



University
of Glasgow

Taylor, Hannah E.F. (2012) *Parents and young people in transition after first episode psychosis*.

D Clin Psy thesis

<http://theses.gla.ac.uk/3721/>

Copyright and moral rights for this thesis are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the Author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the Author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

**PARENTS AND YOUNG PEOPLE IN TRANSITION
AFTER FIRST EPISODE PSYCHOSIS
& CLINICAL RESEARCH PORTFOLIO**

VOLUME I

(Volume II bound separately)

Hannah E. F. Taylor

University of Glasgow
Mental Health and Wellbeing
July 2012

Submitted in partial fulfilment of requirements for the Degree of
Doctorate in Clinical Psychology

© Hannah Taylor 2012

VOLUME I
TABLE OF CONTENTS

Acknowledgements	3
Chapter 1: Systematic Review	
<i>A systematic review of attachment and psychosis: Measurement, Construct Validity and Outcomes</i>	4
Figure 1: Article Selection Process	39
Table 1: Study/ Participant Characteristics	40
Table 2: Outcome measures, references and abbreviations	41
Table 3: Articles investigating attachment and outcomes in psychosis	42
Chapter 2: Major Research Project	
<i>Parents and young people in transition after first episode psychosis</i>	44
Figure 1: Charmaz's (2006) Grounded Theory Process	94
Figure 2: Representation of core categories and their relationships	95
Table 1: Participant Characteristics	96
Table 2: Qualities of warmth	97
Chapter 3: Advanced Clinical Practice I Reflective Critical Account	98
(Abstract Only - for full chapter see VOLUME II)	
<i>Borderline Personality Disorder and Multi-Disciplinary Teams: Understanding the Conflicts and Controversies</i>	
Chapter 4: Advanced Clinical Practice II Reflective Critical Account	100
(Abstract Only - for full chapter see VOLUME II)	
<i>Learning about Leadership: Exploring leadership skills in an inpatient psychology service</i>	
Appendices: Systematic Review	
1.1 Guidelines for submission to <i>Acta Psychiatrica Scandinavica</i>	102
1.2 Electronic search strategy	104
1.3 Risk of bias data extraction sheet	105
1.4 Methodological characteristics of the included studies	107
Appendices: Major Research Project	
2.1 Guidelines for submission to <i>Psychosis: Psychological, Social and Integrative Approaches</i>	110

2.2 Evidence of ethical approval for study	113
2.3 Evidence of management approval for study	118
2.4 Participant information sheet	120
2.5 Consent form to contact parent	123
2.6 Participant consent form (young person)	124
2.7 Participant consent form (parent)	125
2.8 Interview schedule	126
2.9 Extract from an anonymised coded transcript	129
2.10 Extract from the researcher's reflective logbook	130
2.11 Major research proposal	132

Acknowledgements

First and foremost to those who took part in the study, thank you for sharing your stories with me, for helping me to learn and understand. I am most grateful to you and I hope I have done your stories justice.

Thank you to Professor Andrew Gumley for continuing to support and inspire me throughout the course and for your on-going motivation, wisdom and guidance during the research. Also, thank you to Dr. Janice Harper and the ESTEEM team for your help with recruitment and in the development of this study.

Special thanks to Mick, my family and my friends for believing in me and for continuing to support, encourage, listen and laugh (or cry) with me along the way. I could not have done this without you.

CHAPTER 1

SYSTEMATIC REVIEW

A systematic review of attachment and psychosis: Measurement, Construct Validity and Outcomes

Hannah E. F. Taylor*

July 2012

Mental Health and Wellbeing
Institute of Health and Wellbeing
University of Glasgow
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH
+44 141 211 0607 (tel)
+44 141 357 4899 (fax)
Hannahtaylor1984@hotmail.co.uk

* Author for correspondence

Submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology (D.Clin.Psy.)

Prepared according to submission guidelines for Acta Psychiatrica Scandinavica (Appendix 1.1)

Abstract

Objectives: Attachment theory offers a developmental understanding of emotional regulation, interpersonal functioning and adaptation to stressful life events. There has been an increasing interest in applying attachment theory to understand symptoms and interpersonal functioning of individuals experiencing or recovering from psychosis. Therefore, this review sought to identify, summarise and critically evaluate articles that investigated attachment amongst individuals with psychosis. *Method:* Nineteen articles which investigated attachment and psychosis between 1980 and 2012 were systematically reviewed and rated for risk of bias and quality. *Results:* The nineteen articles comprised of eighteen studies and included 1,217 participants. All were recruited via convenience sampling and limitations were noted regarding reporting of basic demographic, clinical and participant flow data. Although a range of attachment measures were employed, two predominant measures were the Psychosis Attachment Measure [29] (48.3 %; n=588) and the Adult Attachment Interview [33] (23.0 %; n= 280). In terms of construct validity, we found small to moderate associations between greater attachment insecurity (as reflected in anxiety and avoidance) and poorer engagement with services, more interpersonal problems, more avoidant coping strategies, more negative appraisals of parenting experiences and more severe trauma. We found small to modest associations between attachment and psychiatric symptoms. In particular, attachment anxiety was associated with positive symptoms, depression and poorer quality of life. Attachment avoidance was associated with positive symptoms, negative symptoms and depression. *Conclusions:* Methodological limitations are highlighted throughout the data, limiting the conclusions. Nonetheless, attachment theory provides a useful framework for understanding psychosis factors related to the development, maintenance and recovery process. In addition, it offers important clinical and research implications.

Keywords

Psychosis, schizophrenia, attachment, outcomes, review

Summations

- The review identified nineteen articles comprising of eighteen studies describing 1,217 participants.
- We found evidence supporting the construct validity of attachment in people with psychosis.
- We found small to moderate associations between attachment and outcomes including positive and negative symptoms, depression and quality of life.

Considerations

- There were methodological problems in the included studies including small samples of convenience, cross sectional designs, and the tendency to preferentially report significant findings.
- There were a range of attachment measures utilised making comparisons across studies difficult.
- There is a need for further studies of attachment in psychosis incorporating more representative sampling, arising in the first episode and using prospective follow-up.

Introduction

There is growing evidence that stressful developmental experiences and traumatic life events including sexual abuse, being in care and homelessness are linked to increased vulnerability to developing psychosis [1, 2]. However, there has been relatively little attention focused on exploring the developmental and interpersonal roots of resilience amongst people experiencing psychosis. Attachment theory [3] has been successful in understanding adaptation to the long-term impact of adverse developmental experiences (e.g., abuse) or stressful life events (e.g., loss) [4]. Strong evidence shows that insecure and disorganised attachment is a major risk factor for psychopathology [5].

Attachment theory is a developmental model of interpersonal and psychological functioning, personal resilience and affect regulation, derived from an understanding of the affectionate bonds created in the context of close relationships, initially with primary care-givers [3]. Attachment theory provides a developmental understanding of affect regulation, emerging from the evolutionary necessity for the infant to establish a safe haven (for distress) and secure base (for exploration). Securely attached infants utilise care-givers as a base to explore, and as a source of safeness in response to perceived threat. In adulthood, secure attachment is characterised by a freedom and autonomy to reflect on and explore painful feelings, and a valuing of close interpersonal relationships. Infants who are insecurely attached show a different pattern of affect regulation. Ambivalent/ resistant attachment is characterized by heightened affective expression (including feelings of anger and anxiety) and a reluctance to explore the world reflected in clinging to the care-giver. In adulthood, ambivalent/ resistant attachment is reflected in preoccupation with attachment experiences and heightened emotional expression. Infant avoidant attachment represents a deactivation of the attachment behaviors reflecting a relative indifference to the attachment figure. In adulthood, avoidant or dismissive attachment is characterised by minimizing and avoidance of attachment related experiences, thoughts and memories. These strategies are functional in their developmental context and are key in the unfolding of interpersonal functioning, resilience and constructive adaptation to threatening life events [5].

Models and measures of attachment

There are two distinct models within the current adult attachment literature which differ in their content, structure and method for assessing attachment. These comprise of a narrative approach and a self-report approach. The narrative approach uses the Adult Attachment Interview (AAI) [6] which measures 'attachment states of mind' on the basis of coherence of the individual's narrative when describing childhood attachment related experiences, parental behaviour and overall coherence of transcript. Main and colleagues [6] state that attachment is related to the organisation of representations of earlier attachment figures reflected through coherence of autobiographical and semantic memories. Therefore, the AAI is based on several key ideas about attachment, including that working models operate at least partially outside of awareness; they are based on attachment relevant experiences; that infants begin to develop models that guide behaviour in attachment relationships in the first year of life, that representations provide guidelines for behaviour and affective appraisal of experience [7]. Attachment is classified using Main and Goldwyn's [8] continuous measurement of attachment classifications, that are secure-autonomous, insecure-dismissing and insecure-preoccupied. In addition, a classification of unresolved can be used with regard to trauma and loss, where the coherence of an individual's narrative breaks down [9, 10]. Another approach to analysing the AAI is the Q-sort method [11] which is used to rate an individual's characteristics based on the attachment classifications described above and correlated with two conceptual attachment dimensions. The first dimension differentiates the attachment classification (security-anxiety) and the second dimension differentiates the strategies used to reduce distress (deactivation-hyper activation) Therefore, the Q-sort method emphasises the relation between emotion regulation and attachment representations.

The self-report approach to assessing attachment was developed from Hazan and Shaver's [12] conceptualisations of romantic love as an attachment process. This framework organised individual differences in ways adults think, feel and behave in romantic relationships. The adult attachment styles were a speculative extrapolation of Ainsworth and colleagues [13] classifications of infant attachment (secure, avoidant and anxious-ambivalent). Several self-report measures of attachment styles in relationships have been developed from Hazan and Shaver's [12] categorical

model including continuous rating scales to account for individual variation [14, 15]. It was revealed that underlying self-report measures are two dimensions of attachment anxiety and attachment avoidance [16, 17]. Brennan and colleagues [18] conceptualised these dimensions as underlying Ainsworth's infant typology. Furthermore, Bartholomew [16, 17] provided an interpretation of these dimensions of adult attachment using Bowlby's [3] internal working models of self and other. In addition, these dimensions could be combined to yield four attachment patterns based on Ainsworth's [13], Hazan and Shaver's [12], and Main and colleagues [6, 8] typologies. The four patterns were named secure, preoccupied, dismissing and fearful, and descriptions of each were used in a categorical measure of adult attachment [17]. Overall, two dimensions underlie self-report measures which are anxiety versus avoidance and model of self versus model of others.

Previous review

In one previous review Berry and colleagues [19] found an over representation of insecure attachment amongst individuals' with psychosis. In addition, all studies were conducted with cross sectional convenience samples limiting generalisability of findings. However, the systematic review did not distinguish between inferred attachment related experiences (e.g., self-reports of parental bonding) and attachment states of mind as reflected in individuals' appraisals of their close personal relationships or their narratives during attachment related discourse. In addition, this review included non-clinical analogue studies which have limited generalisability to clinical samples. Furthermore, in the five years since this review, there has been an increasing interest in the phenomenology of attachment amongst people with psychosis, and its relationship to key outcomes of interest including the influence of social, cognitive, interpersonal and affective factors on the development and course of psychosis.

Aims

This review sought to identify, summarise and critically evaluate articles that have investigated attachment amongst individuals' with psychosis.

Questions

Specifically the following questions were asked:

1. What are the characteristics of articles which have investigated attachment in psychosis?
2. What measures have been used to characterise attachment?
3. What is the evidence for construct validity in the assessment of attachment in psychosis?
4. What is the evidence for the association of attachment with outcomes in psychosis?

Method

Inclusion and exclusion criteria

Inclusion criteria were articles that included (i) a measure of attachment, (ii) participants who experienced psychosis, (iii) were published between 1980 and 2012, and (iv) were written in English.

Exclusion criteria were (i) non-clinical/ analogue studies, (ii) qualitative data, (iii) single case studies or dissertations, (iv) conference extracts, (v) book chapters, (vi) unpublished studies, (vii) articles without a measure of attachment and (viii) attachment was not assessed in relation to outcomes associated to the experience of psychosis.

Outcomes

The outcomes for schizophrenia and psychosis were identified from the National Institute for Health and Clinical Excellence [20] schizophrenia guideline. The outcomes chosen were relevant to the data from the studies and include psychiatric symptoms, relapse/ hospitalisation, engagement, social functioning, psychosocial functioning, insight and quality of life.

Search strategy

A systematic review was conducted by searching computerised databases for relevant articles investigating the relationship between adult attachment style and psychosis or schizophrenia. The following computerised databases searched were: CINAHL (Psychology and Behavioural Sciences Collection, PsycARTICLES) < 1980 to March 2012; EMBASE < 1980 to March 2012; Ovid

MEDLINE (R) < 1980 to March 2012; PsycINFO < 1980 to March 2012; and Google Scholar < 1980 to March 2012.

The computerised search used the keywords [PSYCHOSIS] or [SCHIZOPHRENIA] or [PSYCHOTIC DISORDER] combined with [ADULT ATTACHMENT INTERVIEW] or [ADULT ATTACHMENT] or [ATTACHMENT] (see Appendix 1.2 for the full electronic search strategy). Limits used were humans, written in English and dated between 1980 and March 2012. On-line journal articles titles and abstracts were reviewed for keywords and duplicates were removed. Articles that did not contain these keywords were discarded and the full text was obtained from articles that were potentially eligible. Depending on the electronic database the searches could be limited to electronic journal articles (CINAHL and psycINFO); however, where this was not possible (Google Scholar, EMBASE and MEDLINE (R)) book chapters, conference extracts, single case studies and dissertations were excluded when reviewing titles and abstracts. Hand searches of journals (e.g., British Journal of Clinical Psychology, Schizophrenia Bulletin, Psychology and Psychotherapy: Theory, Research and Practice, Clinical Psychology Review) and references from articles were conducted to identify further relevant articles that may have been missed by the electronic search strategy. Experts were also consulted. The potential articles were then scrutinised using the inclusion and exclusion criteria.

Quality criteria

All selected articles were subjected to evaluation in order to assess risk of bias and quality. An extraction sheet to evaluate the articles was based on the Cochrane Consumers and Communication Review Group data extraction template [21] and Clinical Trials Assessment Measure [22]. The extraction sheet consisted of five sections in order to rate the methodological quality of the introduction, sample, procedure, analysis and discussion. This sheet was piloted on two randomly selected included articles and refined accordingly (see Appendix 1.3).

All the articles were rated using the extraction sheet by two independent reviewers (the author and a Trainee Clinical Psychologist) (see Appendix 1.4). Each reviewer rated the articles by answering the questions in the extraction sheet (e.g., was a patient population used?). The ratings

consisted of yes, no, briefly, unclear, not applicable or a specific answer to the question (e.g., for the question ‘how was attachment measured?’ the specific attachment measure was stated). Before the ratings were carried out the reviewers discussed what constituted each rating and provided examples to improve understanding and accuracy of ratings. Following the independent ratings, the reviewers compared answers article by article and question by question. The percentage of agreement between the reviewers was calculated (99.4%). The reviewers disagreed whether duration of illness was counted if the article stipulated mean age and mean age of onset. This disagreement was resolved by discussions between the two reviewers and consultation with a third reviewer (A.G). It was decided that mean age and mean age of onset was an indication of duration of illness. Following this, 100% agreement was reached between the reviewers.

There were 47 questions on the risk of bias extraction sheet. The maximum score for the risk of bias extraction sheet was 44 because the questions requiring specific answers (n=3) were not included in the maximum score. Scores for each article were calculated based on the number of ‘yes’ ratings received, because this rating demonstrated that the article had met the criterion stated in the question. The total ratings are recorded in Appendix 1.4.

Results

Literature search

The search and exclusion process is summarised in Figure 1. A total of 738 articles were identified from the electronic databases using the search terms. The title and abstract for each journal article was reviewed for the keywords (n=90) and other articles, book chapters, conference extracts, case studies and dissertations were excluded (n=648). The articles were then screened for duplicates (n=53) which resulted in 37 articles. Another 10 articles were identified through manual searches of reference lists from the articles (n=8), searches of specified journals (n=0) and consultation with experts (A.G and A.McB) (n=2). This resulted in 47 articles which were scrutinised using the inclusion and exclusion criteria by two reviewers (H.T and A.G), and 28 were excluded (non-clinical/analogue

studies (n=7), no participant experienced psychosis (n=6), qualitative studies (n=3), unpublished research (n=1), no attachment measure (n=9) and attachment was not assessed in relation to outcomes in psychosis (n=2)). Overall, 19 articles describing 18 studies met the criteria for inclusion into the review. Tables 1 and 3 summarises the characteristics of the 19 articles.

Insert Figure 1 about here

Study/ participant characteristics

The quality of the included studies was determined by the number of ‘yes’ scores each article received out of a possible maximum score of 44. A score ‘yes’ indicated that the criterion in the question had been fully met by the information provided in the article. In the included articles the mean score was 26.3, with a median of 27 and a range of 20-34. Therefore, the articles which scored 27 and above [11, 13, 14, 21, 22, 23, 25, 26, 27, 28] have a lower risk of bias and are of a higher quality (see Appendix 1.4 for each articles total rating).

Insert Table 1 about here

There were 1,217 participants in the included studies (see Table 1). Based on data from 18 articles, the mean age of the participants was 36.8 (range of 15–71 years). However, no data were provided on the age of 49 participants (4%) [38]. Also based on the data of 17 studies, 68% (n=827) participants were male and 29% (n=348) were female. No data regarding gender were provided for 42 participants (3%) [36]. The inclusion or exclusion criteria were not explicitly stated for eight studies [33, 25, 36, 37/38, 39, 41, 29, 32].

All of the studies used a convenience sample and a variety of recruitment sites were identified. Three studies (11%; n=132) recruited from inpatient services [33, 25, 29], five studies (32%; n=388) from outpatient/ community services [26, 27, 28, 30, 32], and four studies (24%; n=291) recruited from both inpatient and community settings [34, 24, 35, 36]. Six studies [23, 37/38,

39, 40, 41, 31] (33%; n=406) did not report the specific recruitment site for example, across Greater Manchester [23], urban mental health services [31] or case management services [39].

The diagnoses of the participants were reported in all studies and included schizophrenia (46.8%; n=570), paranoid schizophrenia (10.0%; n=122), schizoaffective disorder (8.1%; n=98), bipolar affective disorder (5.4%; n=65), manic- depressive illness (3.0%; n=36), schizophrenia spectrum diagnosis (7.9%; n=96), schizophrenia and related disorders (6.1%; n=74), psychotic episode (1.1%; n=13), psychosis NOS (0.7%; n=9), schizophreniform disorder (0.3%; n=4), undifferentiated schizophrenia (2.2%; n=27), persistent delusional disorder (0.2%; n=2), atypical psychosis (0.2%; n=2), mania and psychotic symptoms (0.1%; n=1), recurrent depressive disorder and psychotic symptoms (0.2%; n=2), major depression (1.4%; n=17), substance misuse (0.2%; n=3), Asperger's Syndrome (0.1%; n=1), panic disorder (0.1%; n=1), conversion disorder (0.1%; n=1) and symptoms commonly associated with psychosis (6.0%; n=73). The diagnoses of 477 participants were not confirmed using a diagnostic classification system (39.2%) [33, 23, 25, 35, 28, 41].

Education level was explicitly reported in eight studies [23, 35, 40, 26, 27, 29, 30, 32]. Approximately 43.7% (n=532) of participants received some secondary education and approximately 3.7% (n=45) did not enter secondary education. No data were provided for 53% (n=645) of participants' education level. Medication was reported in three studies (17%; n=201) [26, 27, 29]. There were five studies [33, 23, 34, 41, 31] (30%; n=360) which provided the consent rate. The characteristics of the participants who chose not to take part were not noted in any study. Only one study [31] (4%; n=50) conducted an analysis comparing the participants and those who refused to participate or dropped out. In addition, one article [23] provided a flow diagramme of the recruitment process (8%; n= 96).

Measurement of attachment

Psychosis Attachment Measure (PAM)

A range of attachment measures were used in the included studies (see Table 3). There were seven studies [33, 23, 34, 24, 25, 26, 41] that used the PAM [42] self-report questionnaire (48.3%; n=588). Three self-report versions of the PAM were used (PAM; attachment in general relationships,

attachment towards key worker and attachment in relation to the mental health team) and two informant versions (PAM; key worker and team) [23, 33]. PAM items were derived from existing self-report attachment measures, excluding items referring to romantic relationships [18]. Respondents rate on a four-point Likert scale the extent to which each statement describes how they currently relate to key people in their life. The PAM assesses two dimensions of anxious and avoidant attachment. Total scores are calculated for each dimension by averaging item scores, with higher scores reflecting greater anxiety and avoidance.

Self-report and informant report versions of the PAM have been shown to have good reliability and concurrent validity in populations derived from psychotic and non-psychotic populations [42, 43, 44, 23]. Specifically in a psychosis sample [43], general attachment anxiety and attachment avoidance in close relationships was associated with specific attachment relationships (key-workers or parents) for anxiety ($r=0.71$, $p<0.001$) and avoidance ($r=0.57$, $p<0.001$). Acceptable levels of internal consistency have been demonstrated across the included studies, with Cronbach's alpha coefficients ranging from 0.70–0.86 for the anxiety dimension, and from 0.70-0.91 for the avoidance dimension [33, 23, 34, 24, 25, 26, 41]. Test retest reliability has not been reported in a psychosis population. Furthermore, exploratory factor analysis of the PAM has been conducted but not replicated in a confirmatory factor analysis.

Adult Attachment Interview (AAI)

There were six studies [36, 37/38, 39, 40, 27, 32] that used the AAI [6] (23.0%; $n=280$). The AAI [6] is a semi-structured interview, consisting of 20 questions and probes, allowing categorisation of an adult's state of mind with regard to attachment behaviour. Attachment classifications are allocated on the basis of the coherence of interview response and nature of the representation of attachment. Interview stability has been reported at four year intervals [45]. A key strength of the AAI over other methods of assessing attachment is the strong correspondence between parental AAI responses and infant attachment security [46]. Maternal Coherence of Transcript (CohT) score is the most significant predictor of attachment security in infancy [46]. The AAI can be analysed in two distinctive ways, either by using the Q-sort method or narrative approach.

The Q-sort method was used in five studies [36, 37/38, 39, 40, 32] using the Attachment Interview Q-set [11]. A Q-set consists of 100 items derived from Main and Goldwyn's [8] attachment classifications (see below) and these items are used to describe each participant from most to least characteristic. Two raters perform Q-sorts which are averaged and then correlated with two attachment dimensions. The first dimension differentiates the attachment classification (security vs. insecurity (anxiety), or autonomous vs. non autonomous) and the second dimension differentiates the strategies used to reduce distress (deactivation vs. hyper activation, or avoidant (repression) vs. preoccupation). Kobak (1993) [47] compared the Main and Goldwyn [8] categorical system with the Q-sort approach, discriminant function analysis revealed an 88%–94% concordance rate between the two systems.

The narrative approach was used in one study [27]. Each interview is transcribed verbatim and coded for attachment status by coders trained in the AAI coding system (Version 7.1) [9]. Coding relies on the scoring of overall coherence of narrative as the key index of insecure attachment, which is defined as the degree to which speakers portray their attachment experiences in a coherent and collaborative manner. Insecure attachment is characterised by significant contradictions and inconsistencies in attachment narratives or may be reflected in passages that are exceptionally short, long, irrelevant or difficult to follow [6].

As described by MacBeth et al. (2010) [27], transcripts are allocated one of three "Organised" categories: One 'Secure' Category – "Freely Autonomous" - and two 'Insecure' categories – "Dismissing" and "Preoccupied" [8]. In addition, transcripts can be assigned a category of "Unresolved" with regard to trauma and loss, where the coherence of an interviewee's narrative breaks down. In transcripts coded "Unresolved" an "Organised" category is also assigned. Where there was the presence of two or more contradictory attachment strategies a 'Cannot Classify' (CC) is assigned to these transcripts denoting a global breakdown in discourse and alternating use of attachment strategies [10].

Attachment Style Questionnaire (ASQ)

The ASQ [14], used by two studies [35, 28] (13.9%; n=169), is a self-report measure assessing an individual's internal working model of general relationships. The included studies [35, 28] using Feeney et al.'s (1994) [14] five factor structure indicate variability in internal reliability of the subscales in psychosis populations ($\alpha=0.54-0.79$) compared to non-psychosis populations ($\alpha=0.76-0.84$) [14]. A further exploratory factor analysis of the ASQ [48] identified two subscales of avoidance of social relations ($\alpha=0.88$) and preoccupation with being loved ($\alpha=0.71$). Adequate scale coefficients were found in a psychosis sample (avoidance $\alpha=0.75$, preoccupation $\alpha=0.77$) [35]. It can be used as a continuous measure of attachment security or to divide participants into four attachment style groups including autonomous, avoidant, preoccupied and ambivalent.

The Relationship Questionnaire (RQ)

The RQ [17] was used in one study [30] (8.2%; n=100). This brief self-report questionnaire is an adaptation of the Adult Attachment Questionnaire [12] and categorises adult attachment styles through four brief statements. Participants select the most self-descriptive statement of their friendship patterns. In addition, participants can rate how much each description corresponds to their general relationships. The four attachment styles are secure, fearful-avoidant, preoccupied, and dismissing-avoidant. This measure has not been validated for psychosis populations.

Service Attachment Questionnaire (SAQ)

The SAQ [49], used in one study [25] (6.4%; n=78), is a self-report measure assessing the security of the attachment to staff members and to the hospital. A higher score indicates greater attachment security to service. The psychometric properties of the SAQ were derived from a population of clients from adult mental health services and internal reliability values range from $\alpha=0.62-0.93$, with four out of six subscales meeting acceptable levels [49]. The scales also demonstrated reasonable retest reliability over one month ($r=0.61-0.84$) [49]. Factor analysis highlighted one major underlying construct measured by the questionnaire which accounted for 72% variance and significant correlations indicated construct validity [49]. The alpha in the included study was 0.88 [25].

Revised Adult Attachment Scale (RAAS)

The RAAS [50], used in one study [31] (4.1%; n=50), is a self-report measure of adult attachment based on the AAQ descriptions. It contains three subscales and the internal consistency for these in a psychosis sample were; closeness $\alpha=.86$, dependence $\alpha=.86$ and anxiety $\alpha=.97$ [31]. ‘Secure’ attachment is described as being able to tolerate closeness, dependence on others and low anxiety about rejection [50]. Moderate reliabilities of scores on this instrument have been reported in non-clinical populations; however, it has been criticised due to the difficulty in interpreting particular attachment styles [51].

The Adult Attachment Questionnaire (AAQ)

The AAQ [12], used in one study [29] (2.5%; n=30), is a self-selection measure of psychological and emotional closeness in relationships, based on secure, avoidant and anxious/ambivalent attachment styles. Participants indicate which of three short descriptions of the attachment styles best describe their feelings in relationships. In addition, participants can rate how much each description corresponds to their general relationship style. In the included study [29] internal reliability was satisfactory ($\alpha=0.84-0.88$) and test retest reliability with a one month interval was high ($r_s=0.74-0.83$) in a population of people with schizophrenia; however, low or inconsistent reliability has been reported in non-clinical studies [51].

Evidence for construct validity in the assessment of attachment in psychosis

Evidence of construct validity for the attachment measures used to investigate psychosis can be shown through the association with other theoretically related measures. These measures included domains of engagement with mental health services, interpersonal problems, recovery/ coping style, parental bonding and trauma (Table 2).

Insert Table 2 about here

Engagement with mental health services

Four articles [36, 37, 27, 32] investigated engagement in relation to attachment using the AAI. From clinician ratings, Dozier and colleagues [36] found that greater compliance with treatment was associated with more attachment security ($r=.37$, $p<.05$). Whereas, attachment avoidance was associated with reduced likelihood to seek help ($r= -.55$, $p<.01$) and poor use of treatment ($r=.32$, $p<.05$), and attachment preoccupation was associated with more self-disclosure ($r=.50$, $p<.01$). Furthermore, an overall relationship between attachment and engagement with service was demonstrated (Kruskal Wallis: $X^2=7.11$, $df=2$, $p=.029$) [27]. Specifically, secure attachment was associated with better engagement than avoidant attachment (Mann Whitney U Test: $U=11.5$, $p=.011$), and better treatment adherence than preoccupied attachment (Mann Whitney U Test: $U=3$, $p=.018$). Less avoidant case managers were also shown to formed stronger alliances with more deactivating clients than with less deactivating clients ($r=.53$, $p<.01$) [32].

A further study [37] has shown that these associations between attachment insecurity and engagement problems may be partially accounted for by the attachment security of the person's case manager. In particular, those relying on preoccupied strategies were perceived by their case managers as being more dependent ($r=.61$, $p<.01$). Specifically, case managers who were more insecure themselves, perceived clients who were more preoccupied as having greater dependency needs than clients who were dismissing ($r=.80$, $p<.01$).

Three articles [23, 25, 26] used the PAM to investigate engagement with services. Berry and colleagues [23] found that higher attachment avoidance was associated with lower therapeutic alliance as rated by patient ($r= -.44$, $p<.001$) and by staff ($r= -.33$, $p=.003$), and these effects were maintained when controlling for symptom severity. Similar associations between attachment to services and security of attachment generally ($r= -.39$, $p<0.001$) were also demonstrated using the PAM [25]. More hospital admissions were related to less attachment to services ($r= -.33$, $p=0.004$) and people sectioned under the Mental Health Act reported lower levels of attachment to services than those not under section ($t(76)= -3.27$, $p=0.002$). In addition, higher attachment anxiety was related to greater treatment adherence ($r=.20$, $p=.02$) [26].

Using the AAQ, it was shown that participants with more avoidant attachment spent longer in psychiatric hospitals compared to those with secure attachment ($t(1)=2.29, p<.05$) [29]. Finally, greater insecurity of attachment was associated with greater likelihood to disengage from mental health services than secure attachment ($t(1,49)=3.64, p<0.001$) (RAAS) [31].

Interpersonal problems

Two articles [39, 40] explored the AAI in relation to interpersonal problems. Firstly, one study [39] used the Interpersonal Problem Solving task which focused on interactions with case managers. Those with avoidant attachment were off task significantly more than others ($r= -.54, p<.05$), were more rejecting of their significant others ($r=.52, p<.05$) and were more confused following interactions with case managers ($r=.51, p<.05$). The significant others of clients with avoidant attachment felt less supported ($r= -.53, p<.05$) and more saddened ($r=.57, p<.05$) following the tasks. Secondly, greater use of insecure attachment strategies (avoidance and preoccupation) was highlighted amongst families with higher levels of expressed emotion (over-involvement) ($F(2,37)=3.44, p<.05$) [40].

In addition, two articles [23, 26] explored the PAM in relation to interpersonal problems. Greater interpersonal problems were demonstrated in participants with more attachment avoidance ($r=.28, p<.01$) and anxiety ($r=.58, p<.001$) [23]. Specifically, individual's with higher attachment anxiety displayed more attention seeking behaviour ($t(77)2.82, p=.006$), and individual's with higher attachment avoidance displayed more hostility ($t(77)2.77, p=.007$). These results were maintained when controlling for the influence of symptom severity. Kvrjic and colleagues [26] found higher attachment anxiety was associated to less positive clinician input ($r= -.18, p<.05$), and attachment avoidance was associated with non-supportive clinician input ($r=.19, p=.03$), less positive clinician input ($r= -.23, p=.01$) and poorer relationships with professionals ($r= -.25, p<.01$). In addition, greater discomfort with closeness (ASQ) was related to inappropriate community behaviour ($r= -.309, p<.01$) [35].

Recovery / coping style

Two articles [28, 31] reported recovery style in relation to attachment. Firstly, more avoidant recovery/ coping style was related with the relationships as secondary to achievement scale ($r = -0.41$, $p < 0.01$) (ASQ) [28]. Secondly, insecure attachment (RAAS) was associated with an avoidant coping style (sealing over) [31]. Sealing over was linked to more anxiety about interpersonal rejection ($F(1,42) = 12.20$, $p < 0.001$), lower levels of comfort with closeness ($F(1,42) = 7.43$, $p < 0.01$) and ($F(1,42) = 13.51$, $p < 0.001$) dependence in relationships.

Parental bonding

Three articles [34, 28, 31] explored attachment and parental bonding using the Parental Bonding Instrument (PBI). A relationship was highlighted between greater attachment anxiety (PAM) and more parental overprotection ($r = .24$, $p = .03$), but this result was not maintained when controlling for depression [34]. Whereas, greater attachment avoidance (PAM) was related to perceived lack of parental care ($r = -.31$, $p = .005$) which was maintained when potential confounds were controlled.

Using the ASQ, Mulligan and Lavender [28] showed associations between higher maternal care and lower discomfort with closeness ($r = -0.25$, $p < 0.05$), less need for approval ($r = -0.34$, $p < 0.05$) and less preoccupation with relationships ($r = -0.24$, $p < 0.05$) (ASQ). Lower paternal care was associated with greater discomfort with closeness ($r = -0.22$, $p < 0.05$). Maternal overprotection (intrusive and controlling) was associated with greater need for approval ($r = 0.24$, $p < 0.05$) and greater preoccupation with relationships ($r = 0.32$, $p < 0.05$), whilst paternal overprotection was associated with greater discomfort with closeness ($r = 0.25$, $p < 0.05$). Finally, paternal overprotection was associated with greater discomfort with closeness ($r = -.35$, $p < 0.05$).

Finally, greater parental care was related to more dependence ($r = 0.58-0.61$, $p < 0.01$) and closeness ($r = 0.62$, $p < 0.01$) in relationships (RAAS) [31]. In contrast, parental abuse was related to less dependence ($r = -0.41- -0.58$, $p < 0.01$) and closeness ($r = -0.31- -0.54$, $p < 0.05$) (RAAS). Furthermore, anxiety about rejection (RAAS) was related to greater parental abuse ($r = 0.45-0.54$, $p < 0.01$), and lower care ($r = -0.57- -0.61$, $p < 0.01$).

Trauma

Two articles [34, 41] used the PAM in relation to trauma. Higher levels of attachment anxiety were found in those who had experienced trauma with significant others in childhood compared to those who had experienced trauma with significant others in adulthood, non-significant others and those with no interpersonal trauma ($F(3,76)=3.43$, $p=.021$) [34]. In addition, attachment anxiety was associated with total number of traumatic events ($r=0.38$, $p<0.01$), interpersonal traumatic events ($r=0.37$, $p<0.01$) and severity of posttraumatic symptoms ($r=0.36$, $p<0.01$) [41].

Evidence regarding the association of attachment with outcomes in psychosis

Attachment security was investigated in relation to a number of outcomes including positive and negative symptoms, depression and quality of life.

Insert Table 3 about here

Positive and negative symptoms

There were five articles [33, 23, 34, 24, 26], which used the PAM in relation to positive and negative symptoms. Berry and colleagues [23] found an association between more psychiatric symptoms and higher attachment anxiety ($r=.20$, $p=.047$) and avoidance ($r=.31$, $p=.002$). Only attachment avoidance was associated with more positive symptoms ($r=.35$, $p<.001$), negative symptoms ($r=.24$, $p=.019$), and paranoia ($r=.39$, $p<.001$). Paranoia was associated with avoidant attachment independent of severity of illness. Furthermore, there was an association between change in attachment anxiety and change in total symptoms over 6 months ($r=.30$, $p=.027$), and specifically change in the hallucinations was associated with changes in attachment anxiety ($r_s=.30$, $p=.026$). Links between attachment avoidance and positive symptoms ($r=.18$, $p=.04$) were also demonstrated in another study [26]. A further study by Berry and colleagues [34], showed that more psychiatric symptoms and attachment anxiety were not related ($r=.21$, $p=.068$). Although the magnitude of association was similar to other studies [23] suggesting problems related to statistical power. However, more psychiatric symptoms and greater attachment avoidance was related ($r=.27$, $p=.016$).

Participants who heard more critical or rejecting voices ($t(2,71)=3.14$, $p<.002$) or threatening voices ($t(2,71)=5.25$, $p<.001$) had higher attachment avoidance than those who did not report these themes [24]. Those with higher attachment anxiety reported greater severity of voices ($r=.29$, $p=.014$) and greater distress in relation to voices ($r=.32$, $p=.005$). Furthermore, keyworker informant reported attachment avoidance was related to auditory hallucinations ($r_s=0.63$, $p=0.01$) [33]. Whereas, self-reported attachment avoidance of team relationships was associated with greater duration, frequency, intensity, conviction and disruption of delusional thoughts ($r_s=0.42$, $p=0.49$).

Two articles by Dozier and colleagues [40, 38] explored associations between symptoms and attachment as measured by the AAI. They found that those reporting fewer psychiatric symptoms had greater attachment avoidance (all p values $<.05$ but effect sizes were not reported) [40]. These findings were replicated in a further study which showed that attachment avoidance was associated with lower self-report of psychiatric symptoms ($r=-0.23$ - -0.41) [38]. Furthermore, when rated by others those with avoidant attachment had psychiatric symptoms consisting of conceptual disorganisation ($r=0.35$), delusions ($r=0.30$), hallucinations ($r=0.30$) and suspiciousness ($r=0.55$). Attachment security was linked to less delusions ($r= -0.33$), hallucinations ($r= -0.35$) and suspiciousness ($r= -0.41$).

When using the AAQ [29], those classified with an avoidant ($t(1,29)=3.35$, $p<.01$) or preoccupied ($t(1,29)=2.01$, $p<.05$) attachment style had a greater severity of positive symptoms than those with a secure attachment style. Furthermore, those with avoidant attachment had more severe negative symptoms ($t(1,29)=2.36$, $p<.05$) compared to anxious ambivalent or secure attachment styles.

Ponizovsky and colleagues [30], showed that greater severity of delusions was predicted by more preoccupied attachment ($r^2=0.06-0.08$, $p<.01$) and more avoidant attachment ($r^2=0.05-0.08$, $p<.01$) (RQ). In addition, greater persecution/ suspiciousness was predicted by more preoccupied ($r^2=.20$, $p<.0001$) and more avoidant ($r^2=.17$, $p<.0001$) attachment. Greater hallucinations were predicted by more avoidant attachment ($r^2=.20$, $p<.0001$). Finally, higher attachment anxiety on the RAAS was associated with more positive symptoms ($r=.31$, $p=.03$) [31].

Depression

Three articles [33, 34, 26] explored the PAM in relation to depression. Relationships were demonstrated between greater depression and more attachment avoidance in general ($r_s=0.41$, $p=0.046$) and key worker relationships specifically ($r_s=0.55$, $p=0.01$) [33]. A further study also showed that greater depression was associated with more attachment avoidance ($r=.27$, $p=.018$) and attachment anxiety ($r=.43$, $p<.001$) [34]. In addition, this was supported by Kvrjic and colleagues [26] who found that depression was associated with attachment anxiety ($r=.27-.41$, $p<.001$) and avoidance ($r=.19-.29$, $p<.03$). Finally, more attachment to services (SAQ) and lower depression was related ($r= -0.37$; $p=0.001$) [25].

Quality of life

Two articles explored associations between attachment and quality of life [32, 35]. One study [32] highlighted that greater attachment avoidance was associated with reporting better quality of life ($r=0.38$, $p<.01$) (AAI). In contrast, another study [35] showed that avoidant and preoccupied attachment (ASQ) was associated with lower quality of life ($r= -.342$ and $-.341$, $p<.01$). Specifically, discomfort with closeness ($r= -.477$, $p<.01$), need for approval ($r= -.267$, $p<.05$) and preoccupation with relationships ($r= -.301$, $p<.05$) were associated with lower quality of life. Having more confidence in relationships (ASQ) was associated with a greater quality of life ($r=.332$, $p<.01$) and better social and independent living ($r= -.267$, $p<.05$). Whereas, more difficulties with social and independent living were associated with avoidance ($r=.241$, $p<.05$) and discomfort with closeness ($r=.233$, $p<.05$).

Discussion

This paper aimed at summarising and evaluating studies investigating the relationship between attachment and psychosis. Specifically the methods, construct validity of attachment measures and the association between attachment and outcomes (positive and negative symptoms,

depression and quality of life) in psychosis. We identified 19 articles describing 18 separate studies comprising a total of 1,217 participants with a mean age of 36.8 years.

Construct validity

Problems with engagement and use of mental health services showed small to moderate associations with insecure attachment (AAI, PAM, AAQ, RAAS). Those with secure attachment had better engagement and greater treatment adherence [36, 27] and insecure attachment was related to disengagement [29, 31]. Specifically, avoidant attachment was related to problems in seeking help, poor use of treatment, longer hospital admissions and lower rated therapeutic alliance [36, 23, 29]. Preoccupied attachment or attachment anxiety was related to greater disclosure and more treatment adherence than avoidance [36, 26, 27]. Those with more admissions and compulsory treatment orders had poorer attachment to services [25]. Insecure attachment was also related to the amount and type of input offered by clinicians [26].

In addition, interpersonal problems showed small to moderate associations with insecure attachment (AAI, PAM, ASQ). Specifically those with preoccupied attachment had greater dependency needs, and those with an avoidant attachment had difficulties with interpersonal problem solving, inappropriate or hostile behaviour and had poorer relationships [37, 39, 27, 23, 35, 26]. Insecure attachment (AAQ and RAAS) was also associated with avoidant (sealing over) coping styles [28, 31].

In terms of parental bonding small to moderate associations with the PAM, ASQ and RAAS were shown. Insecure attachment was related to parental lack of care, abuse and overprotection, and secure attachment was related to increased parental care [34, 28, 31]. Trauma was moderately associated to attachment anxiety on the PAM. Specifically childhood trauma, number of traumatic events, interpersonal events and severity of trauma symptoms were shown to be important factors [34, 41].

The associations between attachment measures and theoretically related measures provide evidence of construct validity in the measurement of attachment in people with psychosis. The results state that people with an insecure attachment have problems engaging and using mental health

services, more interpersonal problems, negative experiences related to parental bonding behaviours and were more likely to have experienced trauma. Therefore, these results are in accordance with the behaviours and experiences associated with insecure attachment as described by attachment theory [3].

Outcomes

We found that positive and negative symptoms showed small to moderate associations with attachment. Generally more psychiatric symptoms were related to insecure attachment and fewer symptoms with secure attachment. Specifically on the PAM, AAQ and RQ, attachment avoidance was associated with positive and negative symptoms, paranoia and delusions [33, 23, 34, 24, 38, 29, 30]. PAM attachment anxiety was associated with more psychiatric symptoms, distress and severity of voices [23, 24]. In contrast, attachment anxiety measured by the RAAS was associated with positive symptoms [31]. On the AAI, those with attachment avoidance self-reported fewer symptoms but were rated as more symptomatic by others [40, 38]. Depression was moderately associated with insecure attachment on the PAM [33, 34, 26]. Secure attachment to services was also related to lower depression scores [25]. Finally, there were inconsistent findings between quality of life and attachment, and the majority of the associations were weak. Those with avoidant strategies on the AAI reported greater life satisfaction [32]. However, insecure attachment styles on the ASQ were associated with lower quality of life and avoidant attachment was associated with worse social and independent living [35]. In addition, there was a moderate interaction of dissimilar attachment strategies (AAI) between case managers and participants on participant reporting of life satisfaction [32].

Overall, associations were demonstrated between secure attachment and fewer positive, negative and depression symptoms, and between insecure attachment and more positive, negative and depression symptoms. Associations between attachment and quality of life remain unclear and require further exploration as only two studies investigated this outcome.

Limitations of included studies

There were a number of methodological problems identified in the studies that make generalisability of the above findings problematical. All of the studies, with one exception [23] were cross-sectional making inferences regarding the direction of causality problematic. All studies were conducted with participants with established or chronic psychosis with the exception of two studies who included a first episode psychosis group [35, 27]. Reporting of participant flow including rates of consent was rare with the exception of two studies [23, 29]. Other reporting problems were noted including the description of inclusion and exclusion criteria, medication, diagnosis and educational level. Finally, reporting of data were not consistent and in particular there was a tendency in studies to only report significant findings. This bias means that the small to moderate associations found across studies may over estimate the effect sizes in the wider population of people with psychosis.

Measurement of attachment

There were a variety of measures used to assess attachment, although two measures (PAM and AAI) accounted for the majority of participants in the included studies (n = 868, 66.3%). The nature and methods of attachment measurement varied from self-report questionnaires (PAM, ASQ, RQ, SAQ, RAAS, AAQ) to semi-structured interviews (AAI) and from dimensional descriptions of attachment (AAI-Q Sort, PAM, ASQ, SAQ, RAAS) to categorical descriptions (AAI, RQ, AAQ). There are also differences in approach each measure uses, whether it is based on the person's current state of mind with respect to attachment as reflected in attachment related discourse (AAI) or self-reported perceptions of current relationships [47].

The limitations using self-report are due to biases in reporting for example, effects of social desirability, mood, current relationships or the impact of attachment itself on self-report. For example, individual's who are avoidant of attachment can tend to self-report their attachment as secure. Some studies attempted to account for this potential bias by using both self-report and informant-report measures of attachment [33, 23]. Furthermore, interview measures investigate elements of attachment representations which are reflected in the coherence of semantic and autobiographical memory. Therefore, it is possible that participants may have limited direct awareness of their own attachment

representations when self-reporting. In contrast, narrative approaches to attachment measurement (AAI) can be criticised due to attachment security being measured by coherence of the portrayal of attachment relationships at the semantic and autobiographical memory level. Psychosis populations may experience problems related to conceptual disorganisation and thus produce incoherent narratives unrelated to attachment. Importantly, the one study which utilised the narrative version of the AAI [27] found no associations between Coherence of Transcript and specific psychotic symptoms including AAI. In addition, the time taken to train interviewers and complete the AAI is considerably longer than self-report measures. Importantly, the two most common types of adult attachment measures (self-report of attachment dimensions, and classifications based on the AAI) have a very weak association (.09) [74].

Therefore, overall different measures assess different constructs of attachment as they are based on different theoretical and methodological origins [51]. Due to this lack of convergence between measures and outcomes they are not necessarily directly comparable. Therefore, measures should be used based on the relationship domain and related conceptual processes, with consideration to the underlying theoretical assumptions [7]. This difference between attachment measures highlights considerable limitations in the generalisability across measures and therefore across samples and populations in this review. In addition, it is important to recognise the need to understand attachment in context with wider familial, social and cultural factors which impact on individuals and relationships. This review highlights the use of the PAM self-report measure and AAI interview measure as predominant in psychosis research. In future research, different measures should be compared independently due to the problems in making comparisons, as they are conceptually distinct measurements of attachment. Efforts to prescribe a particular attachment measure to use in psychosis would be premature and limit the potential for new and creative research. Therefore, indicating a lack of distinctive alternative theoretical models of attachment in psychosis.

Strengths and limitations of current review

The strengths of the current review included the systematic search strategy, the exclusion of non-clinical data, and the focus on construct validity and outcomes. All of the articles were rated for risk of bias by two independent raters and a third reviewer, which increased rigour and diligence in the critique to ensure accuracy.

In contrast there were limitations to this review. The search parameters (e.g., written in English language) may have resulted in publication and language bias by overlooking relevant evidence. The measure developed for rating the risk of bias and quality in included studies was developed specifically for this review based on previously validated measures and standards [21, 22]. Therefore, validity of this measure is not established. A final major limitation was the bias in the reporting of significant findings. This bias was due to the heterogeneous nature of the articles and thus the data were not amenable to meta-analysis.

Research implications

In order to establish robust findings relating to attachment and outcomes in psychosis this requires a move from simple cross sectional to longitudinal studies. Longitudinal studies would add to understanding causal links between attachment, symptom development and adaptation, early experiences and trauma in the onset of psychosis and how psychosis itself may impact on attachment. Furthermore, prospective studies in first episode psychosis cohorts could develop an understanding of attachment in evolution of resilience and adaptation. A focus on well specified first episode cohorts would enable improved generalisability of findings. In addition, there needs to be a continued consideration of the relationships between attachment and outcomes. Specifically, attachment measures should be included in studies exploring stressful developmental experiences or traumatic life events and later outcome.

In addition, larger and more representative sample sizes and replicated studies are required. To improve the transparency of data, there needs to be a standardisation in the reporting of significant and non-significant findings. The use of representative samples and the standardisation in reporting all results would help to develop a comprehensive understanding of the ways in which attachment theory

relates to processes of recovery from psychosis. Research also needs to investigate whether attachment is a suitable target for psychological therapies and indeed whether it is a desirable or relevant factor amenable to change. Overall, to make the literature comparable a consensus is required in what the important factors in attachment are, as well as the consistent use of measures of attachment and outcomes across studies.

Clinical implications

The results highlight the importance of understanding attachment as part of an assessment and to utilise attachment theory to understand processes of affect regulation and recovery. Attachment theory is a model of resilience, not a model of psychopathology and contributes to the formulation of an individual's affective, cognitive and interpersonal functioning. Attachment theory could inform hypotheses regarding the interpersonal interactions during intervention that would benefit those with insecure attachment, for example, those with avoidant attachment may benefit from increasing focus on emotion [32] and highlight the importance of integrating interpersonal interventions into existing evidence based practice.

Furthermore, attachment theory may be useful to understand the relationship between staff, young people and the team, and provide a theoretical model to incorporate the interplay between developmental, interpersonal, coping and systemic factors as they influence and are influenced by the functioning of clinical services. Therefore, attachment theory would inform the therapeutic alliance, and offer a way of conceptualising barriers to engagement or interpersonal difficulties within a model of resilience. In addition, it may help staff to reflect on their own interpersonal style and influence on young people, including the importance of creating a safe haven for distress and a secure base for exploration and recovery.

Conclusions

This review has considered how attachment has been measured and related to outcomes in psychosis. We found evidence to support construct validity in the measurement of attachment in people with psychosis. Insecure attachment was related to problems engaging and using mental health

services, interpersonal problems, negative parental bonding behaviours and experiences of trauma. There was also evidence of small effect sizes that attachment (in) security is related to positive and negative symptom severity, severity of depression and quality of life. However, significant methodological challenges were highlighted in the literature, which mean that researchers and clinicians need to be cautious in generalising from these studies. Importantly, the majority of data gathered in this review were from the AAI interview measure and the PAM self-report measure. Due to the lack of convergence between interview and self-report measures future research should compare the outcomes of each measure independently, as they represent conceptually distinct measurements of attachment. Efforts to prescribe the use of particular attachment measures would be premature and limit the potential for new and creative research. Hence, reflecting a lack of distinctive alternative theoretical models of attachment in psychosis. Although attachment has been used as a measurement model, it is not always linked to a clear conceptual model in psychosis and there is a need to develop these models more strongly. Despite these challenges, attachment does provide a promising construct for understanding and measuring the developmental and interpersonal origins of resilience and affect regulation. Further research is merited particularly in larger, more representative, and first episode populations in the context of prospective follow-up.

References

* Included Articles

- 1) Bebbington, P., Bhugra, D., Brugha, T., Singleton, N., Farrell, M., Jenkins, R.,...Meltzer, H. Psychosis, victimization and childhood disadvantage: Evidence from the second British National Survey of Psychiatric Morbidity. *Br J Psychiatry*. 2004; 185:220–6.
- 2) Read, J., van Os, J., Morrison, A. P., & Ross, C. A. Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatr Scand*. 2005; 112:330-50.
- 3) Bowlby, J. *Attachment and loss: Vol. 3. Loss, sadness and depression*. London: Pimlico.1980.
- 4) Fraley, R. C. Attachment stability from infancy to adulthood: Meta-analysis and dynamic modeling of developmental mechanisms. *Pers Soc Psychol Rev*. 2002; 6:123-51.
- 5) Bakermans-Kranenburg, M. J. & Van IJzendoorn, M. H. The first 10,000 Adult Attachment Interviews: Distributions of adult attachment representations in non-clinical and clinical groups. *Attach Hum Dev*. 2009; 11:223-63.
- 6) George, C., Kaplan, N. & Main, M. *Adult Attachment Interview*. Department of Psychology: University of California, Berkley. 1997.
- 7) Crowell, J. A., Fraley, R. C. & Shaver, P. R. Measurement of Individual Differences in Adolescent and Adult Attachment. In: Cassidy, J. & Shaver, P. R. *Handbook of Attachment: Theory, Research and Clinical Applications*. London: The Guilford Press. 2008. p.599-634.
- 8) Main, M. & Goldwyn, R. Adult attachment classification system. In: Main, M. *Assessing attachment through discourse, drawings and reunion situations*. New York: Cambridge University Press. In press.
- 9) Main, M., Goldwyn, R., & Hesse, E. *Adult attachment scoring and classification systems. (Version 7.1)*, Unpublished manuscript, University of California. 2002.
- 10) Hesse, E. Discourse, memory and the Adult Attachment Interview: A note with emphasis on the emerging Cannot Classify category. *Infant Ment Health J*. 1996; 17 (1):4-11.

- 11) Kobak, R. R. *The Attachment Interview Q-Set*. Unpublished document: University of Delaware. 1989.
- 12) Hazan, C. & Shaver, P. Romantic love conceptualized as an attachment process. *J Pers Soc Psychol*. 1987; 52:511-24.
- 13) Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum. 1978.
- 14) Feeney, J. A., Noller, P. & Hanrahan, M. Assessing adult attachment. In J. Cassidy & P. Shaver (Eds), *Handbook of attachment, theory and research* (pp.355- 377). New York: Guildford Press. 1994. p. 355-77.
- 15) Collins, N. L., & Read, S. J. Adult attachment, working models, and relationship quality in dating couples. *J Pers Soc Psychol*. 1980; 58:644-63.
- 16) Bartholomew, K. Avoidance of intimacy: An attachment perspective. *J Soc Pers Relationships*. 1990; 7:147-178.
- 17) Bartholomew, K. & Horowitz, L. M. Attachment styles among young adults: A test of a four category model. *J Pers Soc Psychol*. 1991; 61:226-44.
- 18) Brennan, K. A., Clark, C. L. & Shaver, P. R. Self-report measures of adult attachment/; an integrative overview. In: Simpson, J. A. & Rhodes, W. S. *Attachment theory and close relationships*. London: Guilford Press. 1998. p.46-76.
- 19) Berry, K., Barrowclough, C. & Wearden, A. A review of the role of adult attachment style in psychosis: Unexplored issues and questions for further research. *Clin Psychol Rev*. 2007; 27:458-75.
- 20) NICE. Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care: NICE clinical guideline 82. [Internet]. 2009 [cited March 2012]. Available from: www.nice.org.uk/CG82 [NICE guideline].
- 21) Cochrane Collaboration. Cochrane Consumers and Communication Review Group: Data Extraction Template for Cochrane Reviews. [Internet]. 2011 [cited October 2011]. Available from: http://www.latrobe.edu.au/chcp/assets/downloads/DET_2011.doc

- 22) Tarrier, N. & Wykes, T. Is there any evidence that cognitive behaviour therapy is an effective treatment for schizophrenia. A cautious or cautionary tale? *Behav Res Ther.* 2004; 42:1377–1401.
- 23) * Berry, K., Barrowclough, C. & Wearden, A. Attachment theory: A framework for understanding symptoms and interpersonal relationships in psychosis. *Behav Res Ther.* 2008; 46:1275-82.
- 24) * Berry, K., Wearden, A., Barrowclough, C., Oakland, L. & Bradley, J. An investigation of adult attachment and the nature of relationships with voices. *Br J Clin Psychol.* 2011. Dec: Early View. DOI: 10.1111 /j.2044-8260.2011.02027.x.
- 25) * Blackburn, C., Berry, K. & Cohen, K. Factors correlated with client attachment to mental health services. *J Nerv Ment Dis.* 2010; 198 (8): 572-5.
- 26) * Kvrjic, S., Beck, E. M., Cavelti, M., Kossowsky, J., Stieglitz, R. D. & Vauth, R. Focusing on the adult attachment in schizophrenia in community mental health centres: Validation of the Psychosis Attachment Measure (PAM) in a German- speaking sample. *Int J Soc Psychiatry.* 2011; Jun 10:1-12.
- 27) * MacBeth, A., Gumley, A., Schwannauer, M. & Fisher, R. Attachment states of mind, mentalization, and their correlates in a first episode psychosis sample. *Psychol Psychother Theor Res Pract.* 2010; 84 (1):42-57
- 28) * Mulligan, A. & Lavender, T. An Investigation into the Relationship between Attachment, Gender and Recovery from Psychosis in a Stable Community- Based Sample. *Clin Psychol Psychother.* 2010; 17:269-84.
- 29) * Ponizovsky, A. M., Nechamkin, Y. & Rosca, P. Attachment Patterns Are Associated With Symptomatology and Course of Schizophrenia in Male Inpatients. *Am J Orthopsychiatry.* 2007; 77 (2):324-31.
- 30) * Ponizovsky, A. M., Vitenberg, E., Baumgarten- Katz, I. & Grinshpoon, A. Attachment styles and affect regulation among outpatients with schizophrenia: Relationships to symptomatology and emotional distress. *Psychol Psychother Theor Res Pract.* 2011; Dec:DOI: 10.1111.

- 31) * Tait, L., Birchwood, M., & Trower, P. Adapting to the challenge of psychosis: Personal resilience and the use of sealing over (avoidant) coping strategies. *Br J Psychiatry*. 2004; 185:410-15.
- 32) * Tyrrell, C. L., Dozier, M., Teague, G. B. & Fallot, R. D. Effective Treatment Relationships for Persons With Serious Psychiatric Disorders: The Importance of Attachment States of Mind. *J Consult Clin Psychol*. 1999; 67 (5):725-33.
- 33) * Arbuckle, R., Berry, K., Taylor, J. L. & Kennedy, S. Service user attachments to psychiatric key workers and teams. *Soc Psychiatry Psychiatr Epidemiol*. 2011; May 28.
- 34) * Berry, K., Barrowclough, C. & Wearden, A. Adult attachment, perceived earlier experiences of care giving and trauma in people with psychosis. *J Ment Health*. 2009; 18 (4):280-7.
- 35) * Couture, S., Lecomte, T. & Leclerc, C. Personality characteristics and attachment in first episode psychosis. *J Nerv Ment Dis*. 2007; 195 (8):631-9.
- 36) * Dozier, M. Attachment organisation and treatment use for adults with serious psychopathological disorders. *Dev Psychopathol*. 1990; 2:47-60.
- 37) * Dozier, M., Cue, K. L. & Barnett, L. Clinicians as Caregivers: Role of Attachment Organization in Treatment. *J Consult Clin Psychol*. 1994; 62 (4):793-800.
- 38) * Dozier, M., & Lee, S. W. Discrepancies between self- and other- report of psychiatric symptomatology: Effects of dismissing attachment strategies. *Dev Psychopathol*. 1995; 7:217-26.
- 39) * Dozier, M., Lomax, L., Tyrrell, C. L. & Lee, S. W. The challenge of treatment for clients with dismissing states of mind. *Attach Hum Dev*. 2001; 3 (1):62-76.
- 40) * Dozier, M., Stevenson, A. L., Lee, S. W. & Velligan, D. I. Attachment organisation and familial over involvement for adults with serious psychopathological disorders. *Dev Psychopathol*. 1991; 3:475-89.
- 41) * Picken, A. L., Berry, K., Tarrier, N. & Barrowclough, C. Traumatic Events, Posttraumatic Stress Disorder, Attachment Style, and Working Alliance in a Sample of People With Psychosis. *J Nerv Ment Dis*. 2010; 198 (10):775-8.

- 42) Berry, K., Wearden, A., Barrowclough, C. & Liversidge, T. Attachment styles, interpersonal relationships and psychotic phenomena in a non-clinical student sample. *Pers Individ Dif*. 2006; 41:707-18.
- 43) Berry, K., Barrowclough, C. & Wearden, A. Adult attachment styles and psychosis: an investigation of associations between general attachment styles and attachment relationships with specific others. *Soc Psychiatry Psychiatr Epidemiol*. 2007; 42:972-6.
- 44) Berry, K., Band, R., Corcoran, R, Barrowclough, C. & Wearden, A. Attachment styles, interpersonal relationships and schizotypy in a non-clinical sample. *Psychol Psychother Theor Res Pract*. 2007; 80:563-76.
- 45) Crowell, J. A., Waters, E., Treboux, D., O'Connor, E, Colon-Downs, C., Feider, O., Golby, B. & Posada, G. Discriminant validity of the Adult Attachment Interview. *Child Dev*. 1996; 67:2584-99.
- 46) Fonagy, P., Steele, H. & Steele, M. Maternal Representations of Attachment during Pregnancy Predict the Organization of Infant-Mother Attachment at One Year of Age. *Child Dev*. 1991; 62:891-905.
- 47) Kobak, R. R., Cole, H. E., Ferenz- Gillies, R., Fleming, W. & Gamble, W. Attachment and emotion regulation during mother- teen problem solving: A control theory analysis. *Child Dev*. 1993; 64:231-45.
- 48) Paquette, D., Bigras, M. & Parent. S. Validation of the ASQ and the prevalence of the styles of adult attachment in a French-speaking sample in Montreal. *Can J Behav Sci*. 2001; 33:88-96.
- 49) Goodwin, I., Holmes, G., Cochrane, R. & Mason, O. The ability of adult mental health services to meet clients' attachment needs: The development and implementation of the Service Attachment Questionnaire. *Psychol Psychother Theor Res Pract*. 2003; 76:145-61.
- 50) Collins, N. L. Working models of attachment: implications for explanation, emotion and behaviour. *J Pers Soc Psychol*. 1996; 71:810-32.
- 51) Garbarino, J. J. Comparisons of the constructs and psychometric properties of selected measures of adult attachment. *Meas Eval Counsl Dev*. 1998; 31 (1): 28-45.

- 52) Beck, A. T., Steer, R. A. & Brown, G. K. *Manual for Beck Depression Inventory- II*. San Antonio, CA: Psychological Corporation. 1996.
- 53) Derogatis, L. R. & Spencer, P. M. *Administration and procedures: BSI Manual 1*. Baltimore: Clinical Psychometrics Research. 1982.
- 54) Wallace, C. J., Lecomte, T., Wilde, J. & Liberman, R. P. CASIG: A consumer centered assessment for planning individualized treatment and evaluating program outcomes. *Schizophr Res*. 2001; 50:105–19.
- 55) Addington, D., Addington, J. & Maticka-Tyndale, E. Assessing depression in schizophrenia: the Calgary depression scale. *Br J Psychiatry*. 1993; 163 (suppl.22):39-44.
- 56) Magafia, A. B., Goldstein, M. J., Karno, M., Miklowitz, D. J., Jenkins, J. & Falloon, I. R. H. A brief method for assessing expressed emotion in relatives of psychiatric patients. *Psychiatry Res*. 1986; 17:203-12.
- 57) American Psychiatric Association. *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author. 1994.
- 58) Goldberg, D. P. & Williams, P. *A users guide to the General Health Questionnaire: GHQ*. Windsor: NFER-NELSON. 1988.
- 59) Barkham, M., Hardy, G. E., & Startup, M. The IIP-32: a short version of the inventory of interpersonal problems. *Br J Clin Psychol*. 1996; 35:21–35.
- 60) Parker, G., Roussos, J., Hadzi-Pavlovic, D., et al. The development of a refined measure of dysfunctional parenting and assessment of its relevance in patients with affective disorders. *Psychol Med*. 1997; 27:1193-203.
- 61) Kay, S. R., Fiszbein, A. & Opler, L. A. The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophr Bull*. 1987; 13: 261-76.
- 62) Foa, E. B., Cashman, L., Jaycox, L. & Perry, K. The validation of a self-report measure of post-traumatic stress disorder. The Posttraumatic Diagnostic Scale. *Psychol Assess*. 1997; 9:445-51.
- 63) Markham, H. & Notarius, C. Coding marital and family interaction: Current status. In: Jacob, T. *Family interaction and psychopathology: Theories, methods and findings*. New York: Plenum. 1987.

- 64) Haddock, G., McCarron, J., Tarrier, N. & Faragher, E. B. Scales to measure dimensions of hallucinations and delusions: The Psychotic Symptom Rating Scales (PSYRATS). *Psychol Med.* 1999; 29:879-89.
- 65) Lehman, A. F. A quality of life interview for the chronically mentally ill. *Eval Program Plann.* 1988; 11:51-62.
- 66) Fonagy, P., Target, M., Steele, H. & Steele, M. *Reflective-Functioning Manual Version 5.0 for application to Adult Attachment Interviews.* London: University College London. 1998.
- 67) Drayton, M., Birchwood, M. & Trower, P. Early attachment experience and recovery from psychosis. *Br J Clin Psychol.* 1998; 37:269-84.
- 68) Wykes, T. & Sturt, E. The measurement of social behaviour in psychiatric patients: an assessment of the reliability and validity of the SBS schedule. *Br J Psychiatry.* 1986; 148:1-11.
- 69) Tait, L., Birchwood, M. & Trower, P. A new scale (SES) to measure engagement with community mental health services. *J Ment Health.* 2002; 11:191-98.
- 70) McGuire-Snieckus, R., McCabe, R., Catty, J., Hansson, L. & Priebe, S. 'A New Scale to Assess the Therapeutic Relationship in Community Mental Health Care: STAR.' *Psychol Med.* 2007; 37(1):85-95.
- 71) Green, B. L. Trauma History Questionnaire. In Stamm, B. H. *Measurement of stress, self-report trauma and adaptation.* Lutherville: Sidran Press. 1996. p.366-8.
- 72) Horvath, A.O. & Greenberg, L.S. Development and validation of the working alliance inventory. *J Couns Psychol.* 1989; 36:223-33.
- 73) Hermann, H., Hawthorne, G., & Thomas, R. Quality of life assessment in people living with psychosis. *Soc Psychiatry Psychiatr Epidemiol.* 2002; 37:510-18.
- 74) Roisman, G. I., Holland, A., Fortuna, K., Fraley, R. C., Clausell, E. & Clarke, A. The Adult Attachment Interview and self-reports of attachment style: An empirical rapprochement. *J Pers Soc Psychol.* 2007; 92:678-97.

Figure 1: Flowchart of the article selection process

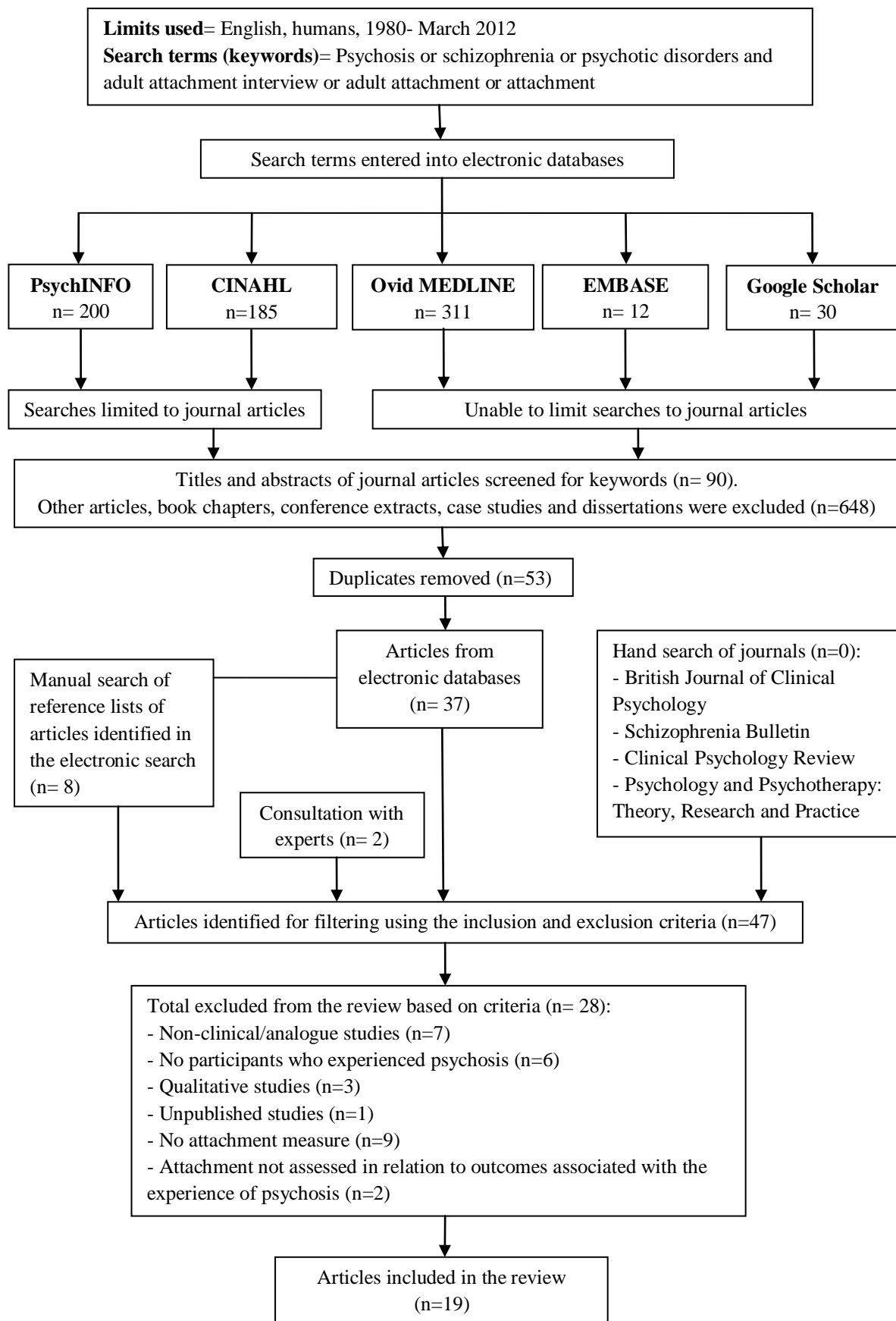


Table 1: Study/ participant characteristics

Reference	Participants					
	No.	Age (years)	Gender	Setting (in/ out)	Medication reported	Classification system (CS) used / Diagnosis
Arbuckle et al. (2011)	24	M 32.4 (SD= 8.7)	15 m/ 9 f	In	No	No CS. Schizophrenia or related psychosis
Berry et al. (2008)	96	M 44 (SD= 12.8)	66 m/ 30 f	Unclear	No	No CS. Schizophrenia, schizoaffective, psychotic episode.
Berry et al. (2009)	80	M 44 (SD= 13.3)	55 m/ 25 f	Both	No	CS used: Schizophrenia, schizoaffective, psychotic episode
Berry et al. (2011)	73	M 39.1 (SD= 11.3)	59 m/ 14 f	Both	No	CS used: Schizophrenia, schizoaffective, psychotic episode
Blackburn et al. (2010)	78	M 39 (SD= 13.8)	62 m/ 16 f	In	No	No CS. Schizophrenia, bipolar, substance misuse, Asperger's Syndrome
Couture et al. (2007)	96	M 23.7 +/- 4.7	63 m/ 33 f	Both	No	No CS. Schizophrenia spectrum diagnosis
Dozier (1990)	42	M 35 (21- 60)	No data	Both	No	CS used: Schizophrenia, manic depressive illness, major depression, atypical psychosis
Dozier et al. (1994) Dozier & Lee (1995)	76	For n= 27 M 35 (23- 48)	45 m/ 31 f	Unclear	No	CS used: Paranoid schizophrenia, undifferentiated schizophrenia, bipolar, panic disorder, conversion disorder
Dozier et al. (2001)	34	M 34 (21- 46)	24 m/ 10 f	Unclear	No	CS used: Schizophrenia, bipolar
Dozier et al. (1991)	40	M 34 (21- 51)	27 m/ 13 f	Unclear	No	CS used: Paranoid schizophrenia, undifferentiated schizophrenia, manic-depressive disorder, depression.
Kvrgic et al. (2011)	127	M 44 (SD= 11.5)	84 m/ 43 f	Out	Yes	CS used: Schizophrenia, schizoaffective disorder
MacBeth et al. (2010)	34	M 23.32 (SD= 7.6)	20 m/ 14 f	Out	Yes	CS used: Schizophrenia, bipolar, mania/ recurrent depression with psychotic symptoms, schizophreniform, persistent delusional, schizoaffective.
Mulligan & Lavender (2010)	73	Males:M 39 (SD= 10.49) Female: M 48.63 (SD=14.5)	55 m/ 18 f	Out	No	No CS. Symptoms associated with psychosis
Picken et al. (2010)	110	Md 38 (18- 61)	99 m/ 11 f	Unclear	No	No CS. Schizophrenia, schizoaffective, schizophreniform, psychosis NOS
Ponizovsky et al. (2007)	30	M 38.4 (SD= 10.2)	30 m	In	Yes	CS used: Schizophrenia
Ponizovsky et al. (2011)	100	M 40.3 (SD= 11.2)	70 m/ 30 f	Out	No	CS used: Schizophrenia, paranoid type schizophrenia
Tait et al. (2004)	50	M 33.8 (SD= 12.0)	31 m/ 19 f	Unclear	No	CS used: Schizophrenia and related disorders
Tyrrell et al. (1999)	54	M 41 (25-62)	22 m/ 32 f	Out	No	CS used: Schizophrenia, schizoaffective, bipolar, depression
Totals:	1,217	M 36.8 (15- 71)	827 m/ 349 f	In- 3 Out- 5 Both- 4 Unclear -6	Yes - 3 No - 15	12 studies used a classification system 1 homogenous sample 21 different diagnoses

Table 2: Outcome measures, references and abbreviations

Measure used	Reference and No.	Abbreviation
Beck Depression Inventory/ Version 2	Beck et al. (1997) [52]	BDI/ BDI-II
Brief Symptom Inventory	Derogatis et al. (1982) [53]	BSI
Client Assessment of Strengths Interests and Goals	Wallace et al. [54]	CASIG
Calgary Depression Scale for Schizophrenia	Addington et al. [55]	CDSS
Clinician ratings	Dozier (1990) [36]	Clinician ratings
Five Minute Speech Sample	Magafia et al. [56]	FMSS
Global Assessment of Functioning Scale	APA (1994) [57]	GAF
General Health Questionnaire	Goldberg et al. (1988) [58]	GHQ
Inventory of Interpersonal Problems- 32	Barkham et al (1996) [59]	IIP- 32
Illness related experiences	Berry et al. (2009) [34]	Illness exp
Illness related variables	Blackburn et al. (2010) [25]	illness variables
Intervention interview	Dozier et al. (1994) [37]	Intervent Interview
Parental Bonding Instrument	Parker et al. (1997) [60]	PBI
Positive And Negative Symptom Scale	Kay et al. 1987 [61]	PANSS
Posttraumatic Stress Diagnostic Scale	Foa et al. (1997) [62]	PDS
Problem solving task	Kobak et al. (1993) [47], Markham et al. (1987) [63]	PS task
Psychotic Symptom Rating Scales	Haddock et al. (1999) [64]	PSYRATS
Quality of Life Interview	Lehman (1988) [65], Dozier & Lee (1995) [38]	QoL interview
Reflective Function	Fonagy et al. (1988) [66]	RF
Recovery Style Questionnaire	Drayton et al. (1998) [67]	RSQ
Social Behaviour Scale	Wykes & Sturt (1986) [68]	SBS
Service Engagement Scale	Tait et al. (2002) [69]	SES
Scale to Assess the Therapeutic Relationship	McGuire-Snieckus et al. (2007) [70]	STAR
Subjective rating	Dozier et al. (2001) [39]	Subjective rating
Trauma History Questionnaire	Green (1996) [71]	THQ
Working Alliance Inventory	Horvath & Greenberg (1989) [72]	WAI
World Health Organisation Quality of Life- Brief Version	Hermann et al. (2002) [73]	WHOQOL-BREF

Table 3: Articles investigating attachment and outcomes in psychosis

Reference	Attachment Measure	Attachment classification / strategies identified	Related outcome measures	Key results
Arbuckle et al. (2011)	PAM	Anxiety, avoidance	PSYRATS CDSS	Attachment avoidance correlated with auditory hallucinations. Self-reported attachment avoidance of team was associated with delusions. Association between depression & avoidance.
Berry et al. (2008)	PAM	Anxiety, avoidance	IIP-32, SBS, WAI PANSS	Interpersonal problems related to attachment. Attachment anxiety related to attention seeking, & avoidance related to hostility. Attachment avoidance related to therapeutic alliance problems. Total symptoms correlated with anxiety & avoidance. Avoidance related to positive & negative symptoms & paranoia.
Berry et al. (2009)	PAM	Anxiety, avoidance	PANSS, CDSS, PBI, THQ, illness exp	Associations between attachment anxiety & parental over-protection, & attachment avoidance & parental care. Higher attachment anxiety in childhood trauma with significant others. Depression associated with greater attachment anxiety. Attachment was not associated with number of hospital admissions or length of illness.
Berry et al. (2011)	PAM	Anxiety, avoidance	PSYRATS PANSS	Attachment avoidance related to critical, rejecting & threatening voices. Attachment anxiety related to voice severity & distress.
Kvrgic et al. (2011)	PAM	Anxiety, avoidance	PANSS, CDSS, BDI-II, SES, STAR	Attachment anxiety related to treatment adherence & positive clinician input. Attachment avoidance related to non-supportive clinician input. Attachment avoidance related to positive symptoms. Depression associated with anxiety & avoidance
Picken et al. (2010)	PAM	Anxiety, avoidance	PDS	Attachment anxiety associated with no. traumatic events, interpersonal trauma and severity of post traumatic symptoms.
Blackburn et al. (2010)	PAM SAQ	Anxiety, avoidance, security	PSYRATS CDSS, illness variables	Associations between attachment to services & security. No. of hospital admissions negatively correlated with attachment to services. Lower attachment to services in those under section. Security to services associated with lower depression. Attachment to service not associated to psychiatric symptoms.
Tyrrell et al. (1999)	AAI Q-sort	Deactivating, hyper-activating, autonomous, non-autonomous	GAF BDI QoL interview WAI	Deactivating clients reported greater general life satisfaction than clients rated as less deactivating. Deactivating clients reported more life satisfaction working with less deactivating case managers. Less deactivating case managers formed stronger alliances with more deactivating clients. No significant effects between hospitalisation and attachment were evident. No association between attachment security & depression.
Dozier (1990)	AAI Q-sort	Security, anxiety, avoidant, preoccupied	Clinician ratings	Compliance was associated with attachment security. Attachment avoidance was associated with reduced likelihood to seek help and poor use of treatment. Attachment preoccupation was associated with more self-disclosure.
Dozier et al. (1994)	AAI Q-sort	Secure, insecure, hyper-activating, deactivating.	Interven interview	Those relying on preoccupied strategies were perceived as having greater dependency needs than those relying on dismissing strategies. Case manager security also accounted for variance in perceived dependency needs. Gender and diagnostic category did not appear to influence attachment or perceived dependency.
Dozier & Lee (1995)	AAI Q-sort	Secure, insecure, hyper-activating, deactivating.	BSI, QoL interview, Clinician rating	Insecure attachment & deactivating strategies rated as more symptomatic. Secure attachment rated as having fewer delusions & deactivating strategies as looser in thinking. Secure rated as less delusional, less likely to hear voices & less suspicious. Dismissing rated as more delusional, likely to hear voices & suspicious. Those able to evaluate attachment & use hyper-activating strategies

				rated as less psychotic.
Dozier et al. (2001)	AAI Q-sort	Security, insecurity, hyper-activation, deactivation	PS task Subjective rating,	Avoidant attachment were off task significantly more than others, were more rejecting of their significant others and were more confused following interactions with case managers. Their significant others also felt less supported and saddened after tasks.
Dozier et al. (1991)	AAI Q-sort	Security, anxiety, repression, preoccupation	FMSS, BSI	Insecure attachment was not associated with familial EE. Over-involved families associated with higher levels of repression & preoccupation. Sample was less secure and more repressing than other samples. Those with a schizophrenia diagnosis were more repressing than affective disorders. Those with repressing strategies reported fewer psychiatric symptoms.
MacBeth et al. (2010)	AAI	Secure, insecure, autonomous, dismissing, unresolved preoccupied,	RF, SES, PANSS, WHOQOL-BREF	Secure attachment displayed significantly higher reflective function than individuals with avoidant attachment. Preoccupied attachment had significantly higher RF than individuals with avoidant attachment. Association between attachment & engagement with service. Secure attachment associated with better engagement than avoidant attachment but there was no difference between secure and preoccupied attachment. No differences between attachment classification & positive or negative symptoms. No differences between attachment & quality of life.
Couture et al. (2007)	ASQ	Autonomous, avoidant, preoccupied, ambivalent	CASIG	Avoidance & preoccupied attachment associated with lower quality of life. Discomfort with closeness, need for approval & preoccupation with relationships associated with lower quality of life. Confidence in relationships associated with greater quality of life.
Mulligan & Lavender (2010)	ASQ	Secure, insecure	PBI RSQ	Association between high maternal care and secure attachment. Maternal care associated with discomfort with closeness, need for approval & preoccupation with relationships. A negative association between paternal care & discomfort with closeness. Maternal overprotection associated with greater need for approval & preoccupation. Paternal overprotection associated with discomfort with closeness. Recovery style related to the relationships as secondary to achievement scale
Ponizovsky et al. (2007)	AAQ	Secure, avoidant, anxious/ ambivalent	PANSS	Avoidant or anxious/ ambivalent attachment had greater severity of positive symptoms. Less positive symptoms related to secure attachment. Avoidant attachment had more severe negative symptoms.
Ponizovsky et al. (2011)	RQ	Secure, fearful-avoidant, preoccupied, dismissing-avoidant	PANSS, GHQ	Delusion severity was predicted by preoccupied & fearful avoidant attachment. Persecution/ suspiciousness were predicted by preoccupied & fearful avoidant attachment. Hallucinations were significantly predicted by fearful avoidant attachment.
Tait et al. (2004)	RAAS	Close, depend, anxiety, secure	PBI SES RSQ, PANSS,	Associations between parental care & dependence, & closeness in relationships. Parental abuse inversely related to dependence & closeness. Rejection anxiety correlated with parental abuse & lack of care. Insecure attachment was associated with likelihood to disengage & related to avoidant coping style. Sealing over associated with more anxiety about interpersonal rejection & lower comfort with closeness & dependence. Attachment anxiety related to positive symptoms.
19 Articles	7 attachment measures	17 types of attachment classification / strategies	27 outcome measures	

CHAPTER 2

MAJOR RESEARCH PROJECT

Parents and young people in transition after first episode psychosis

Hannah E. F. Taylor*

July 2012

Mental Health and Wellbeing
Institute of Health and Wellbeing
University of Glasgow
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH
+44 141 211 0607 (tel)
+44 141 357 4899 (fax)
Hannahtaylor1984@hotmail.co.uk

* Author for correspondence

Submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology (D.Clin.Psy.)

Prepared according to submission guidelines for Psychosis: Psychological, Social and Integrative Approaches (Appendix 2.1)

Lay Summary

Relationships can be an important source of support when experiencing a stressful life event. This is especially true when someone experiences a first episode of psychosis (FEP: hearing voices, having frightening or unusual beliefs). One important source of support is the person's relationship with their parent(s). This study explored how relationships influenced recovery following FEP and how these relationships changed in the context of FEP. The experiences of five parents and five young people were explored using interviews. The data from these interviews were transcribed, anonymised and analysed using a research method called Grounded Theory. Grounded Theory allows researchers to construct a careful line-by-line analysis of each transcript, develop themes from transcripts, and compare these themes across transcripts for larger categories. This analysis enables the researcher to develop new theory and understandings that are closely related to individuals' lived experiences. We constructed five important categories which included the importance of formative (early life) experiences and how these influenced the relationship; the importance of young peoples' independence and the impact of psychosis on independence; the importance of the parent as a safe haven during psychosis; the importance of the parental relationship as a secure base for recovery and the way in which parents experienced emotional distress. These insights enabled us to develop an understanding of the central importance of the parental relationship as source of recovery and resilience in FEP and the needs of parents after FEP.

Abstract

Background: A first episode of psychosis (FEP) is a significant life event for both a young person and their parent. This life event highlights a period of transition which is negotiated within the young person-parent relationship. The way in which the dyad reacts to and copes with the experience is important throughout the episode of FEP. **Aims:** This study aimed at describing how young people and their parents understand their experiences of FEP, and analysing how their relationships influenced recovery, and how psychosis and recovery affected the relationship itself. **Method:** A sample of ten participants, five young people who experienced psychosis and five parents were recruited. Data were collected using individual grounded theory interviews. Narratives were analysed using Grounded Theory. **Results:** A theory of recovery in the context of a parent-young person relationship was developed encompassing five core categories which were constructed through common pathways in which stories of recovery were told. These included formative experiences, independence, safe haven, secure base and parental distress. These categories were reflected across and within the relationships of parents and young people. **Conclusions:** This study provides an understanding of the process of recovery from the context of a parent and young person relationship. Therefore, offers a basis to explore further both relational and systemic factors important in the recovery from psychosis.

Keywords

Psychosis, Grounded Theory, Attachment, Psychological Resilience, Recovery

Introduction

Attachment

Attachment theory offers a developmental model of psychological functioning and emotion regulation (Bowlby, 1969, 1973, 1980). Attachment emerges in the context of a relationship with a primary caregiver who acts as a secure base promoting safety, security, autonomy and exploration. Infant behaviour and the caregiving system increases proximity to the secure base when threatened or ill (Cassidy & Shaver, 2008). The caregiving system is shaped by the primary caregiver's prior attachment experiences of attuned, responsive and sensitive caregivers (Mikulincer & Shaver, 2010). The quality of attachment dyads are operationalised through patterns of infant behaviour, namely secure, insecure-avoidant, insecure-ambivalent and disorganised (Ainsworth, Blehar, Waters & Wall, 1978; Main & Solomon, 1990). Through repetition of early interactions internal working models develop which include mental representations of parent, self as caregiver, child, and the parent-child relationship (Mikulincer & Shaver, 2010). Internal working models form developmental narratives of experience guiding behaviour, attention, and expectations about others (Cassidy & Shaver, 2008). In adulthood behavioural patterns are reflected in narrative organisation observed in the Adult Attachment Interview (AAI) with secure/ autonomous, insecure dismissing, insecure preoccupied and unresolved attachment states of mind which often follow the classification of infant attachment (George, Kaplan & Main, 1996).

Negative interpersonal experiences during childhood and adolescence reduce the opportunity to develop the capacity to mentalise. Mentalisation develops when the primary caregiver helps the infant convert a physical experience into a conscious thought or feeling through mirroring their emotion. This process requires the caregiver to be attuned to the infant to promote reflexivity. Mentalisation enhances resilience and positive adjustment as it creates the capacity to pause and understand behaviour in relation to the mental states of both the self and others (Fonagy, Gergely, Jurist & Target, 2002). Although attachment classifications are relatively stable from infancy to adulthood, negative life events may precipitate the revision of attachment working models and subsequent classification (Weinfield, Whaley & Egeland, 2004). Bowlby (1980) described the greatest threats to

the attachment bond are events that threaten its security, such as extended separation, illness, loss, trauma and neglect.

Systemic attachment strategies

Dallos and Vetere (2009) described how the attachment process can be understood within the systemic context of interpersonal relationships within the family. Core relationship dynamics are shaped by expectations and behaviour from parents' internal working models developed from their attachment history and past relationships (Mikulincer & Shaver, 2010). Therefore, the family develops a system of interactions that drive expectations, beliefs and experiences of safety and trust in relationships which creates a shared emotional and cognitive style (e.g., dismissing emotion and emphasising cognition). Attachment narratives hold these aspects of our relationship experiences, in addition, to self-protective strategies and defences. These narratives fueled by core attachment processes are generalised to relationships outside the family. Consequently, a connection develops between systemic transgenerational models of attachment and internal emotional processes.

Key transitions over individual and family life cycles, such as significant life events, lead to internal and external demands for change through a process of reorganisation and adaptation within the individual and family. This process can challenge the security in relationships which impacts on emotion (Dallos, 2006). Reorganisation is shaped by biological, maturational, relational and cultural factors which depict what is normal and acceptable. Families develop solutions to try and enable change through attachment strategies. However, sometimes change is delayed as it is too threatening to the relationship security or overwhelming for the family's resources to cope and manage. This delay undoubtedly has an emotional and relational impact leading to the potential of more defended strategies being utilised. Family patterns are therefore maintained through attachment fears and anxieties.

In addition, life transitions and stressors (e.g., negative events, chronic strains and traumas) have a damaging impact on physical and mental health (Thoits, 2010); however, the impact can be reduced by many factors including high levels of social support. Therefore, life transitions may increase an individual's vulnerability to experiencing mental or physical health problems, and the reorganisation,

adaptation and support from their family could be protect against or exacerbate the impact of those experiences.

First episode psychosis (FEP)

Psychosis is a significant and traumatic life event which may confirm insecure attachment representations or rupture secure attachment representations (Gumley & Schwannauer, 2006). Due to the distressing experience of psychosis it can threaten to overwhelm the self therefore, attachment strategies are activated by the individual or caregiver in an attempt to restore wellbeing. Attachment strategies elicit responses from others, thereby affecting the interpersonal environment (Dozier, Lomax, Tyrell, & Lee, 2001).

Particular family interactions such as Expressed Emotion (EE: Brown & Rutter, 1966) characterised by emotional over-involvement (EOI), criticism and hostility are associated with functioning and relapse in FEP (Barrowclough & Hooley, 2003). According to Bowlby (1969), criticism functions as an adaptive mechanism to coerce and discourage a family member from problem behaviour or it may act as a defence against the symbolic losses associated with FEP (e.g., loss of a healthy child, loss of expectations). Criticism may therefore reflect the angry and rejecting responses associated with the mourning process (Gumley & Schwannauer, 2006). In addition, criticism may act as a defence by excluding information processing or rejecting mental processes consistent with the reality of loss, which mitigates the painfulness of mourning (Patterson, Birchwood & Cochrane, 2005).

Dozier et al. (2001) suggested that the use of insecure attachment strategies can also elicit EE responses from caregivers. Therefore, conflicts may arise when the young person and caregiver experience different attachment states of mind. For example, an adolescent may be striving to achieve autonomy and individuation (De Goede, Branje & Meeus, 2009), but an episode of FEP may activate the parent's attachment system to maintain proximity. The young person may feel frustrated because this parental response threatens their development, and therefore, reject care which leaves the parent feeling anxious and in despair. Consequently, FEP may threaten the relationship and the family's resources to cope leading to an increase in defended strategies which may in turn fuel unhelpful

interactions (Dallos & Vetere, 2009). In contrast, a parent who is not sensitive or attuned may fail to notice the young person's attempts to elicit their care. A theory has been developed to understand why psychosis emerges in late adolescence (Harrop & Trower, 2001). This theory states that although there are similarities between common adolescent phenomena and many experiences of psychosis, problems may arise in defining a self that is autonomous from a parent's. Alternatively, the difficulties may primarily have developed from not being able to bond to peers.

The developmental stage of emerging adulthood has also been associated with experiences of mental health (Arnett, 2007). Around this time individuals have fewer social roles and obligations, and parental and institutional services no longer provide structure for the individual (Arnett, 2000). Therefore, some may struggle with the increased freedom and exploration, but also find it difficult to seek proximity to their parent because of their increased autonomy and individuation. Overall, the processes of normal development may create difficulties within dyads and impact upon attachment strategies, which could be exacerbated by a first episode of psychosis (Allen, McElhaney, Kuperminc & Jodl, 2004).

Recovery

Attachment has been emphasised in perspectives on recovery narrative after psychosis (MacBeth, Gumley, Schwannauer & Fisher, 2010). Firstly, attachment narratives offer information regarding an individual's attachment security. For example, the ability to provide coherent personal narratives about positive and negative experiences is proposed to reflect the individual's capacity for cognitive and emotional regulation, especially when faced with negative events (Gumley, Schwannauer, MacBeth & Read, 2008). Therefore, the ability to construct coherent narratives is a feature of psychological resilience associated with secure attachment representations. Secondly, research has shown that individuals' with secure attachment representations measured by the AAI (George et al. 1996), had better engagement with clinical services, and were perceived by key-workers to be better engaged with the treatment process (MacBeth et al. 2010). Therefore, secure attachment may aid individuals to seek help and accept treatment. Individuals with insecure attachment representations may find engaging with clinicians overwhelming or threatening therefore

may not seek help and show poor use of treatment (Dozier, 1990). Narratives of recovery from psychosis could provide valuable information regarding processes of interpersonal and affective recovery.

Previous qualitative research with service users highlighted the importance of family relationships in recovery. Windell and Norman (2012) reported that social support, including family relationships, was one of the most important factors in recovery and appeared to buffer the negative impact of stigma by fostering hope and perceived social worth. Furthermore, parents' had a critical role in help seeking and treatment engagement. Anderson, Fuhrer and Malla (2012) also demonstrated the crucial role of significant others in initiating the help seeking process and that parents' often resumed care-giving tasks that were previously relinquished. Therefore, interpersonal relationships with family members support the findings that recovery involves relational factors, and family members are helpful in facilitating the recovery process (Eisenstadt, Monteiro, Diniz & Chaves, 2012).

In addition, qualitative research with family members highlighted some of the important roles of noticing behavioural changes and help seeking at the onset of psychosis (Corcoran, Gerson, Sills-Shahar, Nickou, McGlashan, Malaspina & Davidson, 2007). Parents' also reported maintaining contacts with services, engaging in various caring roles and helping service users to seek out activities to motivate them and keep them connected to the community (Sin, Moone & Wellman, 2005).

A descriptive review of qualitative studies in FEP (Boydell, Stasiulis, Volpe & Gladstone, 2010) reported that eliciting the subjective experiences of others who play important roles in the life of a person with psychosis are critical in furthering our understanding of FEP. Particularly as many service users continue to experience problems with familial relationships. Boydell et al. (2010) also stated that few studies reported a detailed theoretical framework which is critical to address in future research. It was noted that exploring the subjective experience of psychosis and meaning of experiences may lead to more sensitive and person-centred interventions. Research with families and service users may encourage services to become more inclusive of families and recognise their important role in the recovery process. Grounded theory methodology may be helpful in providing a theoretical framework to understand the relational processes throughout a FEP.

Overall attachment provides a framework to understand the intrapersonal and interpersonal factors that mediate the experiences of FEP and recovery for the young person and their parent. In addition, it demonstrates the dynamic process of relational transition that a dyad negotiates during FEP and during normal developmental stages. The direction of causality between psychosis and attachment is unclear, therefore, more detailed investigation into coping and recovery in the context of a parent and young person relationship is required.

Narratives

Narratives shape how we think about our past and future, and attachment narratives focus on stories we develop regarding connections to others (Dallos & Vetere, 2009). In exploring attachment narratives relating to significant life events we can gain insight into how dyads process difficult events and assign meaning to these experiences. Emotional processes immerse narratives and guide how experiences are comprehended and organised in the ‘meaning making’ process. This process relates to the way early relationships and attachment experiences in differing socio-cultural contexts initially shape how narratives develop from our representations of self, others and the world. More specifically inter-subjectivity occurs whereby personal internal experiences are embedded and interwoven into a sense of being part of another’s experience and social world (Dallos & Vetere, 2009). In addition, how lived experience, such as psychosis, influences meaning making and inter-subjectivity through affective, cognitive and interpersonal processes. Overall, this process is important when developing an understanding about how individuals’ and families integrate the meaning of psychosis, adaptation and recovery into their internal and social worlds, and the illustration of this experience offered through the narrative of their stories (Lysaker, Ringer, Maxwell, McGuire & Lecomte, 2010). Therefore, a pathway of communication develops so that others can imagine and co-construct what psychosis means for parents and young people. Previous research highlighted how qualitative research methods (e.g., interviews) are helpful in collating narratives of service users and parents subjective experiences of FEP (Eisenstadt et al. 2012; Sin et al. 2005; Anderson et al. 2012).

Aims

We constructed an interview which stimulated talk about relationships to encourage reflections on parent and young person constructions of their relationship before psychosis, during psychosis and after psychosis. In stimulating a narrative around these relationships over time we designed the interview to permit an understanding of recovery to emerge naturally from the discourse, therefore, we did not seek to force it from preconceptions. The importance of relationships in the development of individual and mutual understandings, and in the construction and sharing of meaning was recognised. As a result, the co-construction of narrative was regarded as an important context to understand recovery. The attachment context was used as the point of departure in this study, to explore the importance of the relationship between a parent and young person, and how they assign meaning to their experiences of FEP as shown through emerging discourses. Recovery was therefore permitted to emerge from the discourse and was not imposed as a preconceived construct in the interview. Hence, this study aimed at developing a theoretical understanding grounded in the experiences of how relationships were influenced and adapted during FEP, and how the relationships influenced recovery.

Method

Qualitative research methods

Qualitative research methods provide in-depth, comprehensive descriptions and interpretations of investigated experiences. The complexities of participants' relational experiences throughout psychosis are likely to be multifaceted. The use of quantitative approaches (e.g., measures or questionnaires) could restrict and limit the data gathered. Therefore, the complexity of participants' narratives and experiences as described above may not be captured using quantitative methods. Qualitative methods allow the researcher to establish valuable insight through the exploration of inner experiences and formation of meanings to understand phenomena in FEP.

Previous qualitative methodologies have been used to explore service user and parental experiences of onset, recovery and adaptation to psychosis. These include grounded theory and interpretative phenomenological analysis (IPA). IPA usually uses a small sample and focuses on understanding the meanings people attach to their experiences to develop an interpretive account of key themes (Smith, Larkin & Flowers, 2009). Grounded theory provides an insight into experiences and offers an interpretative account which extends existing findings through developing a theoretical understanding of phenomena. Thus, it integrates themes into the existing knowledge base which moves on from simply describing the themes. Key themes and a theoretical understanding of psychosis, recovery and adaptation have been developed for young people and parents; however, dyads have not been analysed using grounded theory methodologies. A recent review stated that few studies reported a detailed theoretical framework which is developed in grounded theory (Boydell et al. 2010). Therefore, in this study grounded theory was the preferred approach to explore relational experiences of dyads during FEP for those reasons.

In addition, the focus on the development of theory grounded in participants' narratives forms a theoretical model that can be tested and adapted in future research. Therefore, it links to wider literature which adds to the broader understanding of phenomena and overcomes difficulties associated with generalisability. Grounded theory emphasises the importance of context in understanding experiences (Charmaz, 2006). This study focuses on relationships which can be considered as part of an individual's context when understanding experiences in psychosis. Research into the subjective experiences of others in the life of the service user who has experienced FEP was also recommended in a recent review (Boydell et al. 2010). Finally, as the researcher had no experience using qualitative research methods, grounded theory appeared suitable because it provided guidelines for data analysis (Charmaz, 2006).

Interviews were used because the research aimed to try to understand relational experiences from the participants' points of view and to uncover the meaning of their experiences. Interviews elicit perspectives from the participant's internal subjective world and allow the participant to convey to others a situation from their own perception, in their own words. The interviews were designed to discuss relationships before, during and after FEP, and facilitate reflection and exploration of their

relationship over time and the meanings of these experiences. In stimulating narrative over time the interview allowed the emergence and understanding of recovery to naturally transpire.

Whilst the initial questions were taken from the AAI (George et al. 1996), they were not applied as a structured interview. Instead, the questions were used in a flexible, broad, unrestricted and open-ended way, to invite discussions and reflections around relationships throughout FEP. The attachment context was a point of departure to explore relationships prior to FEP. The questions were not rigidly followed but loosely guided exploration, following the structure of a grounded theory interview (Charmaz, 2006). By using the AAI (George et al. 1996) in an open ended flexible way it encouraged unanticipated narratives to emerge about relationships. Probe examples were inserted into the interview schedule, but not all probes were used. Instead probes were used more flexibly to invite further reflection if required, to help the participant articulate their intentions and meanings. Therefore, the interview moved on from ordinary conversations to examine events, views and feelings of the participant to gain a further understanding (Charmaz, 2006). This emergent technique applied in the interviews allowed the researcher to immediately explore ideas and expressions to learn what was happening and pursue themes. Furthermore, grounded theory interviewing allowed the topics of the interview to narrow in order to gather specific data for developing the theoretical framework.

The process of sharing narratives may help people feel listened to and have a therapeutic benefit from exploring issues, validating difficult aspects and making sense of events. This is particularly pertinent due to the stigma often experienced in mental health by service users and families (Sartorius, 2007), and carers' feeling undervalued by services (Sin et al. 2005). Finally, all of the participants reported that the interview was useful to explore and reflect on their experiences. Overall, there was a clear rationale for using qualitative methods, interviews and grounded theory to explore relational experiences in FEP.

Constructivist grounded theory

This study used Charmaz's (2006) Grounded Theory methodology to provide a theoretical understanding of relational experiences during FEP. This analysis was chosen to develop theory from the data rather than to test hypotheses from existing research by placing assumptions on the data

(Charmaz, 2006). Grounded Theory seeks to show the quality of human experience through adaptable principles that guide the research process. This method allows us to learn and understand experiences through the development of theories. It acknowledges how the developing theory is an interpretation influenced by the researcher, participant and shared relationship where meanings and actions are construed within the social context of the research. For this reason, a constructivist grounded theory approach was used.

The researcher was required to review the literature prior to data collection for the purpose of obtaining ethical approval for the study and identify gaps in the existing knowledge base. This was viewed as sensitizing the researcher to areas of inquiry and ideas to explore as 'points of departure' in questions (McGhee, Marland & Atkinson, 2007). Therefore, sensitizing can be used for developing, rather than limiting, our ideas (Charmaz, 2006). In the current study the literature review provided the researcher with an awareness of how narratives emerge from the interpersonal and developmental context which directly influenced the approach to recruitment, interview schedule and analysis of dyads. However, the researcher held at a critical distance during the analysis from the initial literature search so that the so that a focus was generated from the emerging data, not from the literature review (McGhee, et al. 2007).

Ethical Approval

Ethical approval was granted by the NHS Greater Glasgow and Clyde (NHSGG&C) Research Ethics Committee (reference: 11/WS/0065, Appendix 2.2) and followed by management approval from NHSGG&C Research and Development Directorate (reference: GN11CP290, Appendix 2.3).

Recruitment

Young people recovering from FEP were recruited from ESTEEM first episode psychosis service in South Glasgow. All of the young people had experienced an affective or non-affective psychosis (International Classification of Diseases-10th Revision; WHO, 1992) within the last two years. The diagnosis was provided by a psychiatrist, and confirmed through their case notes. The parent was recruited based on the informed consent provided by the young person.

Research Procedure

The young person was approached by their key-worker and provided with an information sheet (Appendix 2.4). If they were interested they contacted the researcher (HT) by calling, returning the response sheet or contacting their key-worker. The researcher then approached the young person to discuss the study and gain consent to contact their parent. The parent was then contacted by the researcher and provided with an information sheet. Before consent to participate was obtained, all participants had the opportunity to ask questions and right to withdraw was made clear throughout (Appendices 2.5, 2.6 & 2.7; consent forms). Each participant's GP, psychiatrist and key worker was informed of their participation in writing.

Reflectivity

Reflexivity is key throughout the process as grounded theory involves interaction between the researcher and the world which is studied (Cutcliffe, 2000). As a result grounded theories are constructed through our wider interactions with people, perspectives and research practices from both present and past (Charmaz, 2006). Therefore, theories offer a construct of reality through an interpretive representation influenced by various factors, not an exact depiction. Reflexivity involves examining one's previous knowledge, values and role as a researcher on the research process. This allows the researcher to stand back from the research process, and bring awareness to sources of potential bias. Therefore, reflexivity protects the data collection, analysis and interpretations from biases. Memo-writing, a reflective log and supervision helps to make researchers aware of their own potential effects on the data (McGhee, et al. 2007).

In this study, it is important to note that the researcher was a 28-year-old, unmarried, white, British woman without any children. She was a third year trainee clinical psychologist. She did not have any personal experiences of psychosis, but she worked therapeutically with five individuals with psychosis as a trainee clinical psychologist. The complexity of psychosis and conceptualising cases using psychological approaches increased her understanding, and confidence when working in this

area. Furthermore, she became aware of the importance of the young people system in providing support after undertaking an audit into carers' needs in a CMHT. This motivated her to think about relationships and how they could be helpful when recovering from psychosis. The researcher was aware that her experience could impact upon the research, but it was felt that it enhanced the research process and facilitated elements of the data analysis. See Appendix 2.10 for an extract from the researcher's reflective log.

The interview schedule

In line with grounded theory methodology interviews were carried out and audio-recorded (Sony ICD-UX200 Digital Voice Recorder) for later transcription. The interviews were conducted by the first author (H.T) and lasted 60 (+/- 15) minutes. Interview length was flexible depending on the participant response.

The interviews took place separately due to various methodological and ethical considerations (Taylor & de Vocht, 2011). Separate interviews allow participants' to reflect on and express their individual views without being influenced by another person's discourse. Therefore, recognising that people's views are not identical to another's and individual interviews may capture unique perspectives. It may be difficult to discuss unhelpful or negative aspects of their relationship during joint interviews. In addition, it may be emotionally distressing for individual's to hear first accounts of the impact of psychosis on their parent/child and relationship. Finally, individual interviews reduce the possibility of conflicts, unwanted disclosures that violate another's privacy, power imbalances or feelings of vulnerability. The researcher was aware of the potential for individual's to become anxious about what was discussed during separate interviews, therefore, confidentiality was maintained throughout and made clear to the participants.

The interview schedule was developed with a Clinical Psychologist (AG) with expertise in qualitative research methods and psychosis (Appendix 2.8; interview schedules). The interview had three sections referring to different stages within the person's life experiences and relationships. Initially, the section titled 'Early Relationships' was guided by the AAI (George et al, 1996). The questions aimed at stimulating narrative around relational experiences prior to FEP by asking for

descriptions of their relationship, memories of their parent or son/daughter and examples of experiences. The interview then departed from the AAI and focused on the 'Relationship during FEP' with their parent or son/daughter. This interview section included how the relationship changed and helpful or difficult aspects of the relationship. The final section titled 'Relationship after FEP' discussed the here and now, and recovery. The ending focused on hopes for their relationship to enable participants' to look towards the future instead of past experiences.

All interview sections were explored using open questions in a flexible manner intended to initiate discussion and reflection. Probe questions were used to gain an understanding of specific experiences. Prompts, reflecting back and summarising was used to encourage further reflection, and clarify and confirm understanding. A shared language to understand experiences was developed through expansion, clarification and contextualisation of events. Where possible, the participant's language was used and the interviewer was careful not to introduce new ideas or influence the meaning portrayed by participants. The interviewer remained collaborative and listened empathically at all times. Support following the interview was not required for any participant.

Memos were taken about non-verbal behaviour, emotional responses and emergent ideas, and completed as ongoing reflection regarding the research process. The interviews were transcribed verbatim following guidelines from the AAI (George et al. 1996). Frequent research and field supervision with qualified clinical psychologists occurred during the research process. This allowed time to discuss and reflect on the interviews and analysis with others experienced in clinical practice and research. Following grounded theory principles, during supervision the interview schedule was reviewed alongside emerging data. The interview schedule was not changed; however, the process was changed so questions were used to open discussion and not rigidly followed. In addition, less emphasis was placed on discussing specific childhood experiences.

Analysis

The transcripts of dyads were analysed separately and as part of a dyad. Therefore, individual and collective perspectives could be developed from the data, as perspectives may have differed or corresponded. Charmaz's (2006) Grounded Theory methodology was used to complete the data analysis (see Figure 1).

Insert Figure 1 here

Coding

Data were initially constructed through narratives, observations and memos from interviews and the transcription process. Line by line coding was completed by capturing the meaning in fewer words and staying close to the participant's language (see Appendix 2.9). This method allowed the researcher to become familiar with the data and notice emerging or frequent themes which were recorded in memos. Care was taken not to impose pre-conceived ideas on the data.

Focused coding followed which required summarising codes into further themes and using the most frequent codes to categorise the data. Codes from each narrative were not analysed in isolation because they were part of a dyad. Therefore, for each theme, linkages, commonalities and differences between and across dyads were explored through constant comparative analysis. Both shared and distinctive themes surfaced. Shared themes linked and followed on between narratives of dyads, and distinctive themes highlighted lack of agreement between narratives of dyads. Constant comparative analysis was completed for dyads and groups of young people and parents. This analysis resulted in convergent (e.g., being there) and divergent (e.g., family relationships) categories. Further memo-writing and reflexivity assisted the researcher to think about the data in different ways and discover new ideas to provide a level of abstraction from the data. The approach of simultaneous data collection and analysis was taken in order to shape data collection and future sampling, and inform the emerging analysis, known as theoretical sampling (Charmaz, 2006).

Theoretical coding was carried out to specify possible relationships between categories derived from focused coding. Sorting and ordering common themes and memos, and developing

diagrammatical maps to organise, compare and synthesise themes and categories was completed. Thus, core theoretical categories were built into abstract conceptual models and theories by linking the categories together, and with the existing literature (Charmaz, 2000).

A visual representation of the analysis and relationships between core categories was developed through an iterative process of moving backwards and forwards between coding and conceptualising data (see Figure 2). The researcher remained aware of the need to ensure that abstractions remained transparently grounded in the data. Coding and emerging themes were discussed in fortnightly supervision meetings throughout, and coding progressed in light of new insights.

Data gathering concluded when the analysis represented the data collected, no new categories were apparent and the core categories had sufficient depth for a comprehensive understanding, therefore, resulting in theoretical sufficiency (Dey, 1999). Although there was awareness that further analysis was possible, theoretical sufficiency was preferred to theoretical saturation that implies categorisation has been exhausted which is difficult to achieve when exploring individual experiences, and commonalities and differences between them (Dey, 1999).

To ensure credibility and quality the emerging data were checked by a Clinical Psychologist experienced in qualitative methodologies. Furthermore, the researcher engaged in reflective practice through the use of a reflective log, memos and supervision to increase awareness about their own assumptions and interpretations which could influence the data analysis process.

Results

A purposive sample of five young people and five parents' were recruited. The age range of the young people was 22 to 30 (median 26) and three (60%) were female. The age range of the parents was 46 to 65 (median 55) and four (80%) were female. Table 1 shows the participant characteristics.

Insert Table 1 about here

When quotes from the interviews were provided, pseudonyms were used to protect participants' identities whilst maintaining their role. The pseudonyms used for young people were Karen, Emma,

Michael, Kirsty and Alex. The pseudonyms used for parents were Gillian, Sarah, Kate, Lillian and Thomas. Each dyad is stated in Table 1 above. Interviewer comments were reported in bold type whereas comments by participants were in normal type. Brief remarks by the person not speaking were put into parentheses and italics (e.g., *uh huh, right*). Length of pause or other expressions were enclosed in double curly brackets (e.g., {{4 seconds}} or {{laughing}}). To promote transparency and individual interpretations direct quotes were used. The sample was discussed with the intention to highlight limits of relevance and applicability. The results did not represent an exhaustive analysis of all the data but focused on experiences related to psychosis in the context of a dyad.

A theory of five core categories was developed from the data and emerged through common pathways in which stories were delivered. The core categories included formative experiences, independence, safe haven, secure base and parental distress. A visual model of the core categories and the relationships between them is presented in Figure 2. The interview offered participants the opportunity to discuss their experiences as a sequential narrative over time and all engaged with this structure. Their trajectories of experience will be discussed in terms of convergent and divergent themes between dyads and within or between groups of young people and parents.

Insert Figure 2 here

Core category1: Formative experiences

The interview was introduced so participants could describe important relationships in the family and their early life experiences. All participants reflected on life experiences including bereavement, separation through family breakdown or moving home, physical or mental illness of family members, and bullying. It was striking how the narratives of young people and their parents' converged in the expression of their perspectives on the same life experiences which indicated shared importance. Life experiences were constructed in terms of the impact on themselves, each other and wider family. The impact revealed emotions that were painful and upsetting, that pulled the participant's attention onto the significant loss and readjustment which was endured. The significance and endurance of these events was reflected in the initiation of prolonged changes uncovering

additional sources of stress. Many participants' expressed financial difficulties, conflict, fear of future victimisation and role-change. Two contrasting quotations are offered below. First, Gillian constructed the death of her husband in terms of her roles as a partner and then as a single parent. Second, Michael expressed the impact his discovery that his father was not his biological father in terms of increasing distance from his mother and greater self-isolation.

Gillian: *'Yeah it has been a very very difficult time for me, to raise the three of them (yeah) especially, after the death of their father.... but what was difficult was that now these 3 children were looking at me, though their father was not quite a good father, because he was a very responsive- irresponsible man. So I've been quite struggling from from long, even before his death but after his death it was even worse.'*

Michael: *'{{breathes out}} {{5 sec}} I got further away from her, drifted apart (uh huh) since she told me he wasn't my real dad basically (uh huh) and I became more isolated (okay) as I was a teenager. Errr I didn't talk to her and never talked to my dad.'*

Life events and experiences were understood as formative because they resonated through the family to include relationship changes on the one hand and unfolding personal difficulties on the other. This signaled transitions in the functioning of individual's and the wider family. Formative experiences emerged as an important context in the development of emotional experience, coping, support networks, self-identity and awareness of underlying vulnerabilities, which resonated in later experiences of psychosis. Karen poignantly described how her own sense of vulnerability became apparent to her mother during the time she was bullied and then later in psychosis:

Karen: *'After the bullying, I've, kinda like developed this thick skin and my mum and my sisters always say that. They say that I'm the strong one in the family because it's like I'm, you know, umm, thick skinned is like, taking, you know it's like trying to get blood out of a stone (okay), it's like I've kinda like developed that skin. So I think she's seen a side to me that she has never seen before, me being vulnerable again (uh huh), because I think the last time I was vulnerable it was like when I was 11 or something when the bullying started (okay). So she has like seen a different side to me (uh huh), I was you know, still that, you know that vulnerable person, although I did really really well covering it up.'*

Family relationships

Participants seemed to construct family relationships as a context in which the experiences of closeness, support and communication (or a lack of these) were important in understanding the

unfolding impact of formative events. All participants were open to discussing positive and negative aspects of their relationships, indicating they valued their influential nature. For example, family structures were constructed in terms of the degree of closeness felt by participants. The nature of closeness and support were differentiated based upon expectations of siblings compared to senior family members. In addition, to the influence of formative experiences on relationships and need for support. In terms of expectations of support, narratives of young people and parents' diverged.

Overall, for young people the quality of the relationship with their parent was an important context in whether and how they sought support to cope with distressing life experiences. Therefore, formative experiences were rooted in young people's early life experiences and shaped by family relationships, which appeared to have significant implications for the ways individual identities developed and continued throughout the narratives of psychosis. For example, Emma described feeling '*resentment*' towards her mother for the '*wrong choices*' she made and how this impacted upon her:

Emma: *'Erm back then it was she kind a I think put drink before us sometimes (uh huh) so I I I had a lot of resentment towards her so a lot of the time, erm, aye she was away with [NAME], she was always out.. She did ne do it all the time but erm aye she was 'ne reliable so our relationship was 'ne great. I think through ma teens I didn't really have much time for her because I did hold a lot of resentment for the choices that she had made (yeah), I don't think her priorities were always quite right (okay) and it made us have to be a bit more mature because of the way she was (uh huh). So I think that's probably the why the way my sister is the way she is because she's always had to kind a be the more sensible than ma mum was (okay), and I don't think she did it for badness or anything I think she just, well she's not had the easiest life, I think she just made the wrong choices a lot of the time (uh huh).'*

Core category 2: Independence

Young peoples' narratives emphasised the importance of increasing independence reflected in the rising importance of friendships, decision making, moving away from home, working and experimenting with drugs or alcohol. Distancing in their relationships with parents' conveyed the sense of increasing independence and autonomy. Moreover, these processes were seen as developmentally normative by parents'. We understood expectations of increasing autonomy as

shared by parents' and young people as an important context for understanding the emergence of a first episode psychosis in terms of strains on the relationship. The ways in which young people developed independence and autonomy were illustrated by Karen:

Karen: *'I think before I became unwell - -al- although we we we got on but, i- it was at times, although we got on, it was kinda like an on off relationship. Erm and I I knew I really didn't have to rely on her for anything, f- f-for anything. Erm, I had my own money (uh huh), erm, I've got my own car so and I could go anywhere by myself (yeah) I didn't need to wait for her to accompany me to go you know to the shops or whatever I could go anyway. Yeah, you know, I was my own person I could do anything that I wanted to do, you know, and I was doing well at uni, you know (uh huh). Before I became unwell you know I was doing really well with all my other modules (uh huh) so it was kinda like although we get on, but I, I know although at the same time I'd do my own thing and I didn't have to be like oh I need ma my mum to help me with this, so, yeah.'*

Relationship strains

Participants spoke about relationship strains in terms of conflicts, arguments and lack of communication. Sometimes these were constructed as a continuation of earlier relationship difficulties or as a continuation from adolescence. Understandings concerning the development of psychosis were constructed in the context of these growing relationship strains. First, psychosis appeared to be understood as a manifestation of increasing relationship difficulties and the independence needs of the young person. Second, relationship strains were understood as a context in which the young person experienced increasing isolation and loss of access to support to cope with stressors or symptoms. Third, relationship strains created a context to conceal the emergence of psychosis and emotional experiences such as increasing anger and frustration were seen as a manifestation of relationship breakdown rather than emotional, psychological or psychotic breakdown. Therefore, it became gradually more apparent when difficulties related to psychosis developed, young people made a choice not to use the relationship as a source of support or there was no relationship to offer support, primarily due to the relationship strains and increasing independence. Consequently, as difficulties related to emerging FEP unfolded for the young person, there was an absence of family support. For example, Kate noticed different strains in the relationship with her son:

Kate: *'Really what I remember from the last couple of years like he seemed to get depressed and I mean he had 'ne went out the door for about a year, even gave up smoking coz I suppose he did 'ne have to go out the door do you know what I mean (uh huh) and then it was like I'd say about the last 6 months before it that's when he started arguing and stuff and staring and all different things and that's when you started thinking there's something no right (uh huh), but I did 'ne know what it was you know what I mean (yeah) so he was saying there's nothing wrong and he'd say everything was just like my fault and I had these problems and I would say no do you not think you're the one with problems instead of everybody else (ummm), it was just, it was a nightmare (okay).'*

From young peoples' perspectives, difficulties accumulated over time from various areas of their life, these ranged from problems at work or university, pregnancy and changes in relationships or friendships. To manage the accumulating difficulties numerous coping strategies were utilised; for example, using drugs, self-harming, ignoring problems and staying at home. However, without support problems continued as methods of coping exacerbated difficulties over time, and contributed to the accumulating problems. Young people struggled to retain their independence despite increasing problems. Problems coping were sometimes regarded as weakness or vulnerability, which influenced how they perceived others to view negatively (e.g., as a failure). The struggle to retain independence may have resulted in increased isolation, relationship strains and lack of support. Kirsty talked about the 'disappointment' from her mother and how she tried to but could not 'fix' the escalating problems:

Kirsty: *'.....{{5 sec}} err just before I had took like my break down and that (uh huh) it was 'ne that good because I felt myself that I was hiding things from her again (uh huh) and I was cutting again quite a lot, and it was some family party and I got out of the motor and ma dress when up and she seen but I pulled it right down and I just seen the pure disappointment in her face like but she never said anything to me (okay), and then, in the place after a few drinks and that (uh huh) she says 'what were you doing that for again?' coz I'd done that before (right) and I ah at the time I was full of it all the drugs and all that I just kind a ignored it really (yeah) and then, then aye one day I was at ma work (uh huh) and I just I was having a lot of problems then like I was hearing things and (uh huh) strange things were happening and I did ne know, I felt just so out of control and overwhelmed and sort of so I phoned her and I just broke down and told her everything (yeah), errr'*

Researcher: *'You told her about everything?'*

Kirsty: *'Oh everything aye (yeah), coz I could ne fix it out of my head myself anyway it was getting worse and worse (okay)'*

Parents' observed uncharacteristic changes in their son/daughter, such as their behaviour, mood, appearance, physical health complaints, beliefs and attitudes. Withdrawal from friends, family, social

and occupational activities signaled something was wrong and had changed. In addition, arguments increased and became more frequent where their son/daughter seemed to be ‘irrational’ or ‘frustrated’. This was apparent in Sarah’s narrative of how she observed changes in her daughter:

Sarah: *‘Just her personality, she was speaking out more (yeah) just I did ne really notice anything up till then, well we did when she moved into the new flat she was being irrational, she maybe saying things out loud and being irrational, just speaking the way she did ne speak about things, like things like her wee pal that she lived with erm I remember that morning she had a big fight and came to see me at 8 no 7 o’clock in the morning and me and her sister had to go down and get her with all her bags and she had left and taken the cat with her, I just agreed for her to come live with me (uh huh) and after a few days I noticed I said ‘she’s not acting right’ and we found out, we spoke to her flat mate (uh huh) and she says ‘she’s not been right for a few weeks she’s been saying she can hear things in the bathroom down in the flat’ we did ne know any of this (okay)’*

In summary, psychosis became intertwined with the relationship strains that emerged initially during formative experiences and/ or as part of normal development during adolescence. Psychosis then perpetuated the relationship strains, which appeared to destabilise the parent and young person’s relationship further, and exacerbate previous difficulties. Relationship strains and the struggle to retain independence left a lack of support to try to cope with accumulating difficulties. Therefore, normative developmental experiences of independence became thwarted as psychosis began to develop. However, difficulties continued to be understood as part of development until the experiences became overwhelming.

Help seeking as a turning point

Initially young people described seeking help from their parent or admitted needing help when they reached ‘breaking point’. Some parents’ were disappointed by their own initial attempts of gaining support from services. In addition, difficult feelings arose during the separation from their son/daughter as they went into hospital and the awareness of continuing deterioration during the initial engagement with services. This was conveyed by Thomas:

Thomas: *‘It was very hard, very hard but I suppose you you erm come to a realisation that it was getting worse and that he needed a more appropriate intervention than that but it doesn’t make it easier when you drive him down there you know to the GP then down to Mental Health Service, then up to the hospital. It was quite hard but there was some relief in there as well to be honest you you you sort of say that you have passed over the responsibilities to someone else to care and look after him, see he’s safe (uh huh). But I suppose the realisation that errr he was*

hopefully getting the right help (okay) so it was it was mixed it was very hard to leave him there and go away and bring his clothes and that kind a stuff.

Core category 3: Safe Haven

Unexpectedly, processes of reuniting and becoming closer occurred at the point of seeking help. Safe haven referred to how we understood participants' construction of the parental relationship when it was realised that young people were experiencing psychosis. By safe haven, parents were depicted as being available, attuned, empathic, forgiving and a source of safety and support. There was a surprising degree of convergence in the parental and young person's perspectives in this context. Young people showed increased dependence and parents' resumed a nurturing role by taking responsibility for obtaining help and providing support. As they realised their son/daughter was not to blame for the relationship strains, as though earlier roles had been restored. Parents' unconditionally continued to offer support despite the symptoms and relationship difficulties. As a result newfound feelings of closeness arose in the relationship, and consequently existing ruptures in their relationship were reconciled. As a reflection of closeness developing in the relationship both parents' and young peoples' accounts flowed neatly in confluence.

Being there

Young people frequently talked about needing more support than usual and how their parent was their main support. In the ways young people discussed their parent 'being there', there appeared to be a sense of revelation as though they expected a different response (e.g., their parent to 'abandon' them). This revelation may have been due to the relationship difficulties that occurred during the development of psychosis or in early experiences. However, descriptions illustrated parent's doing everything to keep them protected and safe, which was witnessed and felt emotionally. This support appeared to help them start to make sense of their world again. Kirsty emphasised the value of relationships and how important it was to have her mother there for her:

Kirsty: *I think everybody needs somebody (uh huh) because I was keeping it all to ma self and hoping it would go away (uh huh), the voices, the seeing things and wanting to kill yourself, you*

cannae keep things like that to yourself you've got to tell somebody (uh huh) and that's how, a lot of people tell the wrong people and I found my ma who was the right person to tell (yeah yeah) and thank god I'm on the road to being better (uh huh) because you tend to rely on them for everything, to sort out your medication, go and get your medication, be there for you, just try you know you know to encourage you on (yeah uh huh)... what ma mum done for me that's what brought me back I think (yeah).'

Parents' developed an awareness of their own value and importance in 'being there' for their son/daughter. Implicitly and unconditionally parents' were continuously available for their son/daughter due to the awareness their son/daughter relied on them, required more support and had already endured difficulties without help. This awareness may have augmented their dedication in order to try to overcome the troubling time and restore wellbeing.

Giving and receiving support

Parents' were described as proactive and diligent in taking responsibility and working as a team alongside family members and services. Wider family relationships became important for parents at this point so they could rest or go to work. Different domains of support were expressed by participants including practical, emotional, social, financial, religious and moral forms of support. Examples of practical support included encouragement to wash and transportation. Important features of support were listening, understanding and openness in the context of affection and comfort. Aspects of social support were valuable in maintaining a positive outlook (e.g., laughing and spending time together). Giving support reflected the capacity of parents' in being available and attuned to the support required. In addition, to the responsibility parents' hold for their children at all ages and the investment in their wellbeing. By concentrating on support, parents' can avoid or minimise thinking about illness and further problems. The receipt of support may have helped young people to make sense of their experiences, and develop coping strategies and strength to continue. Focusing on giving and receiving support pulls the person's attention to the present and pushes the past or future further away. Support in various forms offers a strategy to manage difficulties and structure time, at the same time as managing the self while facing uncertainty, giving a sense of control.

Providing support would also allow young people time away from the demands and pressures of others and their lives. Some described feeling 'love lost' because when unwell they did not recognise

their parents and their relationships no longer existed. Consequently, support was not reciprocated and parents took responsibility in maintaining the relationship. These difficulties were portrayed by Alex:

Alex: *'Erm..... well because I wasn't trusting people, I'd say paranoid (yeah) erm and failed to recognise them the first few times there was obviously an element of like love lost if you know what I mean (okay), just an absence of me caring for them (uh huh), erm but I'm pretty sure I can't speak for dad but I'm pretty sure that he, he, ... he was erm I don't know how to phrase it, basically just more attached (yeah). Yeah it was very one way in that sense he was having to deal with someone who couldn't really understand the relationship that we had (uh huh), it was gone, but he knew it still existed he still wanted it but I was just lost (uh huh, okay).'*

Researcher: *'And is there anything that was helpful about that relationship?'*

Alex: *'Well when I look back it was definitely helpful, I remember one of the first times when I actually recognised them and, erm you know things started to make sense again and they were always there when that was happening (okay), you know my dad was always there when the first stages of my recovery he was always there.'*

Closeness

Through a supportive relationship young people experienced greater trust and closeness, which helped to reconcile differences. For some this change was so dramatic they expressed surprise and gratitude. Closeness occurred through processes in 'safe haven' of parents 'being there' and 'giving support' as they communicated, spent time together and became acquainted once again. Therefore, they developed a shared understanding and awareness of each other's perspective before and during psychosis, emphasising characteristics of 'safe haven' such as forgiveness and empathy. Experiencing psychosis had enabled closeness to emerge because young people relied upon their parents and parents demonstrated the importance of their son/daughter through 'safe haven'. For example, young people described giving their parents 'a chance' or 'thanked the disruption'. Emma openly described relationship difficulties and how these reconciled through the influential support her mother provided:

Emma: *'Aye I feel well I feel glad, it's a lot better than what it was and I think, at times when maybe in late teens I did ne think my relationship would ever be what it is the now with her. I am just glad that its better and we have got to the point now that erm that we can have this kind of relationship coz I mean there was times when me and her have just never, never thought that it would be like this because she was so unreliable for so long erm aye it's been much better. She's probably been my main support since this started happening (okay) and I've spoken to my family but erm aye she's probably been able to listen and understand a bit more than anyone else has (okay), so it's made the relationship much stronger (uh huh).'*

Trust was important in the receipt of help and developed from the stability in parents' 'being there', particularly as young people appeared to only trust parents. In addition, parental trust in their son/daughter wavered, possibly due to the awareness of independent choices they made and concerns of the reoccurrence of these choices in the contribution of further difficulties (e.g., experimenting with drugs). This related to processes of gaining 'independence', which started prior to psychosis developing. The reduction in relationship strains was greeted with positive emotional experiences, perhaps conferring some sense of hope. Focusing on these emotions may reduce fears about the past or the future and prevent parents' and young people becoming overwhelmed by their experiences. Young people showed appreciation for their parents' support and a new respect developed. That perhaps signified learning about the importance of family support and sharing difficulties as a means of coping. Some young people described their parents' support increased their motivation to recover, which may relate to increased responsibility due to the awareness of the 'safe haven' parents had created for them.

Core category 4: Secure base

Secure base referred to how young people used their parents as a base to venture out independently and reconnect with their external worlds. It became clear through descriptions of recovery that 'safe haven' and emotional closeness facilitated the emergence of a secure base. We used the term 'secure' to reflect how participants discussed experiences with openness, freedom and autonomy regardless of whether these related to positive, negative, or mixed emotional events. Furthermore, they valued the influential nature of their relationships and used them as a context for expression, coping and understanding.

Recovery

When thinking about recovery young people described decreasing amounts of support and feeling relaxed, complimented by parents' descriptions of being needed less and feeling settled. Processes of increasing 'independence' gradually emerged through reconnecting to others and having a sense of future. Participants referred to their experiences as a '*big learning curve*' or a '*roller-*

coaster'. Therefore, an overall awareness of a journey from difficult place to a content, positive place was evident.

As young people reflected on the impact of psychosis, themes of guilt, vulnerability and sadness emerged. Furthermore, they appeared to search for reasons why it happened and how to prevent it, which may have provided a sense of control and manage future uncertainty. Comparisons with others made them feel lucky but saddened due to the awareness others remain unwell. Therefore, feelings of empathy and concern towards others with mental health difficulties were expressed. Taking this perspective of focusing on others may have distanced them from their own fears about relapse and the traumatic nature of their experiences. Therefore, the reality and impact of mental health appeared to continue to be relived in the minds of young people, as they tried to learn from their experiences and regain a sense of future. In contrast, positive reflections of parental support highlighted the importance of relationships. A sense of learning and maturing by taking responsibility for recovery and maintaining wellbeing through important choices about their future were based on their experiences (e.g., respecting others perspectives, maintaining relationships and changing bad habits). Learning may have created a platform of hope to buffer against fears of relapse. Alex aptly described how he was trying to be '*normal again*' but with a new sense of '*responsibility*':

Alex: *'I have always I just sort of errrr, wanted to get back to normal (uh huh), what I think normal is and that maybe involves indulging in things that aren't good for me, but I now have a reputation that maybe I have to you know, look after myself a bit better, not just for my sake but for my dad's and for my mum's sake you know (okay uh huh), so it's just the, in my head it's a good thing that I am trying to be normal again and I'm trying to be (yeah) this person again, but I should really take responsibility.'*

Parents' showed concern about their son/daughter becoming over-dependent and thought about ways to revise support as they recovered. Some parents' found this difficult as they queried how to get the balance of 'secure base' to avoid relapse. Giving the responsibility of recovery to their son/daughter and allow independence may have highlighted the lack of control and renewed potential risks, increasing anxiety and caution. Therefore, it may have been hard for parents' to allow normal developmental experiences to resume. A focus on how they had helped and what they had learned may have also instilled hope for parents' to regain a sense of control for future negative events.

Overall, their experiences of psychosis had put events into a different perspective and they were thankful that recovery had started. Thomas conveyed difficulties in providing the right ‘balance’ of support for his son:

Thomas: *‘well there’s a danger that he becomes over dependent and where you cut off and how you sort of let him be independent so he can look after himself and do these, make these decisions (uh huh). There is a danger that it’s, it’s, you disable his own skills in terms of what he can do (uh huh) and its getting the balance of that right (yeah, yeah) erm I guess that’s the objective of the exercise that he’s an independent adult even if he does have health issues, whatever they are that he manages them or has control, managing them as best he can (yeah). I suppose it’s that worry that erm aye he doesn’t take medication or, which he hasn’t been he does, it’s just his illness would come back.’*

Exploration/ reconnection

Young people talked about recovery in terms of exploring their world again and reconnecting with values and goals in life. For example, they discussed educational or occupational activity, seeing friends and moving out, therefore developing ‘independence’ once again. Some young people wanted parents to take a distant approach, highlighting developmental tasks of separation and increasing independence, but also exploration. This awareness provided a context where future hopes and aspirations surfaced (e.g., vocational attainment and having a relationship). In addition, they commented on ways to repay their parents, which could indicate the sense of value of others and change in perception of how others view them as important, not as a failure. Newfound strength and wisdom about mental health provided a sense of recovery and aspiration to help others learn. Therefore, connecting to a wider community, acknowledging the vulnerability in human experiences and how sharing information can benefit others. Many described not being embarrassed by their experiences but thought about the positives and learned not to judge people. Therefore, altering their perception of the events so not to overwhelm them, but offer a way to understand to allow their life to continue. Others considered wider issues related to discrimination and stigma towards mental health in society, which signified an ability to broadly reflect and a decrease in distress.

Parents’ discussed similar hopes for the future for their son/daughter. Regaining independence through work, education and moving out, as well as managing their mental and physical health were key themes. For others having a relationship and a family were also important. They appeared to have

a memory of the way things were or could be whilst describing hopes. Parent's awareness of their age and that they would not always be there, motivated them to help their son/daughter develop independence skills. Finally, parents' wanted the relationship to continue and some hoped for further recovery. Sarah discussed hopes for her daughter and how she was helping her become independent:

Sarah: *'I just hope that she, aye I've got hundreds, I got a hope that she gets back to uni (yeah), and I hope she just finds happiness, I would love her to be able to be living on her own one day again (yeah), I just hope she gets her independence and her confidence back to be able to have a normal life as well as live with this (yeah), I think it will happen, I think we are doing it the right way the now. I'd like her to learn to use public transport and help her to do that the first, so we are starting with the train, she feels happy on the train but she gets frightened on the bus, aye.'*

Core category 5: Parental Distress

During discussions of recovery parents' began to express a complex interplay of emotions when thinking about how the experience had affected them. Initial distress when realising their son/daughter had psychosis was followed by a continuation of difficult emotions throughout the discourse. We interpreted this expression to be because it was now safe for them to express their feelings because their son's/daughter's needs would not be compromised given they were recovering.

The shock

Initial emotions of fear and distress were revealed as parents' realised their son/daughter was unwell. An array of negative emotions flooded through their narratives (e.g., feeling '*terrified*', '*shocked*' and '*numb*'). They recalled the '*devastation*' in seeing their son/daughter seriously ill and vulnerable. Furthermore, they felt responsible for helping, automatically responding to their son's/daughter's needs and only later realising the impact on them. Therefore, signifying how providing support may have distracted them from the negative emotions and fears about mental health. Focusing on providing a 'safe haven' and helping may have provided them with a sense of control in managing their own emotions and the situation. There were descriptions of helping in every way and remaining hyper-vigilant for symptoms. Some feared their son/daughter would contemplate

suicide or worried about unrelenting difficulties, which highlighted the ongoing sense of fear and uncertainty. Lillian conveyed her initial emotional reaction:

Lillian: *'Erm it's, I was I don't know she was, it was kind a heart breaking to see it and then finding out that there was a problem (yeah) because a lot of the time you're just thinking oh she's just being, her being her sort of thing, I just thought, then when it was as I say if I'd have known she was doing what she was doing I'd have known then that there was something not right (uh huh) but I did ne know (okay).'*

Ongoing difficult emotions of fear, blame, loss and stigma were evident. Parents' constantly worried about what happened and uncertainty of the future in terms of relapse, risk and consequences, perhaps heightened by the awareness of their son/daughters need for independence. Some parents' questioned if they were to blame through decisions they made or had known it could happen (e.g., genetic). Furthermore, they talked of regrets and guilt *'I should have realised'*, which may have surfaced from the inherent sense of responsibility from being a parent. Therefore, parents' frequently referred to *'hindsight'* as they appeared to search for reasons why this happened to avert the psychosis, or attempt to regain control to avoid future distress. Loss and grief were reflected in the comparisons parents' made between their son/daughter and others of similar ages or comments of how they *'should be'* (e.g., independent or married). For some parents', stigma played a role in finding it difficult to talk to others and thinking no-one understands which potentially limits resources to cope. Kate openly reflected on the loss she felt regarding her son and Lillian's narrative signified the continuing emotional pain:

Kate: *'It was horrible you know what I mean you were like is this ma boy kind a thing, he should ne be like this he should be out, like independent (yeah), married, kids and away having his own career or something, you know what I mean (uh huh) and you think well is he always gonna be like this. It was horrible your thinking why could he maybe not be like so and so's kid or something you know what I mean, that's the ways you think (uh huh).'*

Lillian: *'It's hard, you just feel for her sometimes you know to think she could have been maybe married now, kids, well its ..{{15 sec}} {{tearful}} (are you okay?) aye I just hope she gets better. I suppose you think it's not exactly, well was I to blame or (uh huh), coz she's great you know, she would give you her last, she's (yeah), I hope parts of her are coming back.'*

Helplessness and the struggle to keep going

Some parents' remained uncertain about what to do and coped without knowledge of mental health, but previous knowledge at times exacerbated fears about recovery. Parents' discussed feeling sympathy and empathy towards their son/daughter as they could only observe events unfolding. The uncertainty of what to do conflicted with the urge to help, and resulted in distress reflected through descriptions of losing control and feeling disempowered. For example, Thomas recalled how 'sore' it felt when his son kept apologising, and 'black moments' when he deteriorated with no sign of recovery. Words such as 'hard', 'difficult' and 'tough' repeated throughout narratives illustrating how arduous it was to keep going. In addition, parents' struggled to act normal and be strong for their son/daughter. The pressure from supporting their son/daughter, continuing work and looking after the family was evident. This pressure created an awareness of wider impact on parents' whole life, family and friends. Sarah described feeling 'frightened' and how previous experiences of mental health exacerbated these fears:

Sarah: *'I felt there was a lot of pressure on me because it's like your child's screaming out for help and it does ne matter what age they are and trying to be strong and not show it (yeah) and try and not show how frightened you are for them because I am frightened for her because her dad has a serious mental illness so I was just so terrified in case she ended up as serious as that (okay) its maybe a bad thing an all because I know what could come (yeah) so I was always watching for everything.'*

Discussion

This study aimed at exploring participants' narratives involving how relationships were influenced during first episode psychosis (FEP) and how recovery was influenced by those relationships. It was hoped that a theoretical understanding of the role of relationships in recovery would be developed. Interviews provided rich, valuable accounts of how participants understood and constructed experiences of relationships and psychosis. A Constructionist Grounded Theory analysis provided an interpretation of core relational processes of 'safe haven' and 'secure base' in the family context underpinning recovery and adaptation. Participants entered the storytelling process by openly

discussing their early relationship in which ‘formative experiences’ unfolded and impacted on ‘family relationships’. The inter-subjective nature of experiences resounded throughout the narratives of psychosis. All of which entwined with the developmental processes relating to ‘independence’ through separation and individuation from parents and ‘relationships strains’ in the face of accumulating difficulties. ‘Help seeking’ became the turning point through the intricate and elegant ways parents’ became attuned and responded to their young person’s needs creating a ‘safe haven’ and ‘secure base’ for recovery. It became clear young people and parents’ were affected by psychosis, relational experiences and the storytelling process. Attachment experiences were seen as influential and salient through how participants had freedom to discuss their experiences when constructing narratives of past and present, and incorporated the effect on the self and family. However, parental recovery and adaptation appeared unresolved when discussing past events in relation to present experiences leaving a sense of ‘parental distress’.

This study provided a small group of young people and parents’ who by virtue of participating in the study, openness to talking about positive and negative aspects of their experience, and their construction of a coherent narrative were likely to be secure in attachment (Gumley et al. 2008). From this point of view, in a Grounded Theory study it was not possible to purposively sample from other groups who had greater difficulty or refused to talk about their relationship. Aside from these limitations, theoretical constructs developed which showed the importance of ‘safe haven’ and ‘secure base’ as constructs likely to promote positive adaptation and recovery. Identification of these positive relational aspects of recovery allowed them to be used to develop an emerging theory, whereby recovery might break down in the context of failures in relationship functioning. Therefore, this theory can help to understand where there might be a breakdown in relational processes, and where difficulties may occur during recovery. As a result, the theory could change the focus of family therapy by helping to increase positive aspects of relationships (e.g., compassion), and highlight positive relational aspects that could be measured for therapeutic benefit.

We chose to develop a theoretical understanding of these findings by taking the perspective from two distinct domains of research. Firstly, we were interested in social mentalities theory (Birchwood, Iqbal, Chadwick & Trower, 2000) due to the importance given to psychosis as a life

event impacting on adaptational processes. The second perspective was from the Expressed Emotion (EE; Brown & Rutter, 1966) domain of research due to the importance given to the family environment and emotional atmosphere in recovery. Social mentalities theory (Birchwood et al., 2000; Birchwood, 2003) offers a conceptualisation of recovery and states that psychosis can be considered as a life event that initiates negative outcomes for young people for example, depression and social anxiety via the individual's appraisals of personal threat by psychosis leading to loss of social goals, roles and status, as a source of shame, and as a state from which escape is thwarted. Strikingly our data contrasted with this theory. Although considered as a life event which demanded family reorganisation and adaptation (Dallos & Vetere, 2009), psychosis resulted in increasing closeness in parent-young person relationships which successfully enabled positive outcomes of recovery, growth and exploration in young people.

Possible reasons for the contrast could be that the sample of young people were securely attached, had a supportive family and were engaged with services. Previous research highlights the association between attachment security, engagement with services and better use of treatment (MacBeth et al. 2010; Dozier, 1990). Therefore, secure attachment could have been a resilience factor for the participants which facilitated the use of interpersonal supports and affect regulation during FEP (Gumley et al. 2008). In addition, secure attachment may have also been mirrored in the attuned and sensitive response of the parent providing safety and security (Mikulincer & Shaver, 2010).

Recovery from the perspective of a secure attachment representation resembles the 'integrative' recovery style described by McGlashan, Levy and Carpenter (1975). 'Integrative' recovery style is characterised by interest in understanding one's own experiences, and integrating them into one's own life story and understanding of self, world and others. In contrast, insecure attachment representations could resemble a 'sealing over' recovery style. 'Sealing over' is characterised by dismissing or excluding experiences from consciousness, and therefore, the refusal or inability to reflect upon experiences. Tait, Birchwood and Trower (2004) reported that 'sealing over' recovery style was associated with insecure adult attachment and less engagement with services. Highlighting that secure attachment could increase resilience and an 'integrative' recovery style. However, evidence also suggests that the recovery style can change during adaptation to psychosis

(e.g., 'integration' to 'sealing over' or vice versa) (Thompson, McGorry & Harrigan, 2003). The results from this study suggest that the response from family members may promote resilience and recovery. Therefore, could reduce the possibility of the young person developing a 'sealing over' recovery style.

The results imply that family support is critical for practical and emotional support. Parents' provided a network of help for the young person as they would have when they were young, with many taking on tasks they had previously relinquished. These findings support the results from previous research into FEP and the role of parents in supporting recovery (Anderson et al. 2012; Lester, Marshall, Jones, Fowler, Amos, Khan & Birchwood, 2011; McCann, Lubman & Clark, 2009; Sin et al. 2005). In addition, as a result of parents providing support both parents' and young people described feeling closer. Therefore, the family environment appeared to be very supportive and valuable in recovery. The resulting closeness and value of family support has also been reported in previous research (Anderson et al. 2012; Lester et al. 2011; McCann et al. 2009).

Research into Expressed Emotion (EE) in the family environment refers to the measure of three constructs of hostility, emotional over-involvement (EOI) and critical comments. High levels of these constructs are associated with relapse in psychosis (Barrowclough & Hooley, 2003). During the development of the EE concept the construct warmth was also outlined as a measurement of quality in family interactions (Brown, Birley & Wing, 1972). Warmth was defined as positive comments, sympathy and concern, interest in the other as a person, and expressed enjoyment in mutual activities. Brown et al. (1972) found that marked warmth in the absence of criticism and emotional over-involvement (EOI) in family interactions was associated with lower relapse rates and significantly better outcome. However, warmth was excluded from the EE concept because of complex interrelationships with other scales, namely low warmth was associated with high criticism and high warmth was associated with high EOI, and subsequently EE focused on negative interactions (Brown et al., 1972). In a later review of EE by Hooley (1985), warmth was not regarded to be predictive of EE ratings or relapse.

As a result many EE studies failed to consider the context of warmth (Bhugra & McKenzie, 2003) and the construct has remained underdeveloped. Therefore, warmth may be poorly understood

in previous research. The inferred linear causality between high EE and relapse could instill the perception of blaming families (Burbach, In Press, 2013). This perception increases feelings of stigma and focuses on eradicating behaviour instead of developing helpful alternatives. Given the results of this study, examination of the data regarding warmth in EE warrants further consideration. Several studies have reported decreased relapse risk in high warmth households compared to low warmth (Bertrando, Beltz, Bressi, Clerici, Farma, Invernizzi & Cazzullo, 1992; Lopez, Hipke, Polo, Jenkins, Karno, Vaughn & Snyder, 2004; Ivanovic, Vuletic & Bebbington, 1994). Although warmth interacts with other EE constructs (Lopez et al., 2004), it is an emerging protective factor in the course of psychosis. Core categories of 'safe haven' and 'secure base' as a context for recovery in the family system are reminiscent of the warmth construct in EE outlined above. Understanding qualities of warmth may help identify positive skills for families to develop to support their son/daughter recover.

In the current study, parental behaviours in recovery related to the warmth construct (e.g., available, responsive parent's) are compatible with Bowlby's (1988) understanding of safe haven and secure base, and provide greater insight into qualities of warmth. Safe haven was defined as having an accessible attachment figure to provide reliable comfort and security in times of need, responding to problems as they arise, appropriate to the situation and level of need. Secure base concept relates to the responsibility in being attuned, sensitive, reliable and available to respond actively to signals of distress with comfort, reassurance and assistance when required, but also to wait, encourage and support growth, exploration and autonomy. Therefore, parents provide a base from which young people explore the world and can return to if difficulties arise.

Research from non-clinical samples highlighted important aspects of secure base including availability, non-interference and encouragement in enhancing functioning and exploration (Feeney & Thrush, 2010). In addition, Collins and Feeney (2000) identified aspects of care-giving and support seeking derived from the concept of safe haven in adult relationships and these included support, care, commitment, responsiveness, interdependence and trust. Gilbert's (2005) compassionate mind theory conceptualised warmth as qualities of tenderness, gentleness, kindness and concern. These findings are consistent with the categories that emerged in the present study. Overall, it is possible to speculate

the qualities which could define warmth (see Table 2). Further research to define warmth would be helpful but attachment theory offers a basis to start to explore this construct.

The theory of developmental from late teens through the twenties or emerging adulthood (Arnett, 2007) states that individualisation is one of the main characteristics. This is associated with accepting responsibility for oneself, making independent decisions and being financially independent. Therefore, emerging adulthood is about exploration, change, freedom and less social control, resulting in increasing self-sufficiency. This life period has developed from a demographic shift in tasks usually associated with adulthood (e.g., marriage and parenthood) being delayed until later in industrialised societies, therefore, it is no longer normative for late teens to enter adulthood (Arnett, 2000). Furthermore, autonomy and relatedness were also shown to be complimentary dimensions in the relationships with parents during this stage (Arnett, 2000). The characteristics of warmth in the context of a secure base may help to facilitate individualisation, exploration and autonomy, as well as maintain relatedness between the parent(s) and their child as they become an adult. The theory of emerging adulthood also states that individual's may be more vulnerable to experiencing mental health problems around this time because they have increased freedom but fewer social roles and obligations compared to children, adolescents or adults (Tanner, Reinherz, Beardslee, Fitzmaurice, Leis & Berger, 2007; Arnett, 2007). Therefore, the core categories of 'safe haven' and 'secure base' may be helpful in recovery from psychosis and in supporting development. Moreover, all life transitions increase vulnerability to experiencing physical and mental health problems which can be mitigated by social support (Thoits, 2010). Therefore, process of 'safe haven' and 'secure base' may be helpful throughout the lifespan when individuals are faced with negative experiences which require adaptation and reorganisation.

The attachment processes, outlined above and in the current study, are understood in the systemic context of interpersonal relationships in the family (Dallos & Vetere, 2009). This research supports the importance of family emotional atmosphere in determining the course of psychosis and adds to the systemic understanding of recovery. In support, Burbach (In Press, 2013) summarised the importance of attributions that influence warmth; for example, family attributions of the young person's control over symptoms related to decreased warmth, and young person's perception of care

influenced expectations of how their parent regarded them. Therefore, parents' and young peoples' appraisals and beliefs could be related to warmth and are important to consider in future research. Moreover, when thinking about emotional atmosphere recognition of the intergenerational factors requires attention. Particularly parents who have suffered in childhood may struggle to provide an optimum environment such as one of warmth for their son/daughter (Read & Bentall, 2012). Some parents' may not have had the opportunity to observe and learn about these experiences from their own parents (Mikulincer & Shaver, 2010). This awareness encourages parental needs to be identified from an intergenerational perspective when promoting resilience and recovery in families.

Overall, the results show how the warmth construct from EE, attachment theory and systemic theory offer an understanding of the mechanisms which are important to consider in the recovery from FEP. Furthermore, these theories highlight how warmth could be influenced by a range of cognitive, emotional and behavioural variables and ways which warmth could be developed within families through interactional patterns. Therefore, this study provides a model of resilience and coping for young people and families.

In addition, the results highlighted how psychosis challenged parents' representations of the relationship with their son/daughter and their own emotional response. This response is consistent with how transitions in the family life cycle demand reorganisation and adaptation of relationships in the family, and the use of systemic attachment strategies to enable this (Dallos & Vetere, 2009). Parents' emotional responses are understood by existing research in terms of changes in EE over time, and as a developmental process of parental adjustment to the progression of psychosis (Patterson et al. 2005). Attachment theory states that this response could reflect attachment behaviours of parent's and appropriate emotional reactions to the situation where their son/daughter is ill and threatened by psychosis (Bowlby, 1988). The findings in this study highlighted heightened emotional reactions at the initial onset of psychosis which are consistent with these perspectives. Therefore, normal attachment processes may involve high EE when security of the relationship is threatened (Patterson, Birchwood & Cochrane, 2000).

Ongoing parental distress was revealed throughout the course of FEP associated with feelings of loss, blame, fear and helplessness. This distress could reflect how difficulties remained unresolved

and therefore initiated the process of mourning as described in attachment theory. Bowlby (1980) explained how loss and separation lead to processes of mourning and reactions which could be long lasting which involve anger directed at self and others, anxiety, disbelief/denial and an attempt to restore the relationship. Furthermore, if separation or loss becomes enduring then feelings of sadness and hopelessness can emerge. Therefore, findings of 'parental distress' as well as the core affective elements of criticism and anxiety in EE transactions can be encapsulated by normal, adaptive responses to attachment, separation and loss processes involved in psychosis (Patterson et al., 2005). Finally, previous research highlights how EE patterns could become entrenched and problematic over the course of psychosis. Therefore, during recovery from FEP parental needs regarding adaptation require consideration (Patterson et al., 2000).

Parent and child adjustment to physical illness has also shown that some children struggle socially, emotionally and academically, where as other children adjust well and demonstrate growth and resilience. Factors which mediate child distress include lower parental distress and a positive family environment, including less conflict, greater cohesion and more expressiveness (Robinson, Gerhardt, Vannatta & Noll, 2007). Poorer parental adjustment was associated with child characteristics (e.g., behaviour problems and anxiety), care-giving demands and indicators of coping (e.g., family cohesion and social support) (Klassen, Raina, Reineking, Dix, Pritchard & O'Donnell, 2007). Therefore, well being in physical illness is not only dependent on personal characteristics but on social systems and resources around them.

Limitations

The results represented here are from five dyads that were willing to share their individual experiences. Firstly, the small sample size limits the range of experiences that can be gathered from the data. Secondly, this sample highlights a bias of self-selection, and a degree of trust and security in the relationships between the parents and young people. In addition, research states that services users who present with secure attachments are more likely to engage with services (Macbeth et al. 2010). Therefore, they may also be more willing to participate in research than those with insecure attachments. Parents' who had a good relationship with their child may have also been more willing to

volunteer to take part. Therefore, the young people and parents' recruited in this study may have already had a shared understanding of recovery.

Furthermore, those who were selected by key-workers were appropriate for the study. Therefore, the sample will not contain the narratives of individuals who do not have a significant other or may have had a breakdown in their relationship. This construction of a model of recovery in the context of warmth is one interpretation influenced by the perception of ten participants and the researcher, in addition, to the shared relationships in which the meanings of their experiences were construed. Thus, to improve transparency of the categories and allow the reader to make their own interpretations quotes of narratives from the participants were used throughout.

The use of separate interviews may have limited the understanding from the collective, shared meanings attributed to the experiences of the dyad. These perspectives would have been more difficult to identify in separate interviews. In joint interviews, the other person can corroborate or supplement the stories by probing, correcting or challenging (Taylor & de Vocht, 2011). This may have been a useful method for collecting data in this study; however, it may be harder to define individual experiences. Therefore, separate and joint interviews may have lead to further in-depth understandings. In addition, in order to compare and contrast two groups' opinions a Q-sort methodology could have been used instead of interviews. This methodology is useful when seeking to explore and understand the variety of subjective viewpoints on an issue.

The findings do not seek to represent an exhaustive analysis of all the data but to provide an understanding of experiences related to psychosis in the context of a dyad, as set out in the aims. Credibility of the research process and validity of the data were ensured through research supervision by a clinical psychologist experienced in qualitative research methods. Respondent validation may have strengthened the research process but has been criticised because it leads to the development of further data requiring interpretation rather than a validity check (Pope & Mays, 2006).

Finally, other qualitative approaches could have been used to analyse and interpret the data. It could be argued that Interpretative Phenomenological Analysis (IPA) would be an appropriate method for this study. Particularly because IPA uses small samples and focuses on understanding the meanings people attach to their experiences (Smith et al. 2009). However, this study moved beyond

IPA to use narrative context to discuss relationships and how these changed over time to permit discourse about recovery and how recovery may be influenced by those relational processes. Therefore, a Grounded Theory interview was used so that it did not impose recovery as a construct but allowed it to emerge naturally from the data. This structure limited any preconceptions, apart from the attachment context which was used as the point of departure. Grounded Theory also enabled the development of theoretical ideas which would not be permitted in IPA, which can be linked with wider literature and allow a broader understanding. Problems with generalisability can therefore be overcome. Furthermore, grounded theory emphasises the importance of context in understanding experiences (Charmaz, 2006). This study directly explores contextual factors in psychosis as relational experiences in psychosis are the focus. Research into the subjective experiences of others in the life of the service user who has experienced FEP, and the development of theoretical models was also recommended in a recent review (Boydell et al. 2010).

Clinical implications

The findings have important clinical implications when working with service users who have experienced a FEP and parents. Social constructionist approaches explore how people use language in a way that shapes appraisals, how family members construe one another and behave in a way which is coherent to that construction, and how actions of each validate or invalidate the other's construction of their relationship (Burbach, 2013). These approaches are therapeutically useful when delivering family therapy and cognitive therapy in terms of the development of warmth in the emotional atmosphere in the family through interactions and appraisals (Meddings, Gordon & Owen, 2009). It also highlights how intergenerational factors may create barriers to emotional atmospheres in the family and how warmth could be developed within parent-service user relationships. Recent therapeutic practices suggest a need to 'tone up' and promote positive emotions without relying on the assumption that by removing negative emotions then positive emotions will automatically develop (Gilbert, 2005). Therefore, this study highlights the importance of warmth and considers how to develop warmth within families which could foster well-being, resilience and recovery from FEP.

It is important to note, adolescence is generally experienced as a stressful period (Arnett, 1999). Compared to pre-adolescence or adulthood, conflict increases and typically remains high for a couple of years before declining in late adolescence. The amount of time spent with parents and emotional closeness reduces. Adolescents report greater extremes of mood and more frequent changes in mood. Finally, teens and early twenties are the years of highest prevalence of a variety of risk behaviours (e.g., substance misuse, crime and risky sexual behavior). Although these changes are not universal they provide some examples of normative changes during adolescence (Arnett, 1999), which were also apparent in the narratives of the participants'. Later difficulties appeared to emerge for a number of possible reasons; when changes associated with adolescence continued, when life stressors increased/ accumulated, or when there was a lack of social support to cope with increasing stressors. Furthermore, experiences associated with psychosis (e.g., hearing voices and unusual beliefs) were also described. Parents' observed uncharacteristic changes in their young person, withdrawal from usual social and occupational activities, and more frequent arguments or irrational behaviour. These changes have also been reported in previous qualitative studies (Boydell et al. 2010). It may be helpful to think about the changes associated with the onset of psychosis compared to normal development, to inform the assessment and intervention process. It would also be helpful to make these changes clearer to families, G.Ps, schools, workplaces and all healthcare staff, in order to promote earlier help seeking. In addition, this emphasises the importance of others in initiating help seeking and the benefits of early treatment (Anderson et al. 2012).

Attachment theory offers a framework to conceptualise the interpersonal context of psychosis through affective, cognitive and interpersonal factors, and offers an understanding into important factors in recovery and parental adaptation. Firstly, attachment theory is important when considering the family context of warmth in promoting recovery and encouraging this within the family, therapeutic relationship and services. Consideration of variables that could influence warmth (e.g., behaviour, interactions and appraisals) during assessment could highlight areas for intervention. Secondly, attachment theory offers a formulation to understand, validate and normalise parental emotional responses to the situation and inform adaptation processes. This perspective offers various pathways to facilitate adaptation through expression of thoughts and feelings, reflection, support to

learn from experiences and to explore opportunities for growth (Dallos & Vetere, 2009). Therefore, may help parents to put their experiences into a normative familial and cultural framework so that a sense of purpose and recovery occurs. In summary, focusing on strategies helpful to the recovery process and understanding normative processes of adaptation within an attachment theory framework builds on resilience and hope for service users and parents. Integration of attachment theory and positive constructs such as warmth into existing treatment approaches could be helpful.

Furthermore, recovery could also be promoted within clinical practice by using the features of 'safe haven' and 'secure base'. To promote 'safe haven' services could respond by being available continuously and offer various domains of support. In addition, an ethos of being understanding, empathic and forgiving towards service users could be helpful. 'Secure base' could be reflected through services engaging in more active risk taking, gradually decreasing support and promoting service user independence. Furthermore, services could be open for service users to re-engage at any point. Highlighting that services' could be more flexible and reflexive to individual service user needs. The importance of services engaging and liaising with families should also be a priority given their vital role in supporting services users (Lester et al. 2011).

Future research could explore how 'safe haven' and 'secure base' could be developed and measured within services and what the potential benefits of these processes are for service users. In addition, further qualitative research methods could be utilised to interview and analyse service users and significant others together to gain a further collative perspective on interpersonal factors in recovery.

Conclusions

This study offered a model of psychological resilience and recovery in the systemic context of the family through the construct of warmth which was depicted in categories of 'safe haven' and 'secure base'. Furthermore, attachment and systemic theories add to this model and provide a framework to understand attachment behaviour associated with warmth and the emotional responses

of parental adaptation to psychosis. Overall, narratives of parents' and young people were valuable in offering another perspective of recovery from FEP.

References

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978) *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Allen, J. P., McElhaney, K. B., Kuperminc, G.P. and Jodl, K.M. (2004) Stability and change in attachment security across adolescence. *Child Development*, 75, 1792-1805.

Anderson, K. K., Fuhrer, R. & Malla, A. K. (2012). "There are too many steps before you get to where you need to be": Help-seeking by patients with first-episode psychosis. *Journal of Mental Health*, Early Online, 1-12.

Arnett, J. J. (1999). Adolescent Storm and Stress, Reconsidered. *American Psychologist*, 54(5), 317-326.

Arnett, J. J. (2000). Emerging Adulthood: A Theory of Development From the Late Teens Through the Twenties. *American Psychologist*, 55(5), 469-480.

Arnett, J. J. (2007). Emerging Adulthood: What Is It, and What Is It Good For? *Child Development Perspectives*, 1(2), 68-73.

Barrowclough, C., & Hooley, J. M. (2003) Attributions and expressed emotion: A review. *Clinical Psychology Review*, 23, 849-880.

Bertrando, P., Beltz, J., Bressi, C., Clerici, M., Farma, T., Invernizzi, G. & Cazzullo, C. L. (1992). Expressed emotion and schizophrenia in Italy: A study of an urban population. *British Journal of psychiatry*, 161, 223-229.

- Bhugra, D. & McKenzie, K. (2003). Expressed emotion across cultures. *Advances in psychiatric treatment*, 9, 342-348.
- Birchwood, M. (2003). Pathways to emotional dysfunction in first-episode psychosis. *British Journal of Psychiatry*, 182, 373-375
- Birchwood, M., Iqbal, Z., Chadwick, P. & Trower, P. (2000). Cognitive approach to depression and suicidal thinking in psychosis. I: Ontogeny of post-psychotic depression. *British Journal of Psychiatry*, 177, 516-528.
- Bowlby, J. (1969) *Attachment and loss: Vol. 1. Attachment*, (2nd ed.). London: Pimlico.
- Bowlby, J. (1973) *Attachment and loss: Vol. 2. Separation, anger and anxiety*. London: Pimlico.
- Bowlby, J. (1980) *Attachment and loss: Vol. 3. Loss, sadness and depression*. London: Pimlico.
- Bowlby, J. (1988). *A secure base: Clinical Applications of Attachment Theory*. London: Routledge.
- Boydell, K. M., Stasiulis, E., Volpe, T. & Gladstone, B. (2010). A descriptive review of qualitative studies in first episode psychosis. *Early Intervention in Psychiatry*, 4, 7-24.
- Brown, G. W., Birley, J. L. T. & Wing, J. K. (1972). Influence of Family Life on the Course of Schizophrenic Disorders: A Replication. *British Journal of Psychiatry*, 121, 241-258.
- Brown, G. W., & Rutter, M. (1966). The measurement of family activities and relationship: methodological study. *Human Relations*, 19, 241-263.
- Burbach, F. (In Press, 2013). Towards the systemic understanding of family emotional atmosphere and outcome after psychosis. In, Gumley, A., Gilham, A. Taylor, K. & Schwannauer, M. (In Press, 2013). *Psychosis and Emotion: The role of emotion in understanding psychosis, therapy and recovery*. London: Routledge.
- Cassidy, J. & Shaver, P. R. (2008). *Handbook of attachment: Theory, research and clinical applications* (2nd Edition). London: The Guilford Press.
- Charmaz, K. (2000). 'Discovering' Chronic Illness: Using Grounded Theory. *Social Science and Medicine*, 30 (11), 1161- 1172.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage Publications.

Collins, N. L. & Feeney, B. C. (2000). A Safe Haven: An Attachment Theory Perspective on Support Seeking and Caregiving in Intimate Relationships. *Journal of Personality and Social Psychology*, 78(6), 1053-1073.

Corcoran, C., Gerson, R., Sills-Shahar, R., Nickou, C., McGlashan, T., Malaspina, D. & Davidson, L. (2007). Trajectory to a first episode of psychosis: a qualitative research study with families. *Early Intervention in Psychiatry*, 1, 308-315.

Cutcliffe, J. R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing*, 31 (6), 1476- 1484.

Dallos, R. (2006). *Attachment narrative therapy: Integrating systemic, narrative and attachment approaches*. Berkshire: Open University Press.

Dallos, R. & Vetere, A. (2009). *Systemic therapy and attachment narratives: Applications in a range of clinical settings*. London: Routledge.

De Goede, I. H. A., Branje, S. J. T. & Meeus, W. H. J. (2009). Developmental Changes in Adolescents' Perceptions of Relationships with Their Parents. *Journal of Youth and Adolescence*, 38, 75-88.

Dey, I. (1999). *Grounding grounded theory*. San Diego: Academic Press.

Dozier, M. (1990). Attachment organisation and treatment use for adults with serious psychopathological disorders. *Development and Psychopathology*, 2, 47-60.

Dozier, M., Lomax, L., Tyrell, C., & Lee, S. W. (2001). The challenge of treatment for clients with dismissing states of mind. *Attachment & Human Development*, vol 1(1), 62-76.

Eisenstadt, P., Monteiro, V. B., Diniz, M. J. A. & Chaves, A. C. (2012). Experience of recovery from a first-episode psychosis. *Early Intervention in Psychiatry*, 1-5.

Feeney, B. C. & Thrush, R. L. (2010). Relationship Influences on Exploration in Adulthood: The Characteristics and Function of a Secure Base. *Journal of Personality and Social Psychology*, 98(1), 57-76.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002) *Affect regulation, mentalization and the development of the self*. London: Karnac.

George, C., Kaplan, N. & Main, M. (1996) *Adult Attachment Interview*. Unpublished manuscript, Department of Psychology, University of California, Berkley.

Gilbert, P. (2005). *Compassion: Conceptualisations, Research and Use in Psychotherapy*. London: Routledge.

Gumley, A. & Schwannauer, M. (2006) *Staying well after psychosis: A cognitive interpersonal approach to recovery and relapse prevention*. Hove: Wiley.

Gumley, A., Schwannauer, M., MacBeth, A. & Reid, J. (2008). Emotional recovery and staying well after psychosis: an attachment-based conceptualisation. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis*, 2, 127–148.

Harrop, C. & Trower, P. (2001). Why does Schizophrenia develop at late adolescence? *Clinical Psychology Review*, 21(2), 241-266.

Hooley, J. (1985). Expressed Emotion: A review of the critical literature. *Clinical Psychology Review*, 5, 119-139.

Ivanovic, M., Vuletic, Z. & Bebbington, P. (1994). Expressed emotion in the families of patients with schizophrenia and its influence on the course of illness. *Social Psychiatry Epidemiology*, 29, 61-65.

Klassen, A., Raina, P., Reineking, S., Dix, D., Pritchard, S. & O'Donnell, M. (2007). Developing a literature base to understand the caregiving experience of parents of children with cancer: a systematic review of factors related to parental health and well-being. *Support Care Cancer*, 15, 807-818.

Lysaker, P. H., Ringer, J., Maxwell, C., McGuire, A. & Lecomte, T. (2010). Personal narratives and recovery from schizophrenia. *Schizophrenia Research*, 121, 271-276.

Lopez, S. R., Hipke, K. N., Polo, A. J., Jenkins, J. H., Karno, M., Vaughn, C. & Snyder, K. S. (2004). Ethnicity, Expressed Emotion, Attributions, and Course of Schizophrenia: Family Warmth Matters. *Journal of Abnormal Psychology*, 113(3), 428-439.

McCann, T., Lubman, D. & Clark, E. (2009). First-time primary caregivers' experience of caring for young adults with first-episode psychosis. *Schizophrenia Bulletin*, 32, 786–794.

MacBeth, A., Gumley, A., Schwannauer, M. & Fisher, R. (2010). Attachment states of mind, mentalization, and their correlates in a first episode psychosis sample. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 42-57.

Main, M., & Solomon, J. (1990) Procedures for identifying infants as disorganized/ disorientated during the Ainsworth Strange Situation. In Greenberg, M., Cicchetti, D., & Cummings, E. M. (1990) *Attachment in the preschool years*. Chicago: University of Chicago press.

McGhee, G., Marland, G. R. & Atkinson, J. (2007). Grounded theory research: literature reviewing and reflexivity. *Journal of Advanced Nursing*, 60 (3), 334- 342.

McGlashan, T.H., Levy, S.T. & Carpenter, W.T. (1975). Integration and sealing over: clinically distinct recovery styles from schizophrenia. *Archives of General Psychiatry*, 32, 1269-1272.

Meddings, S., Gordon, I. & Owen, D. (2009). Family and systemic work. In, C. Culpitt (2009) *Reaching out: The psychology of Assertive Outreach*. London: Routledge.

Mikulincer, M. & Shaver, P. R. (2010). *Attachment in adulthood: Structure, dynamics and change*. London: The Guilford Press.

Patterson, P., Birchwood, M. & Cochrane, R. (2000). Preventing the entrenchment of high expressed emotion in first episode psychosis: early developmental attachment pathways. *Australian and New Zealand Journal of Psychiatry*, 34(Supp), S191-197.

Patterson, P., Birchwood, M., & Cochrane, R. (2005) Expressed emotion as an adaptation to loss. *British Journal of Psychiatry*, 197, 59-64.

Pope, C. & Mays, N. (2006). *Qualitative Research in Health Care*. Malden, MA: Wiley-Blackwell.

Read, J. & Bentall, R. (2012). Negative childhood experiences and mental health: theoretical, clinical and primary prevention implications. *British Journal of Psychiatry*, 200, 89-91.

Robinson, K. E., Gerhardt, C. A., Vannatta, K. & Noll, R. B. (2007). Parent and Family Factors Associated with Child Adjustment to Pediatric Cancer. *Journal of Pediatric Psychology*, 32 (4), 400-410.

Sartorius, N. (2007). Stigma and mental health. *The Lancet*, 370 (9590), 810-811.

Sin, J., Moone, N. & Wellman, N. (2005). Developing services for the carers of young adults with early-onset psychosis- listening to their experiences and needs. *Journal of Psychiatric and Mental Health Nursing*, 12, 589-597.

Smith, J. A., Larkin, M. & Flowers, P. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: SAGE Publications Ltd.

Tanner, J. L., Reinherz, H. Z., Beardslee, W. R., Fitzmaurice, G. M., Leis, J.A. & Berger, S. R. (2007). Change in prevalence of psychiatric disorders from ages 21 to 30 in a community sample. *Journal of Nervous and Mental Disease*, 195, 298-306.

Tait, L. Birchwood, M. & Trower, P. (2004). Adapting to the challenge of psychosis: personal resilience and the use of sealing-over (avoidant) coping strategies. *British Journal of Psychiatry*, 185, 410-415.

Taylor, B. & de Vocht, H. (2011). Interviewing Separately or as Couples? Considerations of Authenticity of Method. *Qualitative Health Research*, 21 (11), 1576-1587.

Thoits, P. A. (2010). Stress and Health: Major Findings and Policy Implications. *Journal of Health and Social Behavior*, 52(S), S41-S53.

Thompson, K. N., McGorry, P. D. & Harrigan, S. M. (2003). Recovery style and outcome in first episode psychosis. *Schizophrenia Research*, 62, 31-36.

Weinfield, N. S., Whaley, G., & Egeland, B. (2004) Continuity, discontinuity and coherence in attachment from infancy to late adolescence: Sequelae of organization and disorganization. *Attachment and Human Development*, 6, 73-97.

WHO. (1992) ICD-10 Classification of Mental and Behavioural Disorders. Clinical descriptions and diagnostic guidelines. WHO: Geneva.

Windell, D. & Norman, R. M. G. (2012). A qualitative analysis of influences on recovery following a first episode of psychosis. *International Journal of Social Psychiatry*, 0(0), 1-8.

Figure 1: Charmaz's (2006) Grounded Theory Process

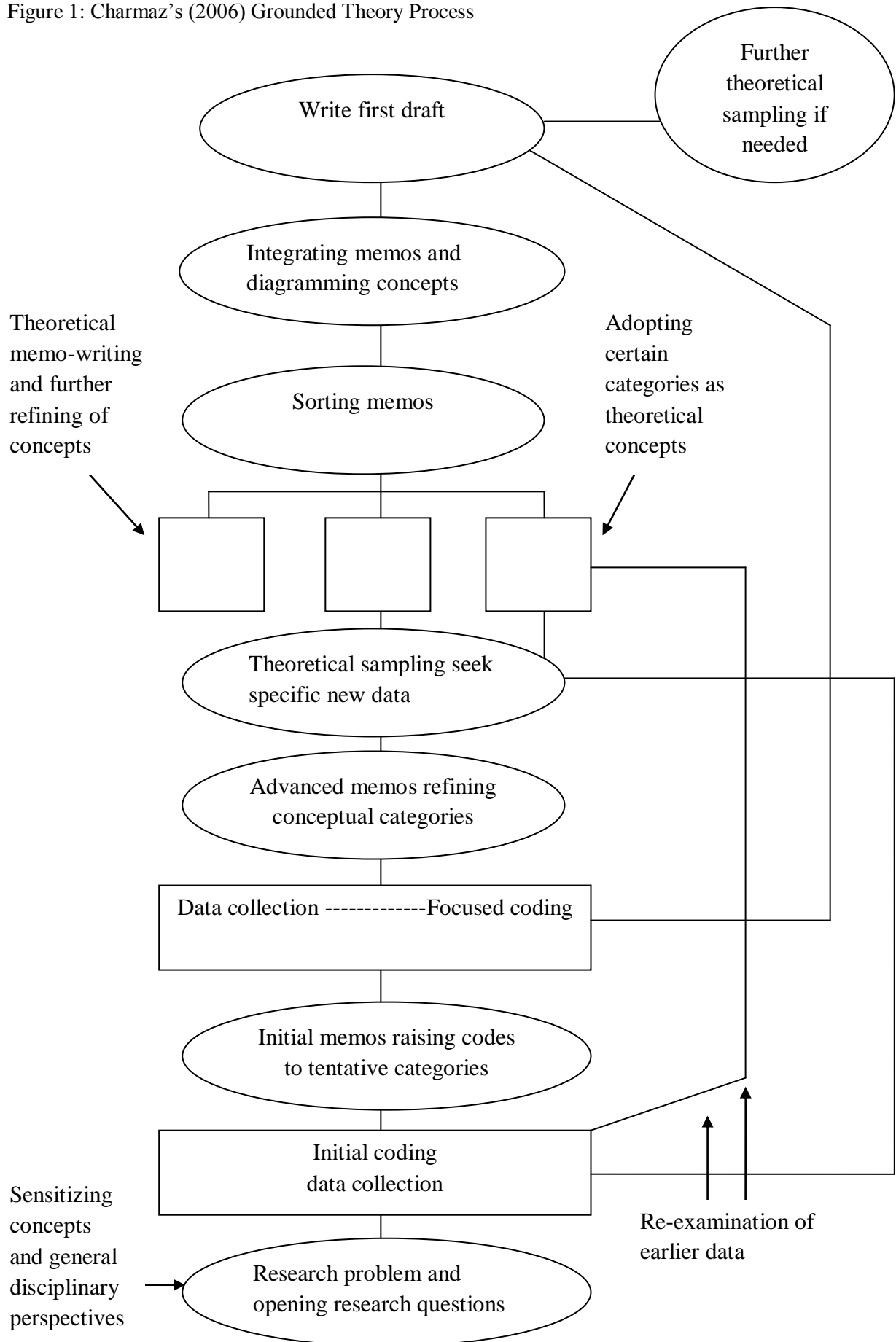


Figure 2: Representation of core categories and relationships between them

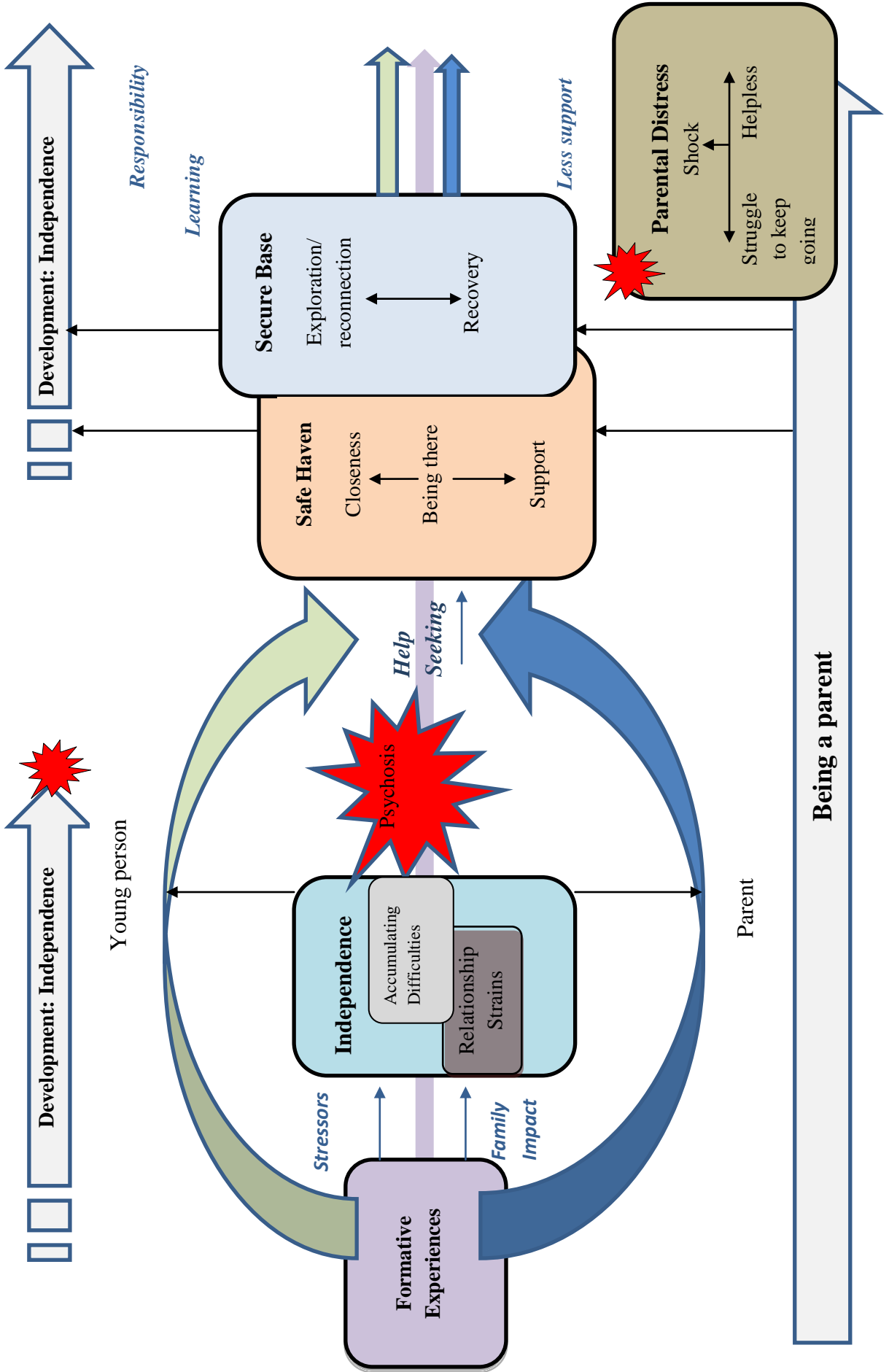


Table 1: Participant Characteristics

Dyad No.	Young person or Parent	Name (pseudonym)	Gender	Age	Transcript No.
1	Young person	Karen	Female	26	2
	Parent	Gillian	Female	65	6
2	Young person	Emma	Female	22	1
	Parent	Sarah	Female	46	8
3	Young person	Michael	Male	27	3
	Parent	Kate	Female	46	9
4	Young person	Kirsty	Female	30	5
	Parent	Lillian	Female	55	10
5	Young person	Alex	Male	25	4
	Parent	Thomas	Male	60	7

Table 2: Qualities of Warmth

Qualities of warmth	Definition
Kindness	The expression of affection, care and love towards others in a friendly and comforting manner, and seeks to understand and forgive. The ability to empathise is key through listening with a non-judgmental and open approach without placing assumptions on the other person.
Reliability	The act of being dependable, honest and consistent. Showing commitment so others become confident in the person's actions instilling trust.
Availability	The expression of enthusiasm and interest to support others. Can be accessed easily and is willing to promptly respond when called upon. Therefore, does not interfere but respects autonomy and is available to offer a range of support.
Sensitivity	Responsive/ attuned to another's needs which is appropriate and in accordance with the situation and level of support required. Shows concern and offers a corresponding and harmonious response. Being thoughtful, considerate and sympathetic to another's difficulties and vulnerabilities through showing dignity and respect.
Security	Expression of responsibility in offering a place of safety, comfort and retreat in which protection and reassurance are provided. This security is guaranteed when needed.
Encouragement	Expression of support of the other person's values and goals, promoting growth, exploration and autonomy when possible therefore, not interfering but showing enthusiasm and interest. Also a want to share activities and interests with others.

CHAPTER 3

ADVANCED CLINICAL PRACTICE I REFLECTIVE CRITICAL ACCOUNT

(Abstract only)

Borderline Personality Disorder and Multi-Disciplinary Teams:

Understanding the Conflicts and Controversies

Abstract

The diagnosis of borderline personality disorder and the assumptions made from this label have both a personal and professional impact on mental health professionals and clients. This reflective account explores the impact of the diagnosis on clients and on professionals from my perspective as a trainee clinical psychologist. I explore working with a person who has been diagnosed with borderline personality disorder and the views of other mental health professionals in this case. The reflection considers a critique of current practice, while drawing on the literature, evidence base and best practice guidelines. Implications for my clinical practice are described, in addition, to thoughts regarding wider implications for clinical psychologists and mental health services. Overall the reflective process is guided by Gibbs' (1988) model of reflective practice and influenced by Casement's (1985) modes of reflection. It is evaluated in terms of learning experiences and therapeutic benefits.

CHAPTER 4

ADVANCED CLINICAL PRACTICE II REFLECTIVE CRITICAL ACCOUNT

(Abstract Only)

Learning about Leadership:

Exploring leadership skills in an inpatient psychology service

Abstract

All clinical psychologists are expected to take on leadership roles from being a trainee to a consultant. This has impacted on training and new ways of working for clinical psychologists within teams and the profession. The reflective account explores how leadership roles are developed as a trainee clinical psychologist. I investigate clinical, professional and strategic levels of leadership and explore ways in which I can, and others have, contributed to the leadership of a clinical psychology service. This includes teaching and training amongst other ways in which psychological systems and resources are managed. The reflection considers my own feelings towards leadership, the skills required for this role and implications for future training and development. Conclusions draw on my own thoughts regarding wider implications for clinical psychologists and mental health services. Overall the reflective process is guided by the Kolb et al., (2001) model of reflective practice, and it is evaluated in terms of learning experiences, skills development and understanding the wider context of the profession.

APPENDICES: SYSTEMATIC REVIEW

Appendix 1.1 Acta Psychiatrica Scandinavica Submission Guidelines (retrieved 12.7.12)

Author Guidelines

Acta Psychiatrica Scandinavica uses ScholarOne Manuscripts, the electronic editorial office. To submit a manuscript, please follow the instructions below:

Submitting Your Manuscript

After you have logged-in, click the 'Submit a Manuscript' link in the menu bar. Follow the prompts and answer the questions as appropriate. Upload your files as instructed. Review your submission before sending to the Journal. Click 'Submit'. You may suspend a submission at any phase before clicking the 'Submit' button. After submission you will receive a confirmation e-mail. The Journal will inform you once a decision has been made on your manuscript.

Authors submitting a paper do so on the understanding that the work has not been published before, is not being considered for publication elsewhere and has been read and approved by all authors.

The authors are requested to pay close attention to the following:

Manuscripts

Consult a current issue of the Journal for style and format. The text should be in double-spacing with broad margins. Review articles/meta-analyses, clinical overview articles and original articles all follow the same concept:

Page 1: A concise, informative title (max 15 words; abbreviations, acronyms, colon, semicolon or the like are not allowed), the authors' names, the names in English of departments and institutions to be attributed, and their city and country of location. Please also include a running title with a maximum of 50 characters (letters and spaces). Name, telephone number, fax number, e-mail address and full postal address of the corresponding author should be stated.

Page 2: Abstract not exceeding 200 words with the following structure: Objective, Method, Results, and Conclusion (the main part of the Abstract is devoted to Results). - Indication of 3 - 5 keywords in strict accordance with [Medical Subject Headings](#).

For review articles/meta-analyses specifically:

Summations. Provide up to 3 significant Summations encapsulating the 'take-home messages' of the paper, and identify the main issues addressed with particular emphasis on their clinical and/or scientific significance. The Summations should be presented succinctly (1 max 2 sentences each), in tabulated form, and logically emerge from the conclusions of the paper (without repeating). However, they must not be dogmatic, raise new issues or pose further questions.

Considerations. In addition, each review article must cite up to 3 noteworthy Considerations in which authors essentially criticise the summations and include any caveats or limitations either of the review process or its conclusions. The *Summations* and *Considerations* are placed immediately below the Abstract/Keywords.

Introduction:

One to two pages concluded by the subtitle *Aims of the Study* (3 to 5 lines without literature references and abbreviations). A thorough *Material and methods* section. It should be possible to read every article by itself. The author cannot refer to design, method and material described in previously published articles. *Results.* Clear and short avoiding double documentation to tables/figures.

Discussion: *Acta Psychiatrica Scandinavica* articles do not have a conclusion section. If the authors find it necessary, they may include a concluding remark of maximum 5 lines as the final part of the Discussion.

Acknowledgements: Should include grants, sponsorships and other support to the study. Some authors may wish to thank other collaborators apart from the authors. It is stressed that only a very few people

can be listed. It is the responsibility of the author to obtain written permission from the persons mentioned.

Declaration of Interest: Must be given if the study in any way involves pharmaceutical companies or other private or public enterprises. Each author must declare him/herself in general and not only in relation to the present study. If the study in any way investigates pharmaceutical compounds, the *Declaration of Interest* must contain information about by whom and which institutions the statistical analyses were performed and an e-mail address where to obtain the protocol. Clinical studies must be registered in online clinical databases. Please state date for registration and registration number.

Reference list: Use the Vancouver system. We recommend the use of a tool such as Reference Manager for reference management and formatting. Reference Manager reference styles can be searched for here: <http://www.refman.com/support/rmstyles.asp>

Tables and figures: Must include legends. A maximum of 5 tables/figures can be included. Figures are given priority.

Abbreviations and symbols

For abbreviations and symbols use *Units, Symbols and Abbreviations for Authors and Editors in Medicine Related Sciences*, Sixth Edition. Edited by D.N. Baron and M McKenzie Clarke. ISBN: 9781853156243, Paperback, April, 2008. All terms or abbreviations should be fully explained at first mention. All units should be metric. Use no Roman numerals. Abbreviations are not allowed in titles, headings and “Aims of the Study”.

References

Should be kept to the pertinent minimum and numbered consecutively in the order in which they appear in the text in accordance with the *Vancouver System*. Identify references in text, tables, and legends by Arabic numerals (in parentheses). References cited only in tables or figure legends should be numbered in accordance with a sequence established by the first identification of that figure or table in the text. Use the style of the examples below, which are based on Index Medicus. Include manuscripts accepted, but not published; designate the abbreviated title of the journal followed by (in press). Papers published electronically, not yet hard copy publication should be identified by their DOI-number. Information from manuscripts not yet accepted should be cited in the text as personal communication. References must be verified by the authors against the original documents. Titles of journals should be abbreviated in accordance with Index Medicus. Examples:

Standard journal article: List all authors when 6 or fewer. When there are 7 or more, list only the first 3 authors and add "et al".

Illustrations/tables

All figures/tables should clarify the text and their number be kept to a minimum and not exceed 5 in total. Avoid data overload. Details must be large enough to retain their clarity after reduction in size. Illustrations should be planned to fit the proportions of the printed page.

Copyright Form

Authors should complete a [Copyright Transfer Agreement \(CTA\)](#)

Please note: The Copyright Transfer Agreement asks you to note who publishes *Acta Psychiatrica Scandinavica*. In that field please write 'Wiley-Blackwell on behalf of John Wiley & Sons A/S'.

US Federal Government employees need to complete the Author Warranty sections, although copyright in such cases does not need to be assigned. Production will not commence until the signed Copyright Transfer Agreement is received. A completed form is not required at submission. The form is also available for download from the ScholarOne Manuscripts site by following the 'Instructions and Forms' link from <http://mc.manuscriptcentral.com/actapsych>. Please note that if delays are to be avoided, a signed form must be sent to the production office as soon as the manuscript has been *accepted* for publication.

Appendix 1.2

Electronic Search Strategy : MEDLINE (OVID)

The following search terms were used to search all databases:

Limits used: - English, Humans

- 1980 to current (March 2012)

Search terms:

Psychosis

Schizophrenia

Psychotic Disorders

1 or 2 or 3

Adult Attachment Interview

Adult Attachment

Attachment

5 or 6 or 7

4 and 8

Appendix 1.3

Risk of Bias Data Extraction Sheet

Risk Variable	Study X
1. Were the aims/ hypothesis clearly stated?	
Sampling	
2. Is the sample: i. Convenience sample (e.g., clinic attenders, referred patients)? ii. Geographical cohort (e.g., all participants eligible in a particular area)? iii. Highly selective (e.g., volunteers)?	
3. Is the sample size based on described and adequate power calculations?	
4. Were the following characteristics of participants described adequately? (a) age (b) gender (c) education level (d) recruitment site (e) a flow diagram of participants	
5. (a) Was a patient population used? (b) If so did it state whether participants were in/ out-patients?	
6. (a) Was the diagnosis of the participants reported? (b) With regard to diagnosis was a homogenous group used? (c) Was length of illness reported? (d) Was the medication the participants were taking reported?	
7. (a) Was DSM-IV or ICD-10 used to confirm the diagnosis? (b) Were psychiatric symptoms assessed with a reliable and valid measure? (c) Was symptom severity noted?	
8. Were the inclusion/ exclusion criteria clearly stated?	
9. (a) Was the response rate of the study noted? (b) Were characteristics of those not to taking part noted? (c) Were analyses conducted comparing participants and those who refused to participate/ drop out?	
Procedure	
10. Was it explicitly stated that attachment was assessed in relation to factors associated with the experience of psychosis?	
11. How was attachment measured?	
12. Was the quality of the attachment measure provided (e.g., factorial validity, reliability, etc.)?	
13. (a) Was the attachment measure used in a standardised way? (b) Was this explained? (c) Was adherence to the procedure assessed? (d) Was the timing of the assessment stated?	

14. Was there an indication of who assessed patients i.e. their qualification and training on measures?	
15. Was the attachment relationship reported?	
16. Was reliability within the sample assessed?	
17. (a) Were any other measures used? (b) Were they described? (c) Was the reliability and validity of each measure provided?	
18. Were other attachment relationships explored?	
19. Were the procedures described in enough detail to be replicable?	
Analysis	
20. Were the analyses planned?	
21. Was the analysis appropriate to the design and type of measure?	
22. Were any additional analyses justified?	
23. Did the analysis include all participants?	
24. Was there an adequate investigation and handling of why drop outs from assessment?	
25. (a) Were the results reported clearly? (b) Were the mean, median, confidence interval and effect size reported?	
Discussion	
26. Where the conclusions drawn in accordance with the data?	
27. Was there a critique of the methodology?	
28. Were the findings provided in context with previous research and theory?	
29. Were the clinical implications specified?	

Appendix 1.4

Methodological characteristics of the included studies

* Question numbers relate to the Risk of Bias Sheet (Appendix 1.3)

Question no.	Article reference					
	Arbuckle (2010)	Berry (2008)	Berry (2009)	Berry (2011)	Blackburn (2010)	Couture (2007)
1.	Yes	Yes	Yes	Yes	Yes	Yes
Sampling						
2.	ii	ii	ii	ii	ii	ii
3.	No	No	No	No	No	No
4. (a)	Yes	Yes	Yes	Yes	Yes	Yes
(b)	Yes	Yes	Yes	Yes	Yes	Yes
(c)	No	Yes	No	No	No	Yes
(d)	Yes	Unclear	Unclear	Yes	Yes	Yes
(e)	No	Yes	No	No	No	No
5. (a)	Yes	Yes	Yes	Yes	Yes	Yes
(b)	In	Both	Both	Both	In	Both
6. (a)	Yes	Yes	Yes	Yes	Yes	Yes
(b)	No	No	No	No	No	Unclear
(c)	No	Yes	Yes	Yes	Yes	No
(d)	No	No	No	No	No	No
7. (a)	No	No	Yes	Yes	No	No
(b)	Yes	Yes	Yes	Yes	Yes	Yes
(c)	No	Yes	Yes	Yes	Yes	Yes
8.	No	Yes	Yes	Yes	No	Yes
9. (a)	Yes	Yes	Yes	No	No	No
(b)	No	No	No	No	No	No
(c)	No	No	No	No	No	No
Procedure						
10.	Yes	Yes	Yes	Yes	Yes	Yes
11.	PAM	PAM	PAM	PAM	PAM	ASQ
12.	Yes	Yes	Yes	Yes	Yes	Yes
13. (a)	Yes	Unclear	Unclear	Unclear	Unclear	Unclear
(b)	Yes	No	No	Yes	No	No
(c)	No	No	No	No	No	No
(d)	No	No	No	No	No	No
14.	Yes	Yes	No	Yes	Yes	Yes
15.	Yes	No	No	No	Yes	Yes
16.	Yes	Yes	Yes	Yes	Yes	Yes
17. (a)	Yes	Yes	Yes	Yes	Yes	Yes
(b)	Yes	Yes	Yes	Yes	Yes	Yes
(c)	Yes	No	Yes	Yes	Yes	No
18.	Yes	No	No	No	No	No
19.	Yes	Yes	Yes	Yes	Yes	Briefly
Analysis						
20.	Yes	Yes	Yes	Yes	Yes	Yes
21.	Yes	Yes	Yes	Yes	Yes	Yes
22.	Yes	Yes	Yes	n/a	Yes	Yes
23.	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear
24.	Unclear	No	No	Yes	No	No
25. (a)	Unclear	Yes	Yes	Yes	Yes	Yes
(b)	Unclear	No	Yes	Yes	Yes	Yes
Discussion						
26.	Yes	Yes	Yes	Yes	Yes	Yes
27.	Yes	Yes	Yes	Yes	Yes	Yes
28.	Yes	Yes	Yes	Yes	Yes	Yes
29.	Briefly	Yes	Briefly	Yes	Yes	No
Rating Totals						
Yes	26	27	26	29	27	25
Briefly	1	0	1	0	0	1
Unclear	4	3	3	2	2	3
No	13	14	14	12	15	15
Specific answer/ n/a	3	3	3	4	3	3

Question no.*	Article reference						
	Dozier (1991)	Kvrgic (2011)	MacBeth (2010)	Mulligan (2010)	Picken (2010)	Ponizovsky (2007)	Ponizovsky (2011)
1.	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sampling							
2.	ii	ii	ii	ii	ii	ii	ii
3.	No	No	No	Yes	No	No	No
4. (a)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
(b)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
(c)	Yes	Yes	Yes	Yes	No	Yes	Yes
(d)	Unclear	Yes	Yes	Yes	No	Yes	Yes
(e)	No	No	No	No	No	No	No
5. (a)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
(b)	Unclear	Out	Out	Out	Unclear	In	Out
6. (a)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
(b)	No	No	No	Yes	No	Yes	No
(c)	No	Yes	Yes	Yes	Yes	Yes	Yes
(d)	No	yes	Yes	No	No	Yes	No
7. (a)	Yes	Yes	Yes	No	No	Yes	Yes
(b)	Yes	Yes	Yes	Yes	No	Yes	Yes
(c)	Yes	Yes	Yes	Yes	No	Yes	Yes
8.	Yes	Yes	Yes	Yes	No	No	Yes
9. (a)	No	No	No	No	Yes	No	No
(b)	No	No	No	No	No	No	No
(c)	No	No	No	No	No	No	No
Procedure							
10.	Yes	Yes	Yes	Yes	Yes	Yes	Yes
11.	AAI	PAM	AAI	ASQ	PAM	AAQ	RQ
12.	Yes	Yes	Yes	Yes	Yes	No	No
13. (a)	Yes	Unclear	Yes	Yes	Unclear	Unclear	Unclear
(b)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
(c)	No	Yes	Yes	No	No	No	No
(d)	No	No	Yes	No	Yes	No	No
14.	No	Yes	Yes	No	No	No	No
15.	Yes	No	Yes	No	No	No	No
16.	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17. (a)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
(b)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
(c)	No	Yes	No	Yes	No	No	Yes
18.	No	No	No	No	No	No	No
19.	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Analysis							
20.	Unclear	Yes	Yes	Yes	Unclear	Unclear	Yes
21.	Yes	Yes	Yes	Yes	Yes	Yes	Yes
22.	Unclear	Yes	n/a	Yes	Yes	n/a	n/a
23.	Unclear	Unclear	Yes	Unclear	No	Yes	Yes
24.	Unclear	Unclear	Unclear	Unclear	No	Unclear	Unclear
25. (a)	Unclear	No	Yes	Yes	Yes	Yes	Yes
(b)	No	No	Yes	Yes	Yes	Yes	Yes
Discussion							
26.	Yes	Yes	Yes	Yes	Yes	Yes	Yes
27.	Yes	Yes	Yes	Yes	Yes	Yes	Yes
28.	Yes	Yes	Yes	Yes	Yes	Yes	Yes
29.	No	Yes	Yes	Yes	Yes	Yes	Yes
Rating Totals							
Yes	23	30	34	31	23	27	28
Briefly	0	0	0	0	0	0	0
Unclear	7	3	1	2	3	3	2
No	15	11	8	11	19	13	13
Specific answer or n/a	2	3	4	3	2	4	4

Question no.*	Reference					
	Dozier (1990)	Dozier (1994)	Tait (2004)	Dozier (1995)	Dozier (2001)	Tyrrell (1999)
1.	Yes	Yes	Yes	Unclear	Yes	Yes
Sampling						
2.	ii	ii	ii	ii	ii	ii
3.	No	No	No	No	No	No
4. (a)	Yes	Yes	Yes	No	Yes	Yes
(b)	No	Yes	Yes	Yes	Yes	Yes
(c)	No	No	Yes	No	No	Yes
(d)	No	Unclear	Yes	Yes	No	Yes
(e)	No	No	No	No	No	No
5. (a)	Yes	Yes	Yes	Yes	Yes	Yes
(b)	Both	Unclear	Unclear	No	Unclear	Out
6. (a)	Yes	Yes	Yes	Yes	Yes	Yes
(b)	No	No	No	No	No	No
(c)	No	No	Yes	No	No	No
(d)	No	No	No	No	No	No
7. (a)	Yes	Yes	Yes	Yes	Yes	Yes
(b)	No	No	Yes	Yes	No	No
(c)	No	No	Yes	Yes	No	No
8.	No	No	Yes	No	No	No
9. (a)	No	No	Yes	No	No	No
(b)	No	No	Briefly	No	No	No
(c)	No	No	Yes	No	No	No
Procedure						
10.	Yes	Yes	Yes	Yes	Yes	Yes
11.	AAI	AAI	RAAS	AAI	AAI	AAI
12.	No	Yes	No	No	Yes	Yes
13. (a)	Yes	Unclear	Unclear	Unclear	Unclear	Unclear
(b)	Yes	Unclear	Yes	No	No	Yes
(c)	No	No	No	No	No	No
(d)	No	No	Yes	No	No	No
14.	Yes	Yes	No	Yes	No	Yes
15.	Yes	Yes	Yes	Yes	Yes	Yes
16.	Yes	Yes	Yes	Yes	Yes	Yes
17. (a)	Yes	Yes	Yes	Yes	Yes	Yes
(b)	Yes	Yes	Yes	Yes	Yes	Yes
(c)	Yes	Yes	No	Yes	Yes	Yes
18.	No	Yes	Yes	No	No	No
19.	Yes	Yes	Yes	Briefly	Yes	Yes
Analysis						
20.	Yes	Unclear	Yes	Unclear	Unclear	Yes
21.	Yes	Yes	Yes	Yes	Yes	Yes
22.	n/a	Unclear	Yes	No	Yes	Yes
23.	Yes	Unclear	No	Yes	No	Unclear
24.	n/a	No	Unclear	Unclear	Unclear	Unclear
25. (a)	Yes	Yes	Yes	Yes	Unclear	Yes
(b)	Yes	Yes	Yes	Yes	Yes	Yes
Discussion						
26.	Yes	Yes	Yes	Yes	Yes	Yes
27.	Yes	Briefly	Yes	Yes	Yes	Yes
28.	Yes	Yes	Yes	Yes	Briefly	Yes
29.	Briefly	No	Yes	Briefly	Yes	Yes
Rating Totals						
Yes	23	21	32	21	20	27
Briefly	1	1	1	2	1	0
Unclear	0	7	3	4	5	3
No	18	16	9	18	19	14
Specific answer or n/a	5	2	2	2	2	3

APPENDICES: MAJOR RESEARCH PROJECT

Appendix 2.1 Psychosis: Psychological, Social and Integrative Approaches (Accessed 12.07.12)

Instructions for authors

Complete guidelines for preparing and submitting your manuscript to this journal are provided below. The instructions below are specifically directed at authors that wish to submit a manuscript to *Psychosis*.

***Psychosis* considers all manuscripts on the strict condition that they have been submitted only to *Psychosis*, that they have not been published already, nor are they under consideration for publication or in press elsewhere.**

Contributions to *Psychosis*, whether research papers, reviews, or first person accounts (from service users or therapists), will be subjected to peer review by referees at the discretion of the Editorial Office.

Manuscript preparation

1. General guidelines

- Manuscripts should be consistent with the Aims and Scope of the journal.
- Papers are accepted only in English. American or British English spelling and punctuation is preferred provided usage is consistent throughout.
- The following word limits apply (including the abstract, tables, figures, and references):
 - Research articles and reviews will not exceed 5,000 words.
- Submitted manuscripts should be anonymised to allow for review. A separate title page should be submitted containing the author name.
- Manuscript should be assembled in the following order: main text; acknowledgements; appendixes (as appropriate); references; table(s) with caption(s) (on individual pages).
- A separate Abstracts of 200 words should also be provided for research papers.
- Each paper should have up to five keywords.
- Section headings should be concise.
- Please include, in the discussion section, a subsection subtitled Clinical Implications (or Practical Implications if you see implications beyond mental health services, e.g., primary prevention).
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms should not be used.
- Authors must adhere to SI units . Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.
- Authors are encouraged to identify at least one 'preferred reviewer' when submitting.

2. Style guidelines

- Description of the Journal's article style, quick guide.
- Description of the Journal's reference style, quick guide. Visit CiteRefs for assistance in ensuring accurate referencing according to APA style.

3. Figures

We welcome figures sent electronically, but care and attention to these guidelines are essential as importing graphics packages can often be problematic.

- Figures must be saved individually & separate to text. Do not embed figures in the paper file.
- Avoid the use of colour and tints for purely aesthetic reasons.
- Figures should be produced as near to the finished size as possible.

- All figures must be numbered in the order in which they appear in the paper (e.g., figure 1, figure 2). In multi-part figures, each part should be labeled (e.g., figure 1(a), figure 1(b)).
- Figure captions must be saved separately, as part of the file containing the complete text of the paper, and numbered correspondingly.
- The filename for the graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).

4. Tables

Tables should be numbered consecutively with Arabic numbers in order of appearance in the text. Type each table double-spaced on a separate page, with a short descriptive title typed directly above and with essential footnotes below.

5. Reproduction of copyright material

Contributors are required to secure permission for the reproduction of any figure, table or extensive extract (more than fifty words) from the text of a source that is copyrighted or owned by a party other than Taylor & Francis or the contributor. This applies to direct reproduction as well as 'derivative reproduction', where the contributor has created a new figure or table that derives substantially from a copyrighted source. Authors are themselves responsible for the payment of any permission fees required by the copyright owner. Copies of permission letters should be sent with the manuscript upon submission to the Editor(s).

6. Informed consent

Manuscripts must include a statement that informed consent was obtained from human subjects. Authors should protect patient anonymity by avoiding the use of patients' names or initials, hospital number, or other identifying information.

7. Code of experimental ethics and practice and confidentiality

Contributors are required to follow the procedures in force in their countries which govern the ethics of work conducted with human or animal subjects. The Code of Ethics of the World Medical Association (Declaration of Helsinki) represents a minimal requirement.

For human subjects or patients, describe their characteristics. For human participants in a research survey, secure the consent for data and other material - verbatim quotations from interviews, etc. - to be used. Specific permission for any facial photographs is required. A letter of consent must accompany any photographs in which the possibility of identification exists. It is not sufficient to cover the eyes to mask identity.

It is your responsibility to ensure that the confidentiality of patients is maintained. All clinical material used in your article must be disguised so that it is not recognisable by a third party. Where possible and appropriate, the permission of the patient should be obtained. Authors are invited to discuss these matters with the editor if they wish.

8. Competing financial interests

A competing interest exists when your interpretation or presentation of information may be influenced by your personal or financial relationship with other people or organizations. Authors should disclose all financial and non-financial competing interests.

Authors are required to complete a declaration of competing interests and submit it together with the manuscript. All competing interests that are declared will be listed at the end of published articles. Where an author gives no competing interests, the listing will read 'The author(s) declare that they have no competing interests'. Please consider the following questions:

1. In the past five years have you received reimbursements, fees, funding, or salary from an organization that may in any way gain or lose financially from the publication of this

manuscript, either now or in the future? Is such an organization financing this manuscript? If so, please specify.

2. Do you hold any stocks or shares in an organization that may in any way gain or lose financially from the publication of this manuscript, either now or in the future? If so, please specify.
3. Do you hold or are you currently applying for any patents relating to the content of the manuscript? Have you received reimbursements, fees, funding, or salary from an organization that holds or has applied for patents relating to the content of the manuscript? If so, please specify.
4. Do you have any other financial competing interests? If so, please specify.

9. Affirmation of authorship

All authors are expected to have made substantive intellectual contributions to, and to have been involved in drafting or revising the manuscript. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. Acquisition of funding, collection of data, or general supervision of the research group, alone, does not justify authorship. With the submission of a manuscript, it is assumed that all authors have read and approved the final manuscript.

10. Acknowledgements

All contributors who do not meet the above criteria for authorship should be listed in an acknowledgements section. Examples of those who might be acknowledged include those who provided general, technical, or writing assistance. Acknowledgement of funding/grants are also included in this section.

Manuscript submission

All submissions should be made online at the *Psychosis* ScholarOne Manuscripts site. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. To ensure blinded review authors should only include identifying information on a title page which can be uploaded separately.

Manuscripts may be submitted in any standard Word format or PostScript. This journal does not accept Microsoft Word 2007 documents. Please use Word's "Save As" option to save your document as an older (.doc) file type. LaTeX files should be converted to PDF prior to submission because Manuscript Central is not able to convert LaTeX files into PDFs directly.

Authors are required to recommend at least two potential reviewers for their paper.

Copyright and authors' rights

As an author, you are required to secure permission if you want to reproduce any figure, table, or extract from the text of another source.

WoSRES

West of Scotland Research Ethics Service

West of Scotland REC 1

West of Scotland Research Ethics Service
Ground Floor, Tennent Institute
38 Church Street
Glasgow
G11 6NT

Telephone: 0141 211 6238
Facsimile: 0141 211 1847

06 October 2011

Prof Andrew I Gumley
Chair of Psychological Therapy
University of Glasgow
Mental Health and Wellbeing
Gartnavel Royal Hospital
Glasgow G12 0XH

Dear Prof Gumley

Study title: Talking the same language? Parents and young people
in transition after first episode psychosis.

REC reference: 11/WS/0065

The Research Ethics Committee reviewed the above application at the meeting held on 04 October 2011. The committee thanked Hannah Taylor for attending the meeting in your absence.

Ethical opinion

The committee had several questions for the researcher which were answered to their satisfaction namely:

Study Design:

The committee wish strongly to make the point that Question A12 is not written in lay terms for committee members and future submissions should have this addressed.

- a) Which of the two parents will be chosen and how are they selecting? It is up to the patient - either mother or father.
 - b) How relevant is the likely difference in relationships of 30+ year olds cf 18 year olds with parents? After the FEP - discussion brings out themes - different age groups will give different answers - this is all relevant.
 - c) Parents may feel that they have done something wrong to cause their offspring to become ill? Feel Guilty. We will be seeing these people when the patient is in recovery and the Duty Mental Health worker will be present at the end of the interview
 - d) The committee wish sight of Management letter approving the use of the extra resources required for the above i.e. the use of the Duty Mental Health Worker for research purposes.
 - e) 40 hours of tape transcription - who is going to do this? This will be done by myself.
 - f) What will happen if important information is found? Yes, this will be fed back appropriately.
-

- g) ESTEEM - Who are they? The patients will all be known to ESTEEM before.
- h) Indemnity - the committee are surprised that the University is not sharing indemnity in this study.
- i) The committee feel that the researchers might wish to look at not restrict themselves by wishing to include only those whose parent/offspring would agree together - it may be that useful information could be gleaned from either party on their own.
- j) The committee wondered if the researchers might take into account participants where the relationships may not be too good.

The members of the Committee present gave a favourable ethical opinion of 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

NHS 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.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study 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 a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

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

Other conditions specified by the REC

The committee feel that the study would benefit from the title being amended to read "Parents and young people in transition after first episode psychosis (FEP)" i.e. delete "talking the same language" from all study documents.

Invitation Letter for Parent/guardian.

- a) "your young person" should be amended to read "son/daughter" where stated.
- b) 3rd paragraph - should read "We hope to understand more about how relationships are influenced by psychosis in order to develop ways of etc. Any reference to "will help" should read "may help"

- c) The committee feel that no personal contact telephone numbers should be added to the PIS -only departmental numbers should be issued.

Information Sheet for Parent/Guardian ✓ The same comments in respect of title should be noted.

a) Page 1 - Any reference to "your young person" should be amended to read "your son/daughter" where stated.

b) Page 1 - "What is the research about" - should read "... I am interested in whether your relationship changed with "your son/daughter" during the first episode of psychosis etc.

c) Page 2 - "Interviews being recorded" - delete "carefully" from line 1.

* d) It should be made clear that the two sides will be interviewed separately from each other and that confidentiality between the interviews will be maintained.

* e) A further sentence should be added in respect of if any further information is discovered then this will be fed back appropriately to the clinicians.

f) A further sentence should be added in respect of the Duty Mental Health Worker being available at the time of the interviews.

* Participant Information Sheet - Young person. The same information in respect of study title should be addressed.

a) Any reference to "will help" should read "may help"

b) It should be made clear that the two sides will be interviewed separately from each other and that confidentiality between the interviews will be maintained.

c) A further sentence should be added in respect of any further clinically important information is discovered then this will be fed back appropriately to the clinicians.

d) Page 2 - top sentence should be enlarged to make clear that if either the parent or the young person does not wish to take part then the other person cannot take part in the study.

e) A further sentence should be added in respect of the Duty Mental Health Worker attending the interviews.

f) Page 3 - "Advantages etc" - 1st line - delete "it is important to be aware that"

✓ Consent Forms: All should have the undernoted added:

a) That GP will be informed

b) Agreement that Duty Mental Health Worker will be present at interview

c) Agreement to the interviews being recorded.

* GP Letter: A separate GP letter for both Parent/Guardians and Young People should be drawn up.

✓ a) Delete - "see the PIS attached etc" - and add a further sentence to the effect that the Key Worker will be involved.

The above amended documents should come back to the Secretary for checking and filing.

It is 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).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Advertisement	1	07 August 2011
GP/Consultant Information Sheets	1	07 August 2011
Interview Schedules/Topic Guides	1	07 August 2011
Investigator CV	Andrew Gumley	19 August 2011
Letter of invitation to participant	for parent/guardian V1	19 August 2011
Other: CV - Student - Hannah Taylor		19 August 2011
Participant Consent Form: Young person	1	07 August 2011
Participant Consent Form: Parent/Guardian	1	07 August 2011
Participant Consent Form: Young Persons consent form to contact Parent /Guardian	1	07 August 2011
Participant Information Sheet: Young Persons Information Sheet	1	07 August 2011
Participant Information Sheet: Parent/Guardian	1	07 August 2011
Protocol	1	09 August 2011
REC application		15 September 2011
Referees or other scientific critique report	Letter from Prof T McMillan	12 July 2011

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

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

Reporting requirements

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
- Notification of serious breaches of the protocol
- 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.

Feedback

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.

Further information is available at National Research Ethics Service website > After Review

11/WS/0065

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

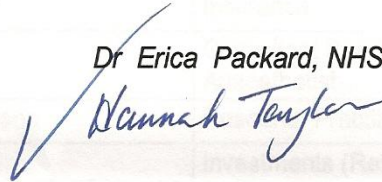


Dr John Hunter
Chair

Email: andrea.torrie@ggc.scot.nhs.uk

*Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments
"After ethical review – guidance for researchers" SL-AR2*

Copy to: *Dr Erica Packard, NHS R&D*





Coordinator/Administrator: Dr Erica Packard/Mrs Elaine O'Neill
Telephone Number: 0141 211 6208
E-Mail: erica.packard@ggc.scot.nhs.uk
Website: www.nhsggc.org.uk/r&d

R&D Management Office
Western Infirmary
Tennent Institute
1st Floor 38 Church Street
Glasgow, G11 6NT,

30 November 2011

Miss Hannah Taylor
Trainee Clinical Psychologist
Mental Health and Wellbeing
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

NHS GG&C Board Approval

Dear Miss Taylor,

Study Title:	Talking the same language? Parents and young people in transition after first episode psychosis
Principal Investigator:	Miss Hannah Taylor
GG&C HB site	ESTEEM South
Sponsor	NHS Greater Glasgow and Clyde
R&D reference:	GN11CP290
REC reference:	11/WS/0065
Protocol no:	V2; 10/10/11
<small>(including version and date)</small>	

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004
 - a. During the life span of the study GGHB requires the following information relating to this site
 - i. Notification of any potential serious breaches.
 - ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file.

Delivering better health

www.nhsggc.org.uk

Page 1 of 2

R&D Approval Letter GN11CP290

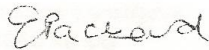
2. **For all studies** the following information is required during their lifespan.
 - a. Recruitment Numbers on a quarterly basis
 - b. Any change of staff named on the original SSI form
 - c. Any amendments – Substantial or Non Substantial
 - d. Notification of Trial/study end including final recruitment figures
 - e. Final Report & Copies of Publications/Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely,



Dr Erica Packard
Research Co-ordinator



Participant Information Sheet

Study Title: Parents and young people in transition after first episode psychosis.

I would like to invite you to take part in a research study. My name is Hannah Taylor and I am a Trainee Clinical Psychologist. I am interested in learning about how relationships change between a young person and their parent/ guardian during a first episode of psychosis. Before you decide to take part it is important for you to understand why the research is being carried out and what it will involve. Please take the time to read this information sheet carefully, and if you have any questions then please ask me. You can phone and speak to me on the following number on a Tues, Wed and Thurs. My work number is XXXXXXXXXX. Other ways to contact me are listed at the end.

What is the research about?

The research is about how a first episode of psychosis may change the relationship between a young person and their parent/ guardian. All life events impact on the relationships we have with those around us. Sometimes this can help us to cope and other times difficulties can arise. I am interested in how your relationship with your parent/ guardian changed during a first episode of psychosis and how you coped with this. Therefore, I am interested in speaking to you and your parent/ guardian.

We hope to understand more about how relationships are influenced by psychosis in order to develop ways of helping both young people and their families more effectively in the future. This is why this particular project is being conducted. You may be helping others understand the changes that happen as a result of psychosis and how you coped with this.

Why have I been asked to take part?

You have been asked to take part in the study because you expressed some interest in participating to your key worker from ESTEEM when they told you about the study or from the posters you have seen advertising the study in the ESTEEM waiting room. **We need both you and your parent/ guardian to take part.**

Do I have to take part?

NO, you do not have to take part in this study. It is up to you whether or not you wish to take part.

If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form to say that you have given permission for myself to contact your parent/ guardian who you would also like to take part.

Before the study starts everyone who participates will be asked to sign a consent form to make sure they know what they have agreed to. If you decide to take part now and then change your mind later, you can withdraw from the study and you do not have to give a reason why. This will not affect the care you receive from ESTEEM.

What will happen next?

If you decide you would like to take part we can arrange a time to meet at your local ESTEEM service. The interview will last around 45 minutes to one hour; however, this depends on how you feel and if you would like to finish the interview earlier that is fine. I will also send a letter to you GP, key worker and Psychiatrist just to let them know that you are taking part in the study. Your interview will be conducted separately from your parent/ guardians interview.

Confidentiality between the interviews will be maintained at all times, this means that I will not pass on any information from your interview to your parent/ guardian. However, if any clinically important information is discovered then this will be fed back to the appropriate clinicians at ESTEEM.

What will I have to do?

At our meeting I will answer any questions or concerns you might have. I will ask if the meeting can be recorded on a digital recorder. You are free to stop recording at any time during our interview. I will then ask you some questions about your experiences.

It is important to remember there are no right or wrong answers. It is your perspective that I would like to hear.

Why are the interviews being recorded?

I need to record the interviews to understand your experiences and our conversation. All the interviews will be transcribed and any personally identifiable information will be removed. Interviews will be anonymous. Therefore, it will not be possible to identify who you are from the interview. After the interviews are transcribed the recordings will be destroyed, and the transcribed interviews will be stored on a password protected and encrypted computer. The only individuals who will have access to this will be myself, and my supervisor Professor Andrew Gumley from the University of Glasgow.

What are the disadvantages of taking part?

It is possible that our discussions may cover topics that are difficult or distressing to talk about. Please remember that you can take a break at anytime and you do not have to discuss the topics that are distressing for you. A Duty Mental Health Worker will be available during our interview if further support is required.

What are the advantages of taking part?

Although there are no direct benefits of taking part the information we learn from this study may help us develop strategies to help other people in a similar situation to yourself and your family. You may also find the process of talking through your experiences useful. It might help you to make sense of how you feel about your experience.

What will happen to the results of the study?

I will provide you with a summary of the results of the study if you request them. The final results of the study will be published in a scientific journal within two years of its completion. The study will also form part of my qualification in Clinical Psychology. There will be no identifiable information in any part of the write up of this study.

Who is organising and funding the research?

The University of Glasgow.

General information about research

If you would like independent information and general advice about taking part in research then please contact Dr Ross White, Clinical Research Fellow from the University of Glasgow on XXXXXXXXXXXXX.

Thank you for taking the time to read this information sheet.

Hannah Taylor

Trainee Clinical Psychologist

Academic Unit for Mental Health and Wellbeing,
Admin Building, Gartnavel Royal Hospital,
1055 Great Western Road, Glasgow, G12 0XH.

If you are interested in taking part in the study please fill out the tear-off slip below and return it in the freepost envelope provided.

Hannah Taylor, Trainee Clinical Psychologist will then contact you to give you more information / arrange your meeting at a time that is suitable for you.

Or telephone Hannah on: XXXXXXXXXXXXXXXXX

Study: Parents and young people in transition after first episode psychosis

Name

Telephone Number

Address

Please tick:

I would like to participate in this study/ would like more information on this study.

Please return this reply slip in the freepost envelope provided



Academic Unit for Mental Health and Wellbeing,
Admin Building, Gartnavel Royal Hospital,
1055 Great Western Road,
Glasgow, G12 0XH

Subject number:

Participant Consent Form to contact parent/ guardian

THIS IS NOT A CONSENT FORM TO PARTICIPATE IN THE STUDY

Study title: Parents and young people in transition after first episode psychosis.

**Please initial the
BOX**

I give consent for Hannah Taylor, Trainee Clinical Psychologist to contact my parent/ guardian (named below) regarding the research topic that I have expressed an interest in (see title above).

Parent/ guardian name: _____

Name of Participant Date Signature

Name of researcher Date Signature

1 copy to the patient, 1 copy to the researcher, 1 Original for the patients' notes

Appendix 2.8

Interview Schedule

Introduction

Could you start by telling me who is in your family?

Refer to the early relationship section for the young person or the parent/ guardian.

Early relationship- Parent

Could you describe your relationship with your child from their early childhood through to adolescence?

Could you choose five adjectives or words that reflect your relationship with your child from as far back as you can remember?

You described your relationship with your child as (insert the adjective provided), can you think of a memory or an incident that would illustrate why you chose that (insert adjective) to describe the relationship?

When your child was upset when they were young, what would you do?

Probes

- When your child was upset emotionally when they were little, what would you do? Can you think of a specific time that happened?
- Can you remember when your child was hurt physically when they were young? Do any specific incidents come to mind?

Was your child ever physically ill when they were young (e.g., had flu, etc)?

Probes:

- Do you remember what would happen? Do you remember what your child would do? Do you remember holding your child when they were upset, hurt or ill?

When was the first time you remember being separated from your child?

Probes:

- How did you respond? How did your child respond? Are there any other separations that stand out in your mind?

Early relationship- Young person

Could you describe your relationship with your parent/ guardian from early childhood through to adolescence?

Could you choose five adjectives or words that reflect your relationship with your parent/ guardian from as far back as you can remember?

You described your relationship with your parent/ guardian as (insert the adjective provided), can you think of a memory or an incident that would illustrate why you chose (insert adjective) to describe the relationship?

When you were upset as a child, what would you do?

Probes:

- When you were upset emotionally when you were little, what would you do? Can you think of a specific time that happened?
- Can you remember being hurt physically? Do any specific incidents come to mind?

Were you ever physically ill when you were young (e.g., had flu)?

Probes:

- Do you remember what would happen? Do you remember what your parent/ guardian would do? Do you remember being held by your parent/ guardian when you were upset, hurt or ill?

When was the first time you remember being separated from your parent/ guardian?

Probes:

- How did you respond? How did your parent/ guardian respond? Are there any other separations that stand out in your mind?

Relationship during FEP- All

Could you describe how your relationship with your child/ parent since the experience of mental health problems?

Probes:

- Has that affected your relationship? In what way? How did the relationship change? In what ways was this different to your relationship before the episode? How did you feel about that?

In what way was that difficult / helpful for your relationship?

Probes:

- What has been difficult for you? What would have been helpful?
- How have you coped with that?
- How has that affected your relationship?

- How do you feel about this?

Relationship after FEP- All

Describe to me what your relationship with your young person/ parent is like now?

Probes:

- Could you describe how your relationship with your young person/ parent has changed over time?
- How do you feel about this? How have you made sense of the changes?
- How has this experience impacted on you?

Looking back is there anything you would have changed or done differently?

- Do you think you have learnt anything from this experience?

Do you have any hopes for your relationship with your young person/ parent in the future?

Anything else you would like to add?

Ending

I would like to thank you for sharing your experiences with me and for taking part in the study.

TRANSCRIPT: 1	CODE
<p>What's your relationship like now?</p> <p>I think that my relationship with my mum now, its, it's, it's relatively good, it's quite good, it's probably the best it's been in a while, because there is so much calmness now. I have my own flat now, my son is here (<i>uh huh</i>) and he is absolutely fine and there's not abnormalities what so ever, and I've got, you know my immigration status has changed as you know and it's all fine. And you know my mental health status is good as well (<i>uh huh</i>). So I think you know, it's really good, it's much more calmer and relaxed and we can have you know, normal conversations like everyone else not constantly worrying about what's the immigration judge going to decide, we can just have regular conversations and watch the TV and laugh and what regular people do, you know it's really good, I'd say it's at its best, although you know, I'd say we don't have that, sometimes, I mean you know we are in a recession, sometimes finances can be a bit tough here and there (<i>okay</i>). But it's not the sort of problems we were having a year ago so it's really really improved for the better.</p> <p>And how do you feel about that?</p> <p>I am really really pleased (<i>yeah</i>), yeah I am really really pleased with the way things have turned out.</p> <p>Okay, could you describe how your relationship has changed over that time?</p> <p>Erm well it's changed in the ways, I suppose the type of the type of support I was getting from my mum I'm not needing as much support now because obviously the first couple of months of being a</p>	<p>Relationship with mum Relatively good. Best its been</p> <p>Calmness now Own flat Birth of son No health problems (son) No other stressors</p> <p>Mental health good</p> <p>More calmer and relaxed</p> <p>Normal conversations</p> <p>Not worrying about stressors</p> <p>Regular daily activities Do what others do Really good</p> <p>Financial difficulties (normalised- recession) Tough Comparison Really really improved</p> <p>Really really pleased Recovery</p> <p>Relationship changed Less support</p> <p>New mum</p>

17th February 2012

Prior to the first interview I felt apprehensive about starting. Reflecting on this I thought about how I was aware of the expressed emotion literature and how families can increase risk of relapse through their interactions. Therefore, I had ideas that the relationships would be strained with high levels of conflict and that it could potentially be difficult for participants to discuss these experiences. I then thought about the importance of being open to the participant's narrative and that my preconceptions could bias how participants' narratives were explored. For example, I could have focused more on negative interactions or problematic aspects rather than exploring both positive and negative experiences in an open manner. I thought back to the reading I had completed about grounded theory and how it is important to be aware of potential biases. To overcome my anxiety and reduce the possibility of biasing how participants' narratives were explored I thought about what I could do. I arrived at the interview setting 30 minutes early so that I could set up the room and allow some time to relax in the environment. During this time I thought about how the participants may also be anxious about meeting me and taking part in the interview. From this I was able to understand the importance of allowing the participant time to feel comfortable in the setting. In addition, I was observant of the benefits of exploring where my anxiety had come from and how allowing time at the start to relax had helped me to be aware of any preconceive ideas, how these could impact on the process and how I could make sure this did not occur.

17th February 2012

Following the first interview I noticed that I felt positive about the interview experience. I thought about how the participant had responded and the insight gained from helping to explore their experiences. The feedback from the participant was also encouraging and highlighted how interviews could be therapeutic. As well as how the focus of this interview had opened up another perspective to view the experience of psychosis. Prior to the interview it had not occurred to me that participants would not have thought about the importance of their relationships nor had the opportunity to discuss their experiences from the beginning to the present time. This really inspired me to think about how assessments for service users and parents are conducted in mental health teams. But also of the value of the relationship and how this was reflected in the ways the participant spoke openly and honestly about positive and negative aspects. Initially, I thought this would be difficult; however, the participant had offered this information without specific questions. This brought to my awareness of how people learn from both positive and negative experiences, which enabled me to be open to

another perspective of the value in discussing negative factors. I wondered whether my awareness of expressed emotion and not wanting to influence the interview had led me to be critical of my own biases instead of reflecting on these to think about them in alternative ways. I could see the benefits of having a critical stance, but also how being open to new insights had influence the validity of my preconceived ideas.

2nd March 2012

During supervision the interviews were discussed and reflected upon. I had been aware that I was trying to ask all of the questions. Having space to think about this allowed me to reflect on how I may have felt under pressure to get the interviews right, and also, self-critical in case I did not understand grounded theory correctly. Having my supervisor's perspective enabled me to think more clearly about the aims of a grounded theory interview and how the process should reflect that. I became more aware of the importance of following the participant in what they discussed and only using the questions if further guidance about the topic was required. I thought about how this could be more insightful and allow the interview to flow on to the areas which the client felt was important. Furthermore, this reflection helped me to think about how it was not helpful to cover lots of detail in specific questions but about being open to the participant's narrative and following that instead. Therefore, although the interview schedule remained unchanged the process, way the interview was used and the aims of the interview were clearer, and helped me to think about the next interview.

23rd July 2012

Feedback from my initial draft of the analysis helped me to understand why it was too descriptive. Although I felt disheartened by my first attempt, it helped me to think about the levels of analysis and why theoretical coding was difficult for me to engage in. Initially, it brought to my awareness that I was trying to stay grounded in the data too much. Examples and discussions with my supervisor helped me to understand how to add the theory into the draft so that it demonstrates the relationships between categories more clearly. In addition, the mind maps and memos were revisited to check the links so that I was clear about the theoretical model. Furthermore, feedback had enabled me to develop knowledge regarding the structure of categories and how to present these within the text. Initially I had wanted to include all of the themes; however, from writing the initial draft it allowed me to see what categories were underdeveloped or other relationships between categories. Therefore, although it had been frustrating I started to further understand the need to go back and forth between the data to check transparency and the emerging categories, which helped to write a more interpretive draft.

**Parents and young people in transition after
first episode psychosis**

Name: Hannah Taylor

Research supervisor: Professor Andrew Gumley

Field supervisor: Dr Janice Harper

Abstract

A first episode of psychosis (FEP) is a significant life event for both a young person and their parent. This highlights a period of transition which is negotiated within the young person- parent relationship. The way in which the dyad reacts to and copes with the experience is important throughout the episode of FEP. This study is concerned with how relationships change during FEP. Objectives are to describe the dyads understanding of the experience of FEP, how they reacted and adapted to this experience, and how it has affected their relationship. Young people who have developed FEP in the last two years are eligible, including their parent/ guardian. Data will be collected using individual in-depth semi structured interviews with the young person and their parent/ guardian. A qualitative research design will be used including Grounded Theory methods. This study aims to provide an exploratory model of how the parent-child dyad is affected by FEP.

Introduction

Attachment

Attachment theory offers a developmental model of psychological functioning and affect regulation (Bowlby, 1969, 1973, 1980). Attachment emerges in the context of an affectional bond towards a primary caregiver who acts as a secure base promoting safety, security, autonomy and exploration. Infant behaviour and the caregiving system increases proximity to the secure base when threatening stimuli is present (Cassidy & Shaver, 2008). The caregiving system is shaped by the primary caregiver's prior attachment experiences of attuned, responsive and sensitive caregivers (Mikulincer & Shaver, 2010). The quality of attachment dyads are operationalised through patterns of infant behaviour, namely secure, insecure- avoidant, insecure- ambivalent and disorganized (Ainsworth et al. 1978; Main & Solomon, 1990). Through the repetition of these early interactions internal working models develop which include mental representations of parent, self as caregiver, child, and the parent- child relationship (Mikulincer & Shaver, 2010). Internal working models form developmental narratives of experience guiding behaviour, predictions and expectations about others (Cassidy & Shaver, 2008). In adulthood behavioural patterns are reflected in narrative organisation observed in the Adult Attachment Interview with secure/ autonomous, insecure dismissing, insecure preoccupied and unresolved attachment states of mind which often emulate the classification of infant attachment (George, Kaplan & Main, 1996).

Negative interpersonal experiences during childhood and adolescence reduce the opportunity to develop the capacity to mentalize. Mentalisation develops when the primary caregiver helps the infant convert a physical experience into a conscious thought or feeling through mirroring their emotion. This requires the caregiver to be attuned to the infant to promote reflexivity. Mentalisation enhances resilience and positive adjustment as it creates the capacity to pause and understand behaviour in relation to the mental states of both the self and others (Fonagy, Gergely, Jurist and Target, 2002). Although attachment classifications are relatively stable from infancy to adulthood, negative life

events may precipitate the revision of attachment working models and subsequent classification (Weinfield et al, 2004). Bowlby (1980) described the greatest threats to the attachment bond are events that threaten its security such as extended separation, loss, trauma and neglect.

Systemic attachment strategies

Dallos and Vetere (2009) described how the attachment process can be understood within the systemic context of interpersonal relationships within the family. Core relationship dynamics are shaped by expectations and behaviour from parents' internal working models developed from their attachment history and past relationships (Mikulincer & Shaver, 2010). Therefore, the family develops a system of interactions that drive expectations, beliefs and experiences of safety and trust in relationships which creates a shared emotional and cognitive style (e.g., dismissing emotion and emphasizing cognition). Attachment narratives hold these aspects of our experiences of relationships, in addition, to self protective strategies and defences. These narratives fueled by core attachment processes are generalized to relationships outside the family. Consequently a connection develops between systemic transgenerational models of attachment and internal emotional processes.

Key transitions over the family life cycle such as significant life events lead to internal and external demands for change through a process of reorganisation and adaptation within the family. This can challenge the security in relationships which impacts on emotion (Dallos, 2006). Reorganisation is shaped by biological, maturational, relational and cultural factors which depict what is normal and acceptable. Families develop solutions to try and enable change through attachment strategies. However, sometimes change is delayed as it is too threatening to the relationship security or overwhelming for the families resources to cope and manage. This undoubtedly has an emotional and relational impact leading to the potential of more defended strategies being utilised. Family patterns are therefore maintained through attachment fears and anxieties.

First episode psychosis (FEP)

Psychosis is a significant and traumatic life event which may confirm insecure attachment representations or rupture secure attachment representations (Gumley & Schwannauer, 2006). Due to the distressing experience of psychosis it can threaten to overwhelm the self, therefore, attachment strategies are activated by the individual or caregiver in an attempt to restore well being. Attachment strategies elicit responses from others thereby affecting the interpersonal environment (Dozier, 2001).

Particular family interactions such as Expressed Emotion (EE: Brown & Rutter, 1966) characterised by emotional over involvement, criticism and hostility is associated with functioning and relapse in FEP (Barrowclough & Hooley, 2003). According to Bowlby (1969) criticism functions as an adaptive mechanism to coerce and discourage a family member from problem behaviour or it may act as a defence against the symbolic losses associated with FEP for example, loss of a healthy child, loss of expectations. Criticism may therefore reflect the angry and rejecting

responses associated with the mourning process. In addition, criticism may act as a defence by excluding information processing or rejecting mental processes consistent with the reality of loss which mitigates the painfulness of mourning. This is supported by Patterson et al. (2005) who reported that those with higher levels of criticism experienced lower feelings of loss.

Dozier (2001) suggested that the use of insecure attachment strategies can also elicit EE responses from caregivers. Therefore, conflicts may also arise when the young person and caregiver experience different attachment states of mind. For example the young person may be striving to meet their developmental stage of autonomy but an episode of FEP may activate the parent's attachment system to maintain proximity. The young person may feel frustrated because this threatens their development therefore reject care which leaves the parent feeling anxious and in despair. Therefore, FEP may threaten the relationship and the family's resources to cope leading to an increase in defended strategies which may in turn fuel unhelpful interactions (Dallos & Vetere, 2009). In contrast a parent who is not sensitive or attuned may fail to notice the young person's attempts to elicit their care. This also highlights how the processes of normal development may create conflict within dyads and impact upon attachment strategies, which could be further exacerbated by an episode of FEP (Allen et al, 2004).

Furthermore certain attachment classifications are linked to symptoms in FEP. Birchwood et al. (2000) described how the distress from hearing voices may be influenced by interpersonal schemata from early relationships. Lysaker (2010) described how metacognitive deficits in schizophrenia become more pronounced with duration of illness. These deficits are revealed through symptoms such as delusions which highlight difficulties in discerning the intentions and emotions of others and failure to identify erroneous thoughts. Therefore, the interpersonal context of the symptoms of FEP may impact on attachment security, and attachment style may also influence symptom manifestation.

Overall attachment provides a framework to understand the intrapersonal and interpersonal factors that mediate the experiences of FEP for the individual and the parent/guardian. It also demonstrates the dynamic process of relational transition that a dyad negotiates during FEP, in addition, to normal developmental stages. The direction of causality between psychosis and attachment is unclear, therefore, more detailed investigation into coping and recovery in the context of a dyad is required.

Narrative

Narratives shape how we think about our past and our future, and attachment narratives in particular focus on stories we develop about our connections to others (Dallos & Vetere, 2009). In exploring attachment narratives relating to significant life events we can gain an insight into how dyads process difficult events and assign meaning to these experiences. Narratives may therefore reflect the dyad attachment state of mind and the strategies used to try and restore safety and wellbeing (George et al. 1996).

Aims and Hypothesis

The point of departure for the current study will be to explore how relationships change as shown through discourse when discussing experiences of FEP. The study aims to develop theories of how relationships change during FEP by analysing narratives between dyads. The narratives will be explored using Grounded Theory methods.

Plan of Investigation

Sample

A purposive sampling method will be used as participants will be selected by criteria relevant to the research question. Recruitment will continue until new data no longer sparks new insights; therefore, when categories become saturated, this is known as theoretical saturation (Charmaz, 2006). It has been suggested that for a DClinPsy research project a sample of between 8 and 20 participants is necessary for good qualitative research (Turpin et al, 1997). Individuals who have experienced FEP and their parent/ guardian will be asked to participate. The inclusion criteria for the young person will be those who are between 16 and 35 years old and have experienced an affective or non-affective psychosis as classified by ICD- 10 (WHO, 1992) criteria. Only the diagnostic categories and clinical descriptions that indicate psychotic symptoms will be used such as schizophrenia, schizotypal and delusional disorders (F20- 29) and mood (affective) disorders with psychotic symptoms (F30.2, F31.2, F31.5, F32.3 and F33.3). The young person would have been diagnosed by a psychiatrist responsible for their care within the last 2 years- this will be verified through case notes. The parent/ guardian will be included based on the consent from the young person. Exclusion criteria will be those who are not fluent in English language, are acutely psychotic, under 16 years old or have a learning disability. These criteria will be established through discussions with the participant and their informants such as the psychiatrist, named nurse or parent/ guardian.

Recruitment

The sample will be recruited through ESTEEM First Episode Psychosis Service in South Glasgow by identifying potential participants during team meetings with direct care staff, meetings with lead clinicians and advertising the project in the waiting rooms. The individual who has experienced FEP will be approached initially by their key worker and offered a chance to discuss the study. They will also be handed or sent an information sheet about the study. If they would like to participate they can contact the researcher directly using the telephone number/ address on the information sheet, contact their key worker or send back the response envelope. The researcher will then approach the young person to discuss the study further and consent to participate will be obtained, in addition, to consent to contact a family member. The family member will then be

contacted by the researcher, provided with an information sheet and requested to give consent if they would like to participate.

Research Procedure

The research will be conducted in an NHS clinic between the hours of 9-5 with another clinician in the vicinity. Individual in-depth semi structured interviews lasting 60 (+/- 15) minutes will take place separately with the young person and their parent/ guardian. An interview agenda will include open questions and demand prompts but will remain flexible. Each interview will be audio recorded and notes taken about non-verbal behaviour, emotional responses, how the researcher felt and emergent ideas. At the end of the interview participants will be offered time to discuss the interview with their key worker and will be offered information about further support.

Interview

The interview will initially be guided by the AAI (George et al, 1996) for the first section of the interview schedule titled 'Early Relationships'. The questions will aim to stimulate narrative around relational experiences throughout FEP. This will be explored using open questions intended to open discussion and reflection. Reflecting and summarizing will be used to clarify and confirm understanding. The interviewer will remain collaborative and empathic throughout. The interview will initially ask about the participant's family to orientate them to the interview process. The participant will then be asked to describe their relationship with either the parent/ guardian or young person, provide memories of the relationship and give examples of specific experiences of when the young person was emotionally upset, separated from their parent/ guardian and when the young person was physically ill. The interview will then depart from the AAI and focus on the participant's relationship with their parent/ guardian or young person throughout FEP.

Data Analysis

The interviews will be transcribed verbatim following guidelines from the AAI (George et al. 1996), the transcripts will be reviewed by independent raters and constant comparisons made. The transcripts will be analysed using Grounded Theory methods (Charmaz, 2006).

To provide an abstract theoretical understanding of the experience of relationships in FEP grounded theory will be utilised. Initially data will be constructed through narratives and observations. As the data is studied it will be separated, sorted and synthesized through qualitative coding. Coding is a means of attaching labels to segments of data that depict what each segment is about and allows comparisons to be made with other segments of data. Codes, comparisons and ideas about the data provide areas to explore during subsequent data collection, therefore, data collection and analysis occurs simultaneously. Through numerous and constant comparisons memos about these comparisons will be made to define categories, specify their properties and define relationships between categories.

Therefore, tentative analytic categories are formed. As more data is collected more information is explored to strengthen the analytic categories allowing them to become more theoretical. Overall grounded theory is flexible and increases the speed of gaining a clear focus on what is happening in the data without sacrificing detail.

Credibility will be checked by a Clinical Psychologist experienced in qualitative methodologies. Supervision will take place to discuss the data, analysis and reflexivity to minimise researcher bias. The sample will be discussed with the intention that the limits of relevance and applicability are known. As the theory will be grounded in the data direct quotes will be reported for the reader to make their own interpretations.

Health and Safety Issues

Interviews will be held in the NHS Greater Glasgow and Clyde health board. Local health and safety procedures for interviewing patients will be followed. A clinician will be available at all times during the interviews and support will be offered at the end of the interview. The primary researcher, Hannah Taylor holds a contract with NHS Greater Glasgow and Clyde.

Ethical Issues

All participants will be informed about the research via an information sheet prior to consent and interviewing. The young person will also be asked for consent to contact their parent/ guardian. All participants will give consent, remain anonymous and be reminded of their right to withdraw at any time. The participant will be notified in the information sheet that their GP, Psychiatrist and key worker will be informed that they are participating in a research study once they have provided consent. Complete confidentiality will be adhered to at all times. If during the interview process the participant feels distressed by their experiences the interview will be suspended and a duty clinician will be available to provide support. Involvement in the study will not impede on any ongoing treatment. Ethical approval will be sought from NHS GG&C Research Ethics Committee and NHS GG&C Research and Development Directorate. All audio recorded data will be stored on an encrypted computer and destroyed following transcription. The qualitative data from the transcription will be anonymised. The participants will be informed that quotes will be used after all the identifiable information has been removed. Participants will be offered feedback therefore a separate locked file of participant information will be kept for the duration of the study and destroyed following feedback.

Financial Issues

Paper, printing, photocopying and envelopes for consent forms, information sheets and letters, £9.43

Freepost labels (x40), £14.00

A digital voice recorder (Olympus DM 550, £159.00), foot pedal and transcription software (Olympus, £120.00) will be borrowed from the university department.

Timetable

31st January 2011:	Draft research proposal
Feb- May 2011:	Work on proposal
16 th May 2011:	Major research proposal
July 2011:	Proposal passed by University
July- Sept 2011:	Ethics form and research and development form submitted
July- Aug 2011:	Work on systematic review
26 th August:	Systematic review outline
Sept 2011:	Research agreement and logbook initiated
Oct- Dec 2011:	Ethical approval granted Advertise for participants Recruitment begins
Jan- Feb 2012:	Interviews continue
March- April 2012:	Final interview, finish transcribing
May 2012:	Complete analysis
June- July 2012:	Write up, bind and submit
August 2012:	Viva.

Practical Applications

This study aims to provide an exploratory model of interpersonal processes during FEP. This may provide a basis for further research into how relationships can promote help seeking, adaptation and recovery in psychosis.

References

- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978) *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.
- Allen, J. P., McElhaney, K. B., Kuperminc, G.P. and Jodl, K.M. (2004) Stability and change in attachment security across adolescence. *Child Development*, 75, 1792- 1805.
- Barrowclough, C., & Hooley, J. M. (2003) Attributions and expressed emotion: A review. *Clinical Psychology Review*, 23, 849- 880.
- Birchwood, M., Meaden, A., Trower, P., Gilbert, P., & Plaistow, J. (2000) The power and omnipotence of voices: subordination and entrapment by voices and significant others. *Psychological medicine*, 30, 337- 344.

- Bowlby, J. (1973) *Attachment and loss: Vol. 2. Separation, anger and anxiety*. London: Pimlico.
- Bowlby, J. (1980) *Attachment and loss: Vol. 3. Loss, sadness and depression*. London: Pimlico.
- Bowlby, J. (1969) *Attachment and loss: Vol. 1. Attachment*, (2nd ed.). London: Pimlico.
- Brown, G. W., & Rutter, M. (1966) The measurement of family activities and relationship: methodological study. *Human Relations*, 19, 241- 263.
- Cassidy, J. & Shaver, P. R. (2008). *Handbook of attachment: Theory, research and clinical applications* (2nd Edition). London: The Guilford Press.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage Publications.
- Dallos, R. (2006). *Attachment narrative therapy: Integrating systemic, narrative and attachment approaches*. Berkshire: Open University Press.
- Dallos, R. & Vetere, A. (2009). *Systemic therapy and attachment narratives: Applications in a range of clinical settings*. London: Routledge.
- Dozier, M., Lomax, L., Tyrell, C., & Lee, S. W. (2001) The challenge of treatment for clients with dismissing states of mind. *Attachment & Human Development*, vol 1, no. 1, 62-g76.
- Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002) *Affect regulation, mentalization and the development of the self*. London: Karnac.
- George, C., Kaplan, N. & Main, M. (1996) *Adult Attachment Interview*. Unpublished manuscript, Department of Psychology, University of California, Berkley.
- Gumley, A., & Schwannauer, M. (2006) *Staying well after psychosis: A cognitive interpersonal approach to recovery and relapse prevention*. Hove: Wiley.
- Lysaker, P. H (2010) Metacognition in schizophrenia spectrum disorders. In: Dimaggio, G., & Lysaker, P. H. (2010) *Metacognition and severe adult mental disorders. From treatment to research*. London: Routledge.

Main, M., & Solomon, J. (1990) Procedures for identifying infants as disorganized/ disorientated during the Ainsworth Strange Situation. In Greenberg, M., Cicchetti, D., & Cummings, E. M. (1990) *Attachment in the preschool years*. Chicago: University of Chicago press.

Mikulincer, M. & Shaver, P. R. (2010). *Attachment in adulthood: Structure, dynamics and change*. London: The Guilford Press.

Patterson, P., Birchwood, M., & Cochrane, R. (2005) Expressed emotion as an adaptation to loss. *British Journal of Psychiatry*, 197, 59-64.

Turpin, G., Barley, V., Beail, N., Scaife, J., Slade, P., Smith, J. A. & Walsh, S. (1997) Standards for research projects and theses involving qualitative methods: suggested guidelines for trainees and courses. *Clinical Psychology Forum*, 108, October.

Weinfield, N. S., Whaley, G., & Egeland, B. (2004) Continuity, discontinuity and coherence in attachment from infancy to late adolescence: Sequelae of organization and disorganization. *Attachment and Human Development*, 6, 73- 97.

World Health Organisation (1992) ICD-10 Classification of Mental and Behavioural Disorders. Clinical descriptions and diagnostic guidelines. WHO: Geneva.