the talkative one and my husband tends to be the quiet one. We have got three other children and (Daughter’s name) is probably the one that is most like me and so you know we might mention how one of her sisters, who is much more like my husband, he is very practical and kind of very chilled and low key and (Daughter’s name) is quite sort of dramatic and you know so I think we talked a little bit about kind of sort of temperaments within the family and how they work, sort of echoed in the children ...”</p>
<b>Exploring pattern of interaction</b>	Identifying unhelpful patterns  Learning new ways to respond  Changing behaviours  Acknowledging role in interactions	<p>“I think the most valuable thing that I have learnt is really that every relationship that you have is completely interactive and so however one person behaves is partly dependent on the how the other person is behaving, which I suppose I probably knew but I don’t think that I ever thought about it as much in depth as I did until we had these problems with (Daughter’s name) because you k now I can see how by when I am able to modify my responses or my behaviour that that can actually make a difference one way or the other to her behaviour.”</p>
<b>Debbie</b>		
<b>Impact of mental health problems on family</b>	How it affects other members of the family  Damage to relationships –bad blood  Burden of caring on own	<p>“I was in such a state of anxiety and frustration and everything else”</p> <p>“I suppose we became more trusting of them it was a long time though as I said before we all met as a family because well there was such ill feeling against (Son’s name) really. Certainly, we had all, it sounds horrible, but before he was sectioned there were times when all of us had wished that he had killed himself, better that than killed anybody else, which is the reason for the</p>

	<p>wellbeing</p> <p>Value of service in keeping other family members well</p>	<p>section because he nearly did and so there wasn't too much love lost with us here and we were worried about having him come home but after he was discharged"</p> <p>"I suppose it was awful because I tended not to side with (Son's name) but be more forgiving of him and the others got cross with me because of that and they were very, very they hated (Son's name) especially the kids and the awful thing was that they were all adolescents, there was four of them very close in age (Son's name) is the eldest but only 5 years between him and his youngest sister. So they were all going through that adolescent age which is very impressionable and shapes your future and all of those things and I suppose it also drove, all that stuff drove a wedge between my husband and I and things were very rocky there as well."</p> <p>"Particularly for me I would have been inside there alongside (Son's name) if it hadn't been for family support"</p>
<b>Relationships/ attachment</b>	<p>Experience as a mother</p> <p>Feeling responsible, Drive to protect child conflicted with need to protect other children</p> <p>Feeling stuck in the middle of family conflict, helpless</p>	<p>"There has been bad blood between all of us first because I sort of as a mum you always take the soft approach don't you and try and find a reason for the bad behaviour."</p> <p>"I always had a gut thought that there was something underlying because he had been such a nice child and my uncle has schizophrenia as well so it was always at the back of my mind that that was the problem, but you know you can't diagnose anything when everything is masked with street drugs and I think the others really took a more objective view of the whole thing that it was bad behaviour and it shouldn't be tolerated and he should have been thrown out long ago."</p>
<b>Reflecting on own experiences/ sense making</b>	<p>Reflecting on childhood experiences</p> <p>Family beliefs and expectations</p> <p>Building a picture within which</p>	<p>"Well, for me I was a kid when my uncle was in (Name of Psychiatric Institution) and stuff like that and to me there is nothing strange about it at all. I used to go and visit him and I was a bit curious really and how strange that he was there and things, because I was only little you just take it as the norm really. I know my mum was also saying I don't stay around him too much just in case, you know, not to worry him or anything but I schizophrenia didn't really mean anything to me then at all"</p> <p>"In my own family my Dad was a Victorian, well you know, and work was a very, very strong</p>

	to understand difficulties Relating to own personal experiences –empathy, insight	ethic and he despised my uncle because he didn't seem to have a proper job. He certainly didn't understand anything, God knows what he would have done if he'd known his grandson had had the same. Yeah, so work in me was a very strong ethic as well and I found it quite difficult when he didn't knuckle down to homework and stuff"  "I suppose I now understand that schizophrenia is brought on by stress and since with my uncle"
<b>Emotional journey</b>	Guilt, frustration Loss – acceptance	"I suppose we thought that a few pills and he would be back to the old (Son's name), you know the one that we lost when he was about 10 I think. And it's quite a bereavement process isn't coming to terms with actually that is never going to be"
<b>Role of diagnosis</b>	Reassuring, an answer Relief –its fixable Value of medication, belief in medication	"I suppose he first had the diagnosis of Schizophrenia when he was first sectioned. Well to me it was so wonderful that they actually said the word, it was something that we suspected for ages and then we could do our research on that, understanding where he came from."  "I suppose you think after the first thing, oh God now they have decided its Schizophrenia they will give him some pills and that will be it"
<b>Talking to each other</b>	Everyone in the family being heard Contracting/negotiating	"I think family support was all about communication, which we hadn't eaten together for ages, we hadn't met as a whole family for ages and we hadn't spoken to each that was quite a bonus! So it was all about communication and they had this idea of a contract with (Son's name) and my daughter the youngest one was actually training to be a nurse at the time, she said that's all a bit tight on (Son's name). I thought that was a bit forgiving of her! She says why don't draw up a contract for all of us."
<b>Therapeutic relationship</b>	Being heard, acknowledged, backed up	"It's just about getting a bond with the therapist isn't it really and I suppose they were both very good but we both found one more easy going than the other"  "One (therapist) in particular became almost a family friend and he you know had all sorts of

	<p>Developing trust</p> <p>Being understood, validated</p> <p>Family friend</p>	<p>things along the way. At one point he was the only person that (Son's name) would talk to you know from the partnership or anywhere else he was the only person that (Son's name) trusted. He certainly helped me too when there has been stuff, not directly involved with (Son's name) but sort of bordering on it and he has been absolutely wonderful."</p>
<b>Relationship with services</b>	<p>Fragility of relationship</p> <p>Feeling told off</p> <p>Power imbalance</p> <p>Blaming</p>	<p>"At the beginning she obviously thought we were parents that didn't know anything about our child at all and she thought he shouldn't be living with his parents when he was 30 years old and x y and z and but the family support people could come in because they had known us all of that time and say no look it's not like that you know, really the best place for him is at home. We were very thankful for both of them for that intervention because, otherwise I think we would have been going frantic and again it still is I think the best place, although he is good he is so much better than he ever way, he is the best now that he has ever been for years and years."</p>
<b>Developing new perspectives</b>	<p>Different perspectives of family members</p> <p>Understanding behaviours</p> <p>Shifting attributions, changing perspectives/empathy</p> <p>Developing realistic expectations</p>	<p>"Yeah I didn't really realised it was something to do with being a negative symptom at the beginning I just thought it was him being a pain!"</p> <p>"Yeah, and to put strategies in place because obviously they are negative symptoms but they are still difficult for the rest of to live with and even though there are symptoms you have still got to conform to a degree and you I suppose as a family we just became slightly more understanding"</p>
<b>Patterns of interaction</b>	<p>Acknowledging role in unhelpful interactions</p> <p>Coping strategies</p>	<p>"I think for a long time and quite naturally (Son's name) wouldn't to (Son's name) and he can't blame him for that and everybody else was a bit wary. I think also we didn't talk to each other much either but I suppose the family therapy, for one thing got most of us in the room together and (Son's name) as he got better started to join us and (Son's name) actually now is actually the most understanding and I think for him it's really given him a huge understanding of the</p>

		problem, he is so good with (Son's name) now"
<b>Societies approach to mental health problems</b>	Changes in approach to difficulties	"In fact, looking back as an adult it was a very different world then very different and horrendous actually and when you understand better where they are coming from well you know you take your hat off to any of them that sort of don't top themselves"
<b>Meaning of recovery</b>	Searching for hope Identifying strengths/exceptions Discovering the 'new' person	"It's more about discovery of the person and seeing all the great assets that that person brings rather than ever thinking he is going to go back and initially I suppose we all thought eventually he would go back to work you know over a period of time it has become a sort of well it became blindingly obviously that he wouldn't yet now he has made so much progress that actually there is a glimmer of hope again that maybe, maybe that he might do a bit of something if the voices let him."
<b>Therapeutic space</b>	Benefit of two therapists Tools used in sessions	"The other therapist has been very good when it comes to knowing more about the medical sort of stuff the drugs and people."  "I can remember doing a genogram which I suppose was a bit of a bonding experience and knowing if there was anything in the background that was pretty obvious as a trigger to all of this. So that was a bit of I suppose fun."
<b>Letter from family member</b>		
<p>"It enabled difficult issues to be included in the agenda –the agenda being determined by each family members concerns, plus any other issues which the two professionals might suggest"</p> <p>"I suppose this need reflected a lack of communication between family members, particularly of sensitive issues"</p> <p>"Until Family Therapist, (Son's name) siblings did not appreciate the problems which he had...although we as parents had told them I do not think it registered at all"</p>		

“I think our other children have a greater understanding about him now and will try to encourage and support him a bit more”

“Their view (siblings of client) was that he had got away with murder, which with hindsight was quite true, but it takes quite a while for parents to reach rock-bottom and evict their child!”

**Andrew**

<p><b>Therapeutic space/experience of therapy</b></p>	<p>Fear of talking about difficulties –therapy space enabling difficult conversations  Forum for expressing feelings</p>	<p>“I had my doubts at first but as soon as we came on it (Therapist’s name) and (Therapist’s name) were absolutely excellent, really, really good. We have been having it about 12 to 18 months and at several times we said that myself particularly that I don’t ever want it to stop at the moment”  “Some of the things we spoke about being difficult but we have been open we have been able to air them in a neutral atmosphere it’s been really good.”</p>
<p><b>Value of therapeutic relationship</b></p>	<p>Significance in maintaining wellbeing  Reciprocity of respect  Qualities of the therapist’s – honest</p>	<p>“We did express our concerns that we thought they might, but they allayed our fears. So yeah I think they are supporting us as patients as well as a liaison that’s how I feel and it’s like a lifeline.”  “They did pick up on it and understand. It’s not everybody that could do it. Some people I can’t open up to or you don’t get that relationship with a person, you either have that relationship with somebody the counsellor or you don’t”  “It is key” (the relationship with therapist’s)</p>
<p><b>Developing new perspectives</b></p>	<p>Identifying positives, exceptions  Offering alternatives, clarity</p>	<p>“Yeah, it’s easier to sit in the room, and discuss it, it is more difficult out there in the real world but I can’t say how good they have been and they picked up on the fact that when we went up to Scotland for two or three days how we really pulled together and ..”</p>

		“But each time we come to the sessions it seems so much easier, it puts clarity on it.”
<b>Patterns of relating</b>	Systemic understanding – understanding the influence of difficulties on each other Identifying unhelpful patterns	“Well I think when my wife has these wipe-outs on a regular basis we started to talk about them and they are well aware of it now and my wife has had them for a long, long time and it’s not an easy one for her. I can always tell when she is going into it so it gets my heart thumping, I think oh no not again.”
<b>Sense making</b>	Developing explanations Acknowledging stressors Awareness, acceptance	“Its finding a way for us to discuss it because we have had a lot of problems, not through our own circumstances but because of what has happened and that has placed us under a lot of stress so it shouldn’t have been like that when we got married. We had six months of a nice life and then a lot of things have happened and so it has been difficult”

## Appendix 11: Summary table of master themes

Superordinate theme	Sub-theme	Theme
<b>Understanding relationships with significant others</b>	<ul style="list-style-type: none"> <li>• How I understand my experience of being a parent, husband/wife, son/daughter, sibling.</li> </ul>	-Developing understanding, insight - Parenting role – protecting, learning when to stand back, let go -Burden of caring -Increasing empathy -Perception of self in relation to family
	<ul style="list-style-type: none"> <li>• How I make sense of my own experiences of being parented</li> </ul>	- Reflecting upon and making links with past experiences -Relevance to current situation -Own mental health difficulties -Mental health difficulties of relatives -Changing perspectives -Influence of own attachment experiences (implicit)
	<ul style="list-style-type: none"> <li>• Developing a sense of family cohesion</li> </ul>	-Being held in mind (by family members) and being mindful of others -Uniting the family
	<ul style="list-style-type: none"> <li>• Family traits</li> </ul>	-Similarities and differences in personalities

Superordinate theme	Sub-theme	Theme
<b>Developing a sense of agency</b>	<ul style="list-style-type: none"> <li>• Storying of experience</li> </ul>	-Telling own story – personal narrative
	<ul style="list-style-type: none"> <li>• Navigating the recovery journey</li> </ul>	-What recovery means and how it is experienced by different family members
	<ul style="list-style-type: none"> <li>• Re-constructing the self, views of others</li> </ul>	-Externalising the problem and internalising personal agency -Role of diagnosis -Family beliefs -Ways of coping –

		“Brushed aside”
	<ul style="list-style-type: none"> <li>• Hope for the future</li> </ul>	<ul style="list-style-type: none"> <li>-Recognising potential</li> <li>-Recognising change</li> <li>-Developing realistic expectations</li> </ul>

Superordinate theme	Sub-theme	Theme
<b>Significance of the therapeutic relationship</b>	<ul style="list-style-type: none"> <li>• Bond with the therapist</li> </ul>	<ul style="list-style-type: none"> <li>-Friendship, trust</li> <li>-Managing endings</li> </ul>
	<ul style="list-style-type: none"> <li>• Role of therapist</li> </ul>	<ul style="list-style-type: none"> <li>-Providing guidance, validation, reassurance, comfort</li> <li>-Facilitate difficult conversations</li> <li>-Navigating emotional journey</li> <li>-Support for the family</li> </ul>
	<ul style="list-style-type: none"> <li>• Space therapeutic relationship created</li> </ul>	<ul style="list-style-type: none"> <li>-Opportunity to discuss sensitive issues</li> <li>-Share problems</li> <li>-Safe space for exploration</li> <li>-Processing difficult feelings</li> </ul>

Superordinate theme	Sub-theme	Theme
<b>Making sense of psychosis/difficulties</b>	<ul style="list-style-type: none"> <li>• Developing a shared understanding of psychosis</li> </ul>	<ul style="list-style-type: none"> <li>-Psychoeducation: What is psychosis, what causes psychosis?</li> <li>-Role of stress</li> <li>-Context</li> <li>-Developing a family perspective –shared construction of meaning, building a picture</li> </ul>
	<ul style="list-style-type: none"> <li>• Understanding the difficulties associated with mental illness</li> </ul>	<ul style="list-style-type: none"> <li>-Distinguishing ‘normal’ behaviours from ‘illness’ behaviours</li> <li>-Multiple perspectives, different ways of talking</li> </ul>

		about difficulties -Developing alternative perspectives
	• Role of diagnosis	-When diagnosis is helpful/unhelpful -Deconstructing difficulties -Influence of stigma, societal expectations

Superordinate theme	Sub-theme	Theme
<b>Exploring and understanding unhelpful patterns of interaction in the family</b>	• Exploring patterns of interactions	-Identifying unhelpful patterns, maintaining factors -Developing understanding – meaning behind behaviours -Feedback loops/cycles
	• Influence of behaviours on each other	-The relationship dance
	• Changing behaviour	-Recognising unhelpful patterns of interaction and changing behaviours/ways of responding -Developing new ways of communicating as a family

Superordinate theme	Sub-theme	Theme
<b>Mechanisms of therapy that were helpful</b>	• Two therapists	-Different perspectives/lens of therapists
	• Normalising	-Normalising, validating, comforting
	• Therapeutic tools	-Genogram, stress-vulnerability model, psychoeducation, making sense, communication, changing patterns of interaction

## Appendix 12: Summary of feedback from participants

All of the participants were written to following analysis of the transcripts to gain their feedback on the findings (a copy of this letter is included in the standard appendices). All ten of the individuals who had participated in the research responded. Overall the participants' feedback was mostly consistent with the descriptions of themes identified.

John, Angela, Mary, Reece, Brian, Anna, Debbie, Andrew agreed with all of the findings. The table below provides a summary of the comments made:

John: *I think that the themes identified are all very relevant and sum up our very valuable experience with the family intervention team and across all members of the family.*

Angela: *I found with the family therapy that no stone was left unturned, which means that your emotions heal completely with no cracks you can move on with your life. Being able to have the tools to move on and somehow the permission from the patient is marvellous.*

Mary: *In reference to point 3.0 (Making sense of difficulties/psychosis), the therapy was particularly helpful in that it helped to deconstruct the labelling term given by the medical diagnosis. Labelling can become a disabling factor if a mind is fragile, sensitive and paranoid: it can hinder the process of healing. Family therapy enabled the family and the main 'user' to break apart the symptoms and see that change was/would be possible and that the label was not a fixed life sentence.*

Reece: *The family support service was a valuable service where as family members, could really express their thoughts and feelings in a facilitated environment, without the worry of their voice not being heard or cut off by other family members. It was essential having the two therapists present because together as a team they could discuss and feedback to the family, which helped create trust and understanding between all parties present in the process. As a trainee counsellor I fully endorse the family support service and praise the two therapists for their time and energy to support our family as they did.*

Andrew: *I find that our sessions are outstandingly helpful in my relationship with my wife (who suffers from depression) and my wife is now starting to feel*

*the same. It takes a long time to help some of the deep rooted problems and interactions that we have and our (mine especially as I am bipolar) fear is that they will soon end due to money and backlog of patients. We are just breaking the ice and it would be terrible if the sessions end too soon. A lifeline would be lost.*

Susan and Richard agreed with most of the themes however didn't identify with the 'significance of the therapeutic relationship' or 'developing a sense of agency' themes. Their feedback regarding the therapeutic relationship was surprising as both made direct reference to the value they placed on their therapists when interviewed. These findings may reflect the time that has passed since their FI or their interpretation of the way the theme was constructed. Further reflection of their interview transcripts revealed that both Susan and Richard found the FI most helpful in supporting them through the crises they experienced with their relative who had experienced psychosis. Indeed, it may be that 'developing a sense of agency' did not factor into their experience of the sessions.

## **Appendix 13: Dissemination statement**

### ***Dissemination to participants:***

- Participants were sent a version of the results and opportunity was provided for further discussion.
- A copy of the full research report or a condensed summary version will be made available for all those participants that are interested.

### ***Dissemination to service providers:***

- An oral presentation regarding the findings will be given to the Family Support Service in Somerset.
- Opportunities to present the findings at relevant service training days will be explored.
- A copy of the full research report will be made available to the Somerset Partnership Research Development Team.

### ***Dissemination to wider research community:***

- This paper will be submitted to the Journal of Family Therapy. This journal has previously published papers from the Family Support Service and other similar topics using qualitative methods.
- Opportunities to present the findings in poster format at national conferences will be explored.

