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Exploring Beliefs, Narratives, and Understandings of Psychosis: Insights from Literature and Staff Stories Utilising the Power Threat Meaning Framework

Section A: What does the current literature tell us about people's beliefs, understandings and narratives of psychosis and how they may develop? A thematic synthesis review.

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Acknowledgments

Thank you to all the participants that took part in the research. I am forever grateful for your time and for sharing your stories with me.

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Summary

Section A: This is a thematic synthesis exploring what the present literature tells us about people's beliefs and understandings of psychosis and how they may develop. A systematic literature review search and synthesis of 11 qualitative studies was completed. Four analytical themes with five subthemes were found and presented. Implications for future research are discussed.

Section B: This is a narrative analysis study looking at staff, who have worked with psychosis, experiences of the Power Threat Meaning Framework (PTMF) team formulation meetings and their subsequent understanding of psychosis. Five research questions were set. To gain each participant's understanding of psychosis, narrative interviews were carried out and narrative analysis methodology was employed with the interview data. Participants were staff members who have supported clients experiencing psychosis and attended PTMF team formulation meetings. Key findings are presented and discussed along with clinical implications and suggestions for future research.

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Abstract

Purpose: The understanding of the causes of ‘psychosis’ continues to shift over time. The understanding of psychosis can impact people’s perception of individuals with psychosis and the self-perception of those people who experience psychosis and their help-seeking behaviours. This review aimed to synthesise studies that have captured people’s beliefs, understandings and narratives of psychosis and consider how these may have developed.
Methods: A literature review was conducted, followed by a thematic synthesis of the included qualitative studies, focusing on either clinicians, clients, or family members and carers, narratives of psychosis. 11 studies with a total of 228 participants were included. The quality of these papers was assessed using the CASP qualitative quality appraisal tool (CASP, 2018).
Findings: Four themes with a total of five subthemes were identified in the studies used (interpreted by the researcher). These themes explored how relationships, support, and fear of blame can influence individual's’ understanding of psychosis. A lack of understanding may lead to confusion and uncertainty, while the type of support and concern about being blamed can shape beliefs about its causes. The quality of the studies varied.
Conclusions: These themes contributed to, and provided evidence for, the variety and development of individual’s beliefs and understandings of psychosis, and highlighted the importance of relationships, clinical interventions and blame in such understandings. They also highlighted the factors that contribute to individuals not developing a clear understanding of psychosis.

Note on Terminology

‘Psychosis’ is a disputed term and one that poses conceptual challenges (Geekie & Read, 2009). Throughout this research, ‘psychosis’ is employed as a comprehensive descriptor encompassing experiences such as hearing voices, having visions, experiencing racing thoughts, ‘paranoia’, and ‘grandiose’ beliefs that others find unusual, without implying ‘illness’ or a ‘disorder’. In this research, whenever disputed terms are employed, they will be indicated using quotation marks upon first use.

Keywords: psychosis, narratives, understandings, beliefs, perspectives

Introduction

The understanding of ‘psychosis’ has shifted over recent years (Read & Larkin, 2008). In the past, it was commonly perceived as an ‘illness’ or ‘disorder’ with a biological basis attributed to ‘genetics’ or ‘brain pathology’ (Read et al., 2013). As the medical model has grown, it has been questioned how it impacts ‘diagnosed’ individuals and their family members’ conceptualisation of ‘mental illness’ (Barr & Rose, 2008). Genetic factors understandings are cited more for ‘schizophrenia’, which entails similar experiences as psychosis, than other ‘disorders’ such as post-traumatic stress, alcohol dependence, and depression (Cavanagh et al., 2004; Link et al., 1999). This dominant medicalised model of psychosis has meant that social causes have been neglected (Jarvis, 2007). However, more recently, psychosis has been associated with both childhood and later-life traumas (Morgan & Fisher, 2007; Morrison et al., 2003; Read & Larkin, 2008; Read et al., 2004), social disadvantage (Stilo et al., 2013), as well as experiences of discrimination (Pearce et al., 2019). With multiple understandings having underpinned psychosis for many years, people carry a variety of beliefs about what psychosis is, how it comes about, and what it means for the individual. This leads to a wide variety in people’s narratives of the cause of psychosis. It is likely that this variation may cause confusion for those who are diagnosed or receive support for such diagnoses and their wider support network.

Individuals’ beliefs, understandings and narratives of psychosis can impact several aspects of a person’s life. Firstly, individuals experiencing psychosis often face some of the most profound forms of prejudice and discrimination due to the stigma associated with their experiences (Angermeyer & Matschinger, 2003). Concerningly, such attitudes do not seem to be improving (Baba et al., 2017; Martin et al., 2000). Conflicting theories have arisen regarding the most effective approach to address this stigma. On one hand, there is the promotion of a 'disease' model to decrease stigma and mitigate the blame and guilt experienced by individuals who have received a ‘diagnosis’ (Austin & Honer, 2007; Rusch et al., 2010). However, evidence suggests that such a disease model may cause people to think that those with psychosis have no control over their behaviour, which feeds into the widespread fear that those with psychosis are unsafe and unpredictable (Read et al., 2004). Due to the growing understanding of the association between trauma and psychosis (de Vries et al., 2019; Schäfer & Fisher, 2011), it is important to consider how trauma narratives may impact stigma. Studies have shown that if psychosis is framed as a meaningful response to adversity, the associated stigma is reduced (Longdon & Read, 2017). Additionally, Seery et al. (2021) found that when an individual's difficulties were explained using a medical model, there were higher rates of stigma reported by the public as opposed to when the difficulties were explained using the Power Threat Meaning Framework (PTMF). The PTMF provides an alternative way of conceptualising disturbing or disturbed behaviour and regards these as a result of the misuse of power and subsequent adversities people face in life (Johnstone & Boyle, 2018). It aims to provide a holistic understanding of distress and an individual's response while highlighting the socio-political and interpersonal factors contributing to it. The PTMF can help move services away from an illness approach to mental distress to a model that considers the misuse of power, subsequent adversities, and the meaning we make of these. As such, it’s important to understand how people’s views about psychosis may change. The PTMF allows an individual's story to be created and considered alongside their experience of distress. The centrality of the person’s narrative in the PTMF shows why it’s important to look at the narratives people hold regarding emotional distress.

Secondly, narratives of psychosis influence an individual's help-seeking behaviour (Adderley et al., 2020; Saravanan et al., 2008). For example, those who may hold a medicalised view of psychosis may go to their general practitioner after noticing their ‘symptoms’, whereas someone with a narrative of psychosis being caused by supernatural or spiritual causes may instead seek help from a healer or religious leader (Read et al., 2004; Temesgen et al., 2022). Alternatively, it might be that what the individual is offered as help will determine the understanding, beliefs and narratives they then hold about psychosis. For example, if somebody is offered medication for their difficulties, they will likely believe they have a biological illness that needs treatment and might dismiss any alternative narratives.

Thirdly, it is important to recognise people's understanding of psychosis in terms of their hope for the future. Psychosis can be viewed as an enduring and ‘chronic illness’ (Alyahya et al., 2020), which may have further consequences for people willing to engage in any support offered due to a feeling of hopelessness. Literature states that spirituality (de Wet et al., 2015) and internal and external resources proving to the individual that they are in control of their experiences (Henderson and Cock, 2015) play an important role in recovery. Such attitudes do not align with psychosis being an enduring and ‘chronic illness’ and, therefore, the promotion of alternative attitudes should be instilled where possible to tackle such feelings of hopelessness.

The Present Review

This review aimed to synthesise qualitative studies that captured people’s beliefs and understandings of the causes of psychosis and considered how these develop. Qualitative research was chosen to gather individuals’ rich stories and understandings that quantitative research would not be suited to capture. The review aimed to capture the beliefs and understanding of the causes of psychosis held by clients who experience psychosis, family members, carers, and clinicians. It sought to search, find, and synthesise literature that can answer the review question: What does the current literature tell us about people’s beliefs, understandings and narratives of psychosis and how these may develop? Additionally, in line with the aim of thematic synthesis going beyond the content of the original studies (Thomas

& Harden, 2008), this paper aimed to develop theories behind how people develop their understanding of psychosis.

Method

Review Design and Registration

This review aimed to evaluate qualitative research with the aim of synthesising the understandings of psychosis to answer the review question presented. Firstly, a systematic search of the literature was conducted, followed by a critical appraisal of these studies, and finally, a synthesis was performed using thematic synthesis methodology, as informed by Thomas and Harden (2008). The review's protocol was formally registered and accepted with the International Prospective Register of Systematic Reviews (Prospero, https://www.crd.york.ac.uk/Prospero/) prior to the final search, confirming the uniqueness of this review.

Methodology

There has been an increasing acknowledgement of the importance of integrating qualitative research into the evidence base to support informed decision-making in healthcare (Renjith et al., 2021). Thematic synthesis was developed to allow for the synthesis of qualitative studies. The purpose of thematic synthesis methodology is to find similarities and differences across empirical qualitative studies, and this methodology has been shown to provide "explicit and transparent links" between conclusions and the findings of primary studies (Thomas & Harden, 2008, p. 1). A new model, framework, or theory is then produced from the synthesised qualitative studies. As such, quantitative studies, mixed-method studies and systematic reviews were excluded. This approach was selected for this study, as the thematic synthesis methodology would facilitate extending the current literature to build a model that answered the review question. The approach has been summarised in Table 1.

Table 1

Summary of the three steps of Thomas and Harden's (2008) thematic synthesis approach

Step	Description
Step 1	Coding the finding sections of the studies 'line-by-line'. An example of a coded paper is in Appendix A.
Step 2	Developing descriptive themes from the codes, whilst putting the review question to the side, to generate as many themes as possible. An example of the development of a descriptive theme is in Appendix B.
Step 3	Generating analytical themes from the descriptive themes that will form a model to answer the review question.

Search Strategy

The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research Type) framework (Cooke et al., 2012) was implemented to guide the search strategy. All five domains were established to be combined within the search:

- Sample: any of the following: clinical staff, clients, carers, and family members of someone with psychosis
- Phenomenon of Interest: people's understanding of the causes of psychosis
- Design: peer-reviewed journals only

- Evaluation: what are the narratives of psychosis, what influences their development, and how these may change over time
- Research Type: qualitative design studies

The literature search was carried out across four electronic databases: PsycINFO, ASSIA, Pub Med, and Web of Science. The search was conducted on December 28th 2023, and organised in advance with the choice of search terms being influenced by preliminary internet research through Google Scholar and past reviews of narratives of psychosis or similar mental health difficulties. There were no date restrictions used in the search. The search terms used are presented in Table 2.

The key search terms were combined with the Boolean operators ‘AND’ and ‘OR’, along with expanded subject headings, to retrieve all documents that included any of the search terms. Titles were screened first for relevance, followed by abstracts and, finally, the whole paper. The reference sections of the studies retrieved were also searched.

Table 2

Literature search terms

Search terms used (combined with AND)
“narratives” or “understanding*" or "perspective*" or "belief*" or "views" or "model"
"psychosis*" or "schiz*" or "psychotic like experiences”
"clinician" or "client" or "service user" or "family" or "carer" or "general public"
"change" or "shift" or "develop"
"qualitative" or "qualitative methods" or "interview" or "focus group"

Inclusion and Exclusion Criteria

The review inclusion and exclusion criteria are outlined in Table 3. The experiences under the diagnosis ‘schizophrenia’ have multiple experiences in common with psychosis, including hearing voices, seeing things others do not, holding beliefs others may consider unusual and experiencing overwhelming thoughts. Considering the commonalities, studies with a focus on schizophrenia were included.

Table 3

Inclusion and exclusion criteria

Inclusion criteria:
• Studies that specifically focus on understandings and beliefs of the causes of psychosis or similar experiences such as ‘schizophrenia’ • Qualitative studies • Studies written in the English language • Peer reviewed journals • Specific experiences of psychosis, such as post-partum and drug-induced psychosis
Exclusion criteria:
• Studies not focused on any participant’s individual understandings and beliefs of psychosis (e.g. mental health clinician, service user, carer etc.) • Mixed methods design, quantitative designs and systematic reviews in line with thematic synthesis methodology

Data Extraction

A data extraction was employed to outline the primary characteristics of each study, including location, sample size and demographic, mental health phenomena researched, aims, data collection method, analysis method and findings. Table 4 outlines the data extracted for all 11 studies.

Quality Assessment

The quality of the studies was assessed using the Critical Appraisal Skills Programme Tool (CASP, 2018; Appendix C). The CASP is the most widely used method to assess the quality of qualitative studies (Long et al., 2020) and encompasses 10 questions. The checklist covers various aspects of the research, including the clarity of research objectives, the suitability of the research design, methodology, data collection, data analysis, and the lucidity of the research findings. The quality assessment process is shown in Table 5 in order of the scores, with the highest quality studies towards the top. When conducting the analysis, studies with lower quality were given less weight than higher quality papers. Studies were not excluded since they would still contribute to theory development.

Reflexivity and epistemology

The researcher comes from a clinical psychology background and was aware of her personal and professional view of psychosis. She recognised holding a preference towards a trauma-informed understanding of psychosis, which was also considered to be linked to her personal experiences. A friend of the researcher had experiences of psychosis following periods of difficulty, highlighting to her the likely role of previous life experiences on an individual's experiences of distress. Efforts were made to manage this bias through discussions with a supervisor.

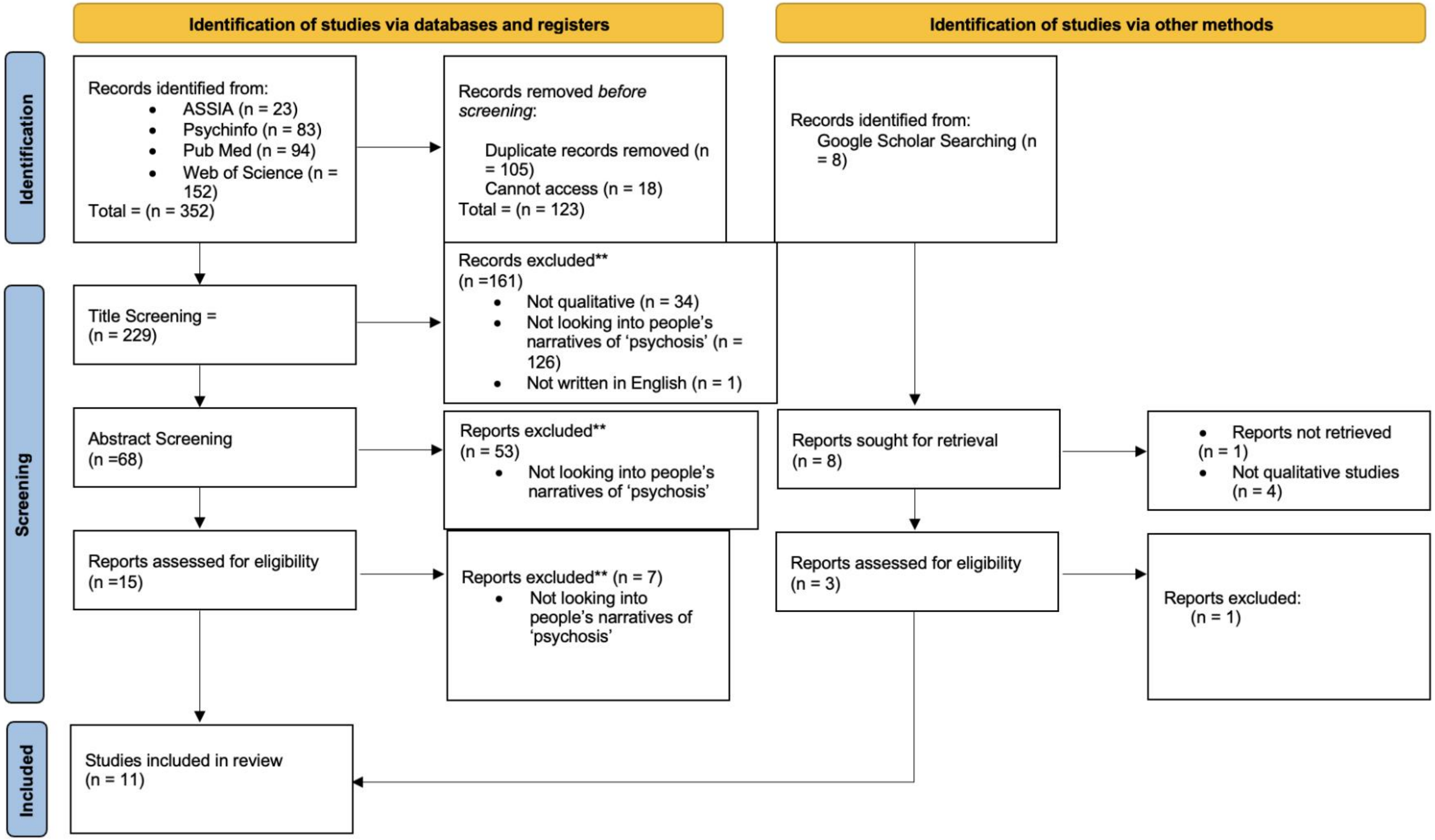
A critical realist (Schiller, 2016) epistemology approach was used due to the review aiming to gather individual's understanding of psychosis based upon their lived experience of experiencing psychosis themselves, knowing a loved one who had experienced it or working with clients experiencing it. Critical realism proposes that we make sense of the world based upon our own experiences (Pilgrim, 2022) and, therefore, fits as the underlying epistemology of this review.

Results

Figure 1 shows the selection process and the number of studies found at each stage via a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Page et al., 2021). There were 18 articles that were inaccessible despite logging into the database using university credentials and emailing the authors. Therefore, these could not be included in the review.

Figure 1

PRISMA flow diagram (Page et al., 2021)



Overview of Included Studies

After conducting the literature search, 11 studies were included. These studies have been numbered (Table 4) and will be referred to by their study number throughout the review. The publication dates of the studies included ranged from 2001 to 2022. Six studies were conducted in the United Kingdom, and two were conducted in the United States of America. The remaining three studies were conducted in Pakistan, Sweden, and Japan. A total of 228 participants' individual narratives of psychosis have been reported in this review. The participants were aged between 16 and 76 (109 females and 119 males). Between the studies, there were 31 clinicians (psychologists and psychiatrists), 97 carers or family members, and 100 client narratives of psychosis or 'schizophrenia' diagnosis. Not all studies included a breakdown of participant ethnicity (2, 6, 7, 8, 10), which meant that it was not possible to present a summary of this demographic. However, the studies were conducted in a range of countries, which was considered a strength, and it was hoped that this ensured a diverse group of participants across the studies. Seven studies focused on psychosis (2, 3, 4, 5, 9, 10, 11), and four focused on schizophrenia (1, 6, 7, 8). Study 10 specifically focused on puerperal psychosis. Table 4 summarises the included studies.

Table 4

Overview of studies included and synthesised (ordered in assessed quality)

Study no.	Author	Year	Location	Sample size and demographics	Mental health phenomena researched	Aims	Data collection	Data analysis	Main findings related to this review
1	Callard et al.	2012	UK	19 participants (17 female and 2 male) aged between 30 – 60. 14 white, 2 Asian/Asian British, 1 Black/Black British and 2 mixed heritages. All participants were family members (5 mothers, 1 father, 1 ex-wife, 10 sisters, 1 brother, 3 daughters, 2 nieces and 2 cousins)	Schizophrenia	"The primary objective of the study was to investigate participants' views regarding participation in genetic research on schizophrenia"	Interview	Grounded theory	All participants expressed agreement in the role of genetics in the aetiology of schizophrenia and went back to previous generations to demonstrate this. Mothers tended to highlight genes removing blame from the parents. Children highlighted the role of their parents in the development of their illness and tended to show a development in their understanding away from just their genes. This study showed that a concern about being blamed can lead to a different understanding

									of psychosis and that genetic causes of psychosis were more prevalent among parents than siblings and clients.
2	Laithwaite & Gumley	2007	UK	13 participants (1 female and 12 male) aged between 22 and 60. Ethnicity unknown. All participants were clients (individual's who had experiences psychosis).	Psychosis	“The current study presents a user’s perspective on being a patient in a high-security setting and the factors he/she considers important in his/her recovery.”	Unstructured interviews	Grounded theory	Contrasting accounts of recovery were found, and two themes were developed with a number of subthemes. One theme in this study was: *past experiences of adversity.* All 13 participants spoke about past experiences that led to them being in hospital, thus highlighting past events underlying their beliefs about the cause of psychosis. The subthemes were: *parental break-up and loss, feeling rejected and worthless, relationships with significant others and perceptions on past selves.*

3	Gibbs et al.	2020	UK	13 participants (11 service users and 2 clinical psychologists) aged between 18 and 65. 4 females and 9 males. Both psychologists were female and white British. Service users were 37% white British, 18% white/black African, 9% white/black Caribbean, 9% white/mixed European, 9% black British, 9% black Caribbean and 9% black African.	Psychosis	"This study set out to explore service user experiences of formulation during individual therapy for psychosis and develop a grounded theory of the processes involved."	Semi-structured interviews	Grounded theory	Three categories were found with sub-categories within these. One theme, *linking previous experiences with current ways of being* reported service users discussing *significant life events*, which may have left them vulnerable to experiencing mental health difficulties. This theme also reported that service users had noticed *patterns* in their behaviour, which may have related to early experiences. This aligns to the participants having a belief of previous life experiences influencing the development of their psychosis. This was built upon within another theme,

Making use of new understandings spoke to the influence of having psychological interventions and allowing them to reflect back using their formulation.

Participants spoke of their understanding of psychosis changing during psychological interventions. They were *"spotting the patterns"* throughout their life and felt they had *a "new start"* following their experience. Their understanding became more shaped around their past/previous experiences and this developed through their psychological interventions and through talking to those around them.

A medical model understanding was not

									mentioned during this paper.
4	Spencer et al.	2022	UK	10 participants aged 16-41 (mean age 28). All white British, 5 females and 5 males. All participants were clients (individuals who had experiences psychosis).	Psychosis (first episode; FEP)	“The principle aim of this study was to explore the personal impact of case formulation for SUs that engaged with cognitive behavioural therapy for the treatment of FEP.”	Semi-structured interviews	Reflexive thematic analysis	Participants commented on holding and developing understandings of their experiences of psychosis based upon previous experiences. They found comfort with holding a view of the importance of their previous life experiences since it reduced their self-blame for their experience of psychosis. Psychological interventions helped to shape their understanding.
5	Judge et al.	2008	US	15 participants (8 males and 7 female) with a mean age of 24. 12 participants were Caucasian, 2 were African American and one was Asian.	Psychosis	“We employed a qualitative approach in order to elicit and then analyse the subjective meanings, concerns, and lay knowledge individuals describe with respect to illness recognition”	Semi-structured interviews	Grounded theory and content analysis	Participants saw psychosis as who they were and did not hold a view of having an illness until told by a doctor. Participants were all treated with medication but not psychological interventions despite

				All participants were clients (individual's who had experiences psychosis).					wanting this. Here their understandings shifted from being a part of who they were/something they needed to go through to understand themselves to an illness as told so by clinicians.
6	Stålberg et al.	2004	Sweden	16 participants aged 16-55 (All siblings of those with a schizophrenia diagnosis, mean age 31, 8 females and 8 males). Ethnicity unknown.	Schizophrenia	"We aim to explore how schizophrenia patients' siblings perceive the sibling relationship and their role."	Face-to-face semi-structures interviews	Grounded theory	Siblings presented a medical model by commenting on genetics and their own fears of becoming unwell. However, some also reflected on childhood events which contributed to their sibling's experience. Fear of being the sibling of someone who was experiencing schizophrenia seemed to promote the idea that it might be hereditary.
7	Barker et	2001	UK	16 participants	Schizophreni	"This study explores the	Semi-	Grounded	Client participants

al.		aged 25-50. Ethnicity unknown. 8 males and 8 females. 8 service users and 8 close relatives.	a	narratives used by both clients and family members to explain the process of developing schizophrenia."	structured interviews	theory	commented on their experiences of schizophrenia in being beneficial in some way and did not hold a medical understanding but that it gave them their identity. They reported feeling like it was something they had to go through in order to know who they were. They were all given medication which was commented on being helpful but it did not shift their understandings to being more aligned with a medical model. There were comments on how psychology may have been helpful. Relatives commented on not having an understanding of psychosis and that clinicians did not explain it very clearly.

8	Mizuno et al.	2013	Japan	14 participants (4 female and 10 male) aged 37-76. Ethnicity unknown. 8 parents, 3 siblings, 2 spouse and 1 sister-in-law.	Schizophrenia	“The purpose of this study was to explore the caregiving experiences of female family caregivers of persons with schizophrenia through focus group interviews”.	Focus groups	Content analysis	The theme ‘*Family perceptions of illness and relatives with schizophrenia’* Including the subthemes: *inability to comprehend illness over time, cling to hope for improvement, strong and weak points of relatives with schizophrenia and attitudes toward marriage of relatives with schizophrenia.* This indicated a genetic belief regarding psychosis. Participants generally held a medical understanding of schizophrenia which emphasised stigma they experienced as a relative. They spoke to genetic explanations. Only siblings in the study commented on the possible impact of previous life events. Parents emphasised biological factors.

									Participants commented on clinicians not giving clear explanations.
9	Naeem et al.	2016	Pakistan	92 participants (33 clients, 30 carers, 14 psychologists and 15 psychiatrists) aged between 18 and 68. 45 females and 47 males. All participants were from Pakistan.	Psychosis	“Our aim was to develop guidelines for adapting CBT for psychosis in Pakistan by incorporating the views of the patients, their carers and mental health professionals.”	Semi-structured interviews	Thematic analysis	A theme ‘*causes of illness’* reported that most patients and carers related the psychotic experiences with psycho-social problems and stress. Nearly one-third of clients and carers believed in spiritual or religious causes. One-third of clients believed in biological causes, although half of the carers held such beliefs. A theme ‘*awareness of illness and pathways to care’* showed that most client participants said that they suffer with a mental or ‘psychological illness’ with some saying it is both physical and mental illness and six believed they had a ‘brain disease’. Almost all participants began seeking treatment from nonmedical healers first which may speak to spiritual or psychological initial understandings of psychosis. Within a theme ‘*management of illness’,* clients and families tended to use a bio-psycho-

									social model of management of psychosis with additional emphasis on spiritual and religious causes. This may indicate a bio-psycho-social model understanding of psychosis and its cause.
10	Glover et al.	2014	UK	7 women aged 25-45. Ethnicity unknown. All participants were clients (individual's who had experienced Puerperal psychosis).	Puerperal psychosis	“This study aimed to gain further insight into women’s individual experiences of puerperal psychosis and the context in which they make sense of it, in order to consider the possibilities for a more holistic understanding of puerperal psychosis”	Interviews	Thematic analysis	Four themes were found. One theme was ‘*the path to puerperal psychosis’* where the women reported stressful events in their lives before and during their pregnancy. They also reported worries during the pregnancy, pregnancy disrupting work/relationships/life in general and having prior psychological problems which they attributed to the development of their understanding of psychosis. Another theme *‘snap out of it’* showed that women reported expectations by others, mainly other mothers, that they should

be able to just stop being 'ill'. This highlighted perspectives people held of believing psychosis was in the participants control and that they should be able to snap out of it at any time.

In another theme '*perceived causes'*, women reported being previously told that puerperal psychosis was unavoidable because it was caused by biological factors related to childbirth. Despite this, women persisted in discussing other factors in the onset and maintenance of their 'condition'.

Participants commented on not knowing themselves during their experience of PP and feeling like a different person. Medical explanations were mostly given by professionals

									and understood by the participants. However, reflections on stress, fear and existing difficulties were commented on.
11	Corcoran et al.	2007	US	13 participants (3 female and 10 male) aged between 16-24). 31% white, 38% African American, 15% Hispanic, 8% East Asian and 8% mixed. All participants were family members.	Psychosis	“We sought to elicit a trajectory of behavioural changes over time, as well as to examine attributions, coping strategies and help-seeking patterns by family. “	Interviews	Thematic analysis	*“The ‘premorbid’ period: essentially normal but vulnerable”.* Clients were described by their families as being mostly normal and happy children but having some vulnerabilities (e.g. sensitive, shy, socially awkward, slow at school. This may speak to the participants feeling that these vulnerabilities were a factor in the development of psychosis. *Slow but profound changes in behaviour and mood occurred in teen years.* Families reported social withdrawal, inability to keep friendships, seeming different,

nervous, academic failure, low mood, sleeping all day, and anger. This, again, feeling that these factors influenced the development of psychosis

The breaking point: triggers for help-seeking and entry into the mental health system. Families reported consulting their networks before psychiatric help as a last resort or on recommendation. This may speak to an initial understanding outside of the medical model and, therefore, not going directly to psychiatric help.

Future expectations. Most families had a diminished expectation for the future regarding their relative getting married, having children. This may speak to participants holding a biological view of psychosis and concerns about their relative having children due to perceived genetical factors.

Assessment of quality

All 11 studies were assessed for their quality using the CASP (2018) qualitative tool, as described above. Table 5 shows the results of the assessment of study quality, and Table 6 shows an overview of study quality. All studies clearly outlined their aims for the study and why the researchers thought it was important and relevant to wider literature. Similarly, all studies used an appropriate methodology and research design when considering their aims. It could not be ascertained if study 11 had used appropriate participant recruitment since they did not state how they recruited their participants or their inclusion criteria. However, they did note where the participants were sampled from and that the selection process was not random but "represented a sample of convivence" (p. 309). All other studies were found to have an appropriate recruitment strategy. Not all papers provided the ethnicity and gender of their participants (2, 6, 7, 8, 10), however, they all stated the age range or average age of participants. All studies collected their data in a way that addressed the research issues, with 10 studies using one-to-one interviews to gather their data and Study 8 using focus groups. These approaches were generally described in good detail.

A weakness across some studies (3, 4, 5, 8, 9, 10, 11) was the lack of the researchers' reflections in describing their own relationship with the participants, for example, identifying their own role, potential bias, and influence. Four studies had no mention of this (8, 9, 10, 11), and three studies (3, 4, 5) mentioned it, but not to a high standard. All the remaining studies demonstrated this to a high standard (1, 2, 6, 7).

Study 11 failed to mention any ethical considerations and five studies failed to mention them to a high standard (6, 7, 8, 9, 10). Most studies showed rigorous data analysis and defined it clearly (1, 2, 3, 4, 5, 6, 7, 8, 9, 10). There was a clear statement summarising the findings in all studies. The studies varied in how they addressed the value of the research, from discussing how it may contribute to existing knowledge to identifying where new research is necessary or the clinical or community implications.

Table 5

Assessment of study quality

Authors CASP items	1 Callerd et al. (2012)	2 Laithwaite & Gumley (2007)	3 Gibbs et al. (2020)	4 Spencer et al. (2022)	5 Judge et al. (2008)	6 Stålberg et al. (2004)	7 Barker et al. (2001)	8 Mizuno et al. (2013)	9 Naeem et al. (2016)	10 Glover et al. (2014)	11 Corcoran et al. (2007)
Aims	2	2	2	2	2	2	2	2	2	2	2
Methodology	2	2	2	2	2	2	2	2	2	2	2
Design	2	2	2	2	2	2	2	2	2	2	2
Recruitment	2	2	2	2	2	2	2	2	2	2	1
Data collection	2	2	2	2	2	2	2	2	2	2	2
Reflexivity	2	2	1	1	1	2	2	0	0	0	0
Ethical issues	2	2	2	2	2	1	1	1	1	1	0
Data analysis	2	2	2	2	2	2	2	2	2	2	1
Findings	2	2	2	2	2	2	2	2	2	2	2
Value	1	1	2	1	1	1	1	1	2	1	1
Quality score	19	19	18	18	18	18	18	17	17	16	13

Table 6

Overview of study quality

	Aims	Methodology	Research design	Recruitment	Data collection	Reflexivity	Ethical issues	Data analysis	Findings	Valuable
Total met	11	11	11	10	11	4	5	11	11	2
Total partially met	0	0	0	1	0	3	4	0	0	9
Total not met	0	0	0	0	0	4	1	0	0	0

Thematic Synthesis findings

Following the thematic synthesis, four analytic themes were identified with an additional five subthemes (Table 7).

Table 7
Themes and subthemes identified across studies including contributing studies

Themes	Subthemes
Theme 1: Changes in relationships may lead to developments in beliefs and understandings of psychosis *(all 11 studies)*	Experiencing psychosis may lead clients to evolve and refine their beliefs about psychosis *(2, 3, 4, 5, 7, 10, 11)* The quality of clients' relationships with others and whether they feel comfortable sharing their experiences may influence how they understand psychosis *(2, 3, 7, 9, 10)* The relationships between parents, siblings, carers, and clinicians and their relationships with clients may play a crucial role in shaping their understandings of psychosis *(1, 6, 8, 9, 11)*
Theme 2: The type of support offered may influence individual's' understanding of psychosis *(2, 3, 4, 5, 6, 7, 9, 11)*	The dominance of medication-based approaches may lead individuals to understand psychosis primarily as a medical illness *(2, 5, 6, 7, 9, 11)* Psychological approaches may foster an understanding of psychosis as arising from previous life experiences *(3, 4, 5)*
Theme 3: Concern about being blamed can shape individuals' understanding of psychosis, potentially leading to varying interpretations of its causes and nature *(1, 3, 4, 6, 8, 10)*	
Theme 4: A lack of understanding of psychosis may cause confusion and uncertainty for individuals and their families *(7, 8, 11)*	

Changes in relationships may lead to developments in beliefs and understandings of psychosis

This theme captured how changes in relationships, including with the self, before, during, and after an experience of psychosis may lead to developments in people's beliefs and understandings of psychosis. All 11 studies contributed to this theme. Most studies focused on clients and family members, with only two studies involving clinicians (9, 3).

Subtheme one: Experiencing psychosis may lead clients to evolve and refine their beliefs about psychosis

Seven studies contributed to this subtheme (2, 3, 4, 5, 7, 10, 11). These studies varied in quality, with four (2, 3, 4, 5) being in the top five quality studies, one in the middle (7) and two (10, 11) at the lower end of quality.

Experiences of psychosis were interpreted to affect clients' relationships with themselves, leading to differing beliefs about their own identity and their experiences of psychosis. Prior to their experiences, participants appeared to not hold specific understandings of psychosis, with clients' stating their experiences were not understood by themselves or those around them (7), and so these may develop as a result of experiencing it for themselves. There was a split between participants finding psychosis helpful in discovering their identity or feeling that they had lost who they were.

This subtheme suggests that participants who held a narrative of psychosis resulting in helpful change, such as gaining self-understanding or seeking support, may be less likely to develop and hold a medical model understanding of psychosis.

Instead, they view it as something they needed to go through to find themselves. They did not appear to present psychosis as something distinct or as a threat to who they were. They did not attribute psychosis to any typical models of psychosis, such as medical, trauma, or spiritual models. Instead, psychosis was interpreted to be seen from the start, during, and after as a beneficial experience.

Participants with an understanding of feeling they had lost themselves due to psychosis appeared to align strongly with a medical model and saw it as something that needed to be *"cured"* (Naeem et al., 2016, p. 49). These participants may have developed and subsequently held a medical model understanding of psychosis and wanted to be rid of psychosis and go back to who they were prior to experiencing psychosis. They tended to identify as being in a better place prior to their experience, with a resulting feeling of loss and overwhelm. A woman with puerperal psychosis reported feeling like someone else had taken over her brain *"I was trying to explain it to [husband] that someone had sawn off my head to get my brain and put someone else's in and I didn't know me anymore"* (Glover et al., 2014, p. 260). A mother (Corcoran et al., 2007) reported her daughter having no belief in herself or in her own future by hearing her say *"I'll be alone, I don't have nothing… nothing good will happen to me"* (p. 311). Across studies, several client participants commented on having little hope for their future (6, 8, 9, 11).

In contrast, some participants reported that experiencing psychosis had allowed them to understand themselves and reported, in some cases, feeling lost prior to their experience of psychosis. Study seven found all eight client participants reported their experience as beneficial in some ways, with six individuals highlighting it as being important in developing their identity. One participant said, *"It makes me another person, the person who I am rather than family."* (p.207). Additionally, study five found that participants saw their initial unusual experiences as a part of who they were and did not consider them to be an ‘illness’ until they were told so by a doctor, *“The doctors asked (about voices), but I related it to my actual self.”* (p. 97) and *“I thought that was just the way I was”* (p. 97). One participant commented that psychosis had acted as a trigger to reach out for support and, as a result, had become an “*entirely different person”* away from drugs and alcohol (Laithwaite & Gumley, 2007, p. 313). Additionally, study five reported that some participants found meaning in their experience and developed a deeper understanding of who they were.

Subtheme two: The quality of clients’ relationships with others and whether they feel comfortable sharing their experiences may influence how they understand psychosis

Five studies contributed to this subtheme (2, 3, 7, 9, 10). These studies varied from the higher end of quality (2, 3) to the lower end (7, 9, 10). This theme may suggest that a client’s understanding of psychosis can be influenced by their ability to communicate their experiences. The likelihood of them sharing such experiences may be influenced by the severity of interpersonal difficulties prior to their experience. When participants were able to share their experience and communicate with others, they felt that the cause of their psychosis could be understood (3, 4, 5). This may have been by people understanding what has happened to them in the past and their life context. If they were unable to share, the participants may have felt that the cause of psychosis is their fault, that they have done something wrong, and, consequently, may be judged by others.

Clients felt like they would be judged by disclosing their experience to those who are not professionals, *“Well basically I’ll show it to doctors but I don’t want to show it to others because I just don’t want them thinking about me or seeing me in a* *different way"* (Gibbs et al., 2020, p.252). Additionally, a woman experiencing puerperal psychosis reported critical comments from other women, which caused her to feel judged, exacerbating her feelings of distress, *"everybody telling me to pull my socks up, without a doubt everyone telling you that you could just snap out of it if you wanted"* (Glover et al., 2014, p. 261). This quote may also point to the participant feeling that the cause of her psychosis is her fault and feeling blamed by others because she is not pulling her socks up or snapping out of it. However, if clients were able to talk to others about their experiences, it was valuable in their recovery by *"building bridges"* (Laithwaite & Gumley, 2007, p. 311). Similarly, a client reported sharing their psychological formulation with others helpful by allowing them to have open communication and feeling understood by others, *"I think it made us more understandable to each other and able to talk about stuff."* (Gibbs et al., 2020, p. 252).

Participants may have initially developed an understanding of psychosis as something to be ashamed of and hide from others. There was a split in participants between those who felt able to share their experiences with others and those who did not. Generally, those who were able to share with those around them, outside of clinicians, felt a benefit from doing so. In this sense, their understanding may have shifted from feeling ashamed about their experiences to feeling accepted and not judged or othered. There was no shift reported among those who did not share their experience with others.

Subtheme three: The relationships between parents, siblings, carers, and clinicians *and their relationships with clients may play a crucial role in shaping their understandings of psychosis*

Participants with different relationships to an individual with psychosis were included (1, 6, 7, 8, 11). These studies varied in their quality, ranging from the lowest (11) to the highest (1). These relationships varied from parents, siblings, carers, and clinicians and appeared to have an impact on future prospects, beliefs involving the medical model, influencing the chronicity of psychosis and the likelihood of personal achievements.

Some comments may point to the predominance of a genetic and medical model understanding of psychosis among family members. There were similarities between some client participants and others' views of psychosis having a negative impact on the client's future, for example, future romantic relationships, job prospects and having children. For instance, study eight recorded a parent's reluctance to support their child's prospects for marriage, citing a perceived social stigma, *"They have the right to marry someone regardless of whether they have a mental health illness or not… However, in reality, I have no choice but to discourage them"* (p. 74). Similarly, a sibling's comment reflected scepticism about future achievements, *"my younger brother who has no job is too optimistic and dreams of getting married"* (p. 74). Only one brother was supportive of the idea of his sibling with schizophrenia getting married. Study 11 found one mother who believed her son could get married and have children.

There were beliefs perhaps aligning with a medical model of chronicity among the papers. Another similarity between client participants and others' understandings was the longevity of psychosis (6, 8, 11). A sibling commented on their permanent loss of their sister following her experience of psychosis, *"Somehow I've lost my sister the way she was before and I think I won't get her back,"* (Stålberg et al., 2004, p. 448). Similarly, a mother commented on their child's experience being something that will always need to be dealt with, *"The S word – schizophrenia – I'm going to deal with it for the rest of my life"* (Corcoran et al., 2007, p. 313). This indicates a sense of hopelessness amongst family members, *"There is no end to this issue"* (Mizuno et al., 2013, p. 75).

Relatives commented on the stigma towards psychosis and similar experiences and the subsequent understanding this led to (6, 8, 9, 11). Stigma was mostly commented on when considering genetic understandings. One sibling reported how her sister's experiences impacted her own future relationship *"Once I had to give up marrying a man. When I talked to his parents about my sister's illness, they immediately opposed our marriage, saying 'you will sully the purity of our blood.' Generally, people believe that a psychiatric illness is inherited and transmitted and brings disgrace to a family"* (Mizuno et al., 2013, p. 75). As discussed above, relatives tended to make similar assumptions about what psychosis meant for the client's future (e.g. not getting married or having children). It is possible that the stigma they receive as family members may reinforce their own beliefs about their relative's future, which may reinforce a genetic understanding of psychosis.

Throughout studies, parents', siblings' and carers' mostly presented a medical understanding of psychosis by talking about 'psychiatric illness', genetics and using diagnostic labels such as 'schizophrenia'. It was not clear if this understanding developed as a result of their relative experiencing psychosis or if this was a longstanding belief. However, these beliefs were reinforced by participants' wider family members or others around them.

These medical model understandings appeared to have an impact on their opinions on what their relative could achieve in the future and their belief in the chronicity of psychosis. There were no examples where experiencing a relative's psychosis had an impact on their medical model belief, so no changes or new understandings were gained.

The type of support offered may influence individuals' understanding of psychosis

This theme captured the dominance of the narrative of the medical model in services at the time of the studies, which led to most participants being offered medication and little or no psychological intervention. The support participants were offered appeared to have an impact on how they developed their understanding of psychosis, with a lack of treatments outside of medication leading to a mostly medical narrative of psychosis. However, those participants who were offered psychological interventions showed an understanding that their past and present experiences on psychosis, possibly lending to a trauma understanding of psychosis. Eight studies contributed to this theme across the two subthemes (Table 7).

Subtheme one: The dominance of medication-based approaches may lead individuals to understand psychosis primarily as a medical illness

Six studies contributed to this subtheme (2, 5, 6, 7, 9, 11). This subtheme highlighted the prevailing narrative of a medical cause of psychosis. These studies varied in their quality, ranging from the lowest (11) to the second highest (2).

Participants reported clinicians focusing on physical symptoms associated with their medication and experiences:

"They put me on Seroquel, started me in the study. I talk to her [the clinician] and she explains what the medication is doing, but she doesn't really analyze my issues or

get in- side my head. I’m not getting any psychological help. They’re just curious about how much weight I’ve gained.” (Judge et al., 2008, p. 98).

This may have influenced this participant’s understanding of psychosis by highlighting physical causes, the role of medication in treatment and subsequent monitoring of physical symptoms. This narrative from the clinician may cause the client to perceive psychosis as an illness and minimise other understandings. A result of this may have led to clients requesting medication only and doubting the effectiveness of psychological interventions, *“how can you treat me with talking? Can talking cure my illness?”* (Naeem et al., 2016, p. 49). This limited understanding of how psychology could be helpful may reflect the participants strong belief in a medical model, possibly reflecting the treatment they had received up to this point. It was not clear if this understanding was already there for most participants. This may be due to them not previously considering what may cause psychosis prior to their own experience.

Subtheme two: Psychological approaches may foster an understanding of psychosis as arising from previous life experiences

Three studies contributed to this theme, which highlighted the role of psychology in the development of participants’ understanding of psychosis (3, 4, 5). These studies were among the top five studies in quality.

All three studies (3, 4, 5) found the participants who received psychology to be grateful for an opportunity to stop and think about patterns in their lives and what might be going on for them. The psychological interventions may have shown the participants the influence of their past, the way they behaved and thought about their experiences, and their understanding of psychosis. The opportunity to engage in psychological interventions helped to develop an understanding of psychosis that included the participants' stories and their own experiences. It appeared to offer participants an alternative narrative to their difficulties, one that diverged from what they may have heard up to this point (such as medical understandings), and this was generally well received. It may have resulted in a change in their understanding of psychosis. For example, a change from a medical understanding of psychosis to a trauma understanding encompassing the influence of their past on their present experiences.

Psychological formulations were found to be helpful and showed clients the significance of what has happened to them in the past based on their experience *"it was quite positive spotting the patterns of the way things happened throughout my life"* (Gibbs et al., 2020, p. 249). With psychological interventions, people were able to shift from self-blame to self-empowerment (Spencer et al., 2022), which resulted in clients finding motivation to make changes in their lives. For example, participants commented on taking control of working towards their goals by reducing behaviours (e.g. avoidance) that they found were contributing to their difficulties. In a different paper, three participants cited their written formulation as an *"accomplishment"* or a *"new start"* (Gibbs et al., 2020, p. 250). This was interpreted to demonstrate the role of psychological interventions in shaping how the clients felt about their experiences and how they made sense of these. Their perception shifted from blaming themselves for developing psychosis to seeing the experience as a catalyst for self-empowerment. This may highlight the benefit of psychological interventions and, here, psychological formulations in broadening individuals' beliefs about psychosis.

Concern about being blamed can shape individuals' understanding of psychosis, potentially leading to varying interpretations of its causes and nature

Six studies contributed to this theme (1, 3, 4, 6, 8, 10). This theme included the highest quality paper (1) with the others varying between the highest and lowest quality.

This theme demonstrates that an individual's understanding of psychosis may be influenced by the attribution of blame they may feel for its cause. Clients tended to attribute the cause of their psychosis to previous life events, absolving themselves of fault. Conversely, parents appeared to develop a narrative portraying psychosis as an illness by emphasising the role of biological factors. Overall, this was interpreted by the researcher to underscore the possible influence of perceived blame on the different understandings and beliefs of psychosis among clients and their families. No clinicians' perspectives contributed to this theme.

The influence of past events and environmental factors on the development of psychosis was frequently cited by clients. Study one described one participant's experience of growing up with an abusive mother at home, attributing her as the cause of his and his siblings' experience of mental distress. Additionally, clients found comfort in considering the role of previous experiences in the development of their psychosis and commented that it relieved them of self-blame (4).

It was notable that siblings and clients spoke more about the influence of previous life events and their impact on psychosis than parents did. Mizuno et al. (2013) stated that only siblings cited childrearing as a cause, with one sibling saying, *"although it is controversial, I think that a lack of parental affection and child-rearing by mothers could be a cause"* (p. 74). Siblings' view of the importance of environmental factors was also prevalent in Stålberg et al.'s (2004) paper, *"It could be anything, such as tragic events, childhood, anything"* (p. 452). However, it should be noted that siblings also reported concerns about hereditary causes of psychosis (6), *"There is a certain hereditary, or more correctly, you inherent a sensitivity for the illness, the psychiatric illness"* but when this perspective was presented, siblings tended to emphasise a combination between biological and environmental factors in causing psychosis. It might be that siblings felt comfortable citing additional causes for psychosis due to not feeling responsible for their sibling's previous life events and any possible environmental factors.

In contrast, parents typically emphasised the role of biological factors, such as adolescents, and genetics in psychosis (8, 10), possibly to distance themselves from feelings of shame or guilt. This was noticed even if it appeared that the parents were not directly responsible for any harm experienced by their child, who then experienced psychosis. Additionally, it was noted in study 11 that when parents did cite factors outside of biological causes it was down to choices made by their child, *"[He] got involved with different people… not healthy people… late parties, they talk a lot of funny things, some into drugs".* This may be seen as the parents absolving themselves of blame and, instead, placing this within their child and their own choices leading to the development of psychosis.

A lack of understanding of psychosis may cause confusion and uncertainty for individuals and their families

Despite engagement with mental health services, individuals and their families often appeared to struggle to understand psychosis, as highlighted by three studies (7, 8 ,11). These studies are all in the lower five studies in terms of quality.

For example, four relatives of individuals with schizophrenia reported that they still did not fully understand their relative's experiences, sometimes attributing this confusion to the lack of clear communication from clinicians (7). Some families believed that clinicians intentionally withheld detailed explanations, perhaps anticipating the family's reaction, *"The psychiatrist did not provide me with a detailed explanation, probably because he thought that I would become confused and not be able to accept the fact."* (Mizuno et al., 2013, p. 75). This might speak to clinicians' own perspective of psychosis as something too complicated for individuals to understand. This was seen to cause a barrier to others ability to develop their own understanding of psychosis. Similarly, study 11 found that three family members reported clinicians as providing little information.

It is possible that prior to encountering psychosis in whatever way they did, these participants had not considered the cause of psychosis or what it really is. This theme highlighted that despite experiencing psychosis or having a relative who has, people may struggle to develop an understanding of psychosis and the influence clinicians may have on this.

Discussion

This review sought to answer the question: *What does the current literature tell us about people's beliefs, understandings, and narratives of psychosis and how these may develop?* To achieve this, 11 qualitative studies that sought or included the aim of exploring how people's beliefs, understandings and narratives of psychosis or similar experiences developed and changed were analysed. A systematic literature search, critical appraisal, and thematic synthesis methodology were conducted. Four themes and five subthemes were identified. Each theme was supported by several studies of both high and moderate quality, which were considered during the synthesis process. The analytical themes developed were: *changes in relationships may lead to developments in beliefs and understandings of psychosis, the type of support offered may influence individuals' understanding of psychosis, concern about being blamed* *can shape individuals' understanding of psychosis, potentially leading to varying interpretations of its causes and nature and a lack of understanding of psychosis may cause confusion and uncertainty for individuals and their families.*

The theme *changes in relationships may lead to developments in beliefs and understandings of psychosis* explored how changes in relationships, including with the self before, during, and after experiencing psychosis may influence the development of an individual's understanding of psychosis. Within this theme, there were views suggesting that psychosis will impact the individual for the rest of their life. These views were interpreted to be related to the medical model. The wider literature encompasses similar and conflicting findings. While the duration of experiencing psychosis or a 'related diagnosis' has been reported to extend over several years (Alyahya et al., 2020), numerous studies demonstrate that recovery from psychosis is possible. Nixon et al. (2010) found that recovery is more likely when childhood trauma experiences are addressed. Further research showed that opportunities for individuals to share their experiences with others (Brown & Kandirikiria, 2007) and have a space to regain a sense of purpose in life (Wood & Alsawy, 2017) contribute to recovery. It could be argued that these factors are more likely to be addressed if the individual is offered psychological interventions. Thus, adopting a psychological and trauma-informed understanding of psychosis may lead to changes in this understanding of psychosis being lifelong. This is supported by the review, which found that those who accessed psychological therapy found motivation to make changes in their lives (Spencer et al., 2022) and, therefore, did not appear to view their experiences of psychosis as lifelong. This demonstrates that holding a medical understanding of psychosis may lead to a belief of psychosis being chronic when compared to those who hold a trauma-informed understanding of psychosis.

The review showed parallels with a systematic review that looked at identity changes in people experiencing psychosis (Conneely et al., 2021). Both found psychosis to be associated with personal growth and a meaningful transformation in the individual's life. This might be thought to be surprising when considering the discourse typically surrounding psychosis, which frequently includes violence towards themselves or others (Aracena, 2012; Delahunt-Smoleniec & Smith-Merry, 2020; Owen, 2012). When considering the reviews highlighting the role psychosis can play in personal transformation, they may speak to a spiritual understanding of psychosis.

The theme *the type of support offered may influence individuals' understanding of psychosis* explored the influence of medical or psychological interventions on people's understandings of psychosis. Throughout the studies, medication and hospitalisation were prioritised over psychological interventions, which may have influenced participants understandings in line with the medical model, although it cannot be confirmed if these understandings existed prior to psychosis as participants appeared to not hold specific understandings of psychosis before their own experiences of psychosis. People generally reported finding medication helpful and showed ambivalence towards psychological interventions. In wider literature, Wiesjahn et al. (2014) found that positive attitudes towards medication were correlated with having biological causal beliefs and less endorsement of psychological causal beliefs about psychosis. Similarly, causal explanations among clinicians have been found to be associated with attitudes towards treatment. For example, clinicians who held a biological understanding of psychosis were more likely to endorse medication and those with psychosocial beliefs endorsed Cognitive Behavioural Therapy (Carter et al., 2017). These findings may highlight the importance of offering a variety of interventions not only to support clients but also to allow opportunities for them to consider factors causing their experiences that do not align with the initial support offered. For example, opportunities to consider understandings outside of the medical model and to reflect on the possible impact of their own life experiences and gain their own understanding of their experiences.

The theme *concern about being blamed can shape individuals' understanding of psychosis, potentially leading to varying interpretations of its causes and nature* showed that the blame an individual may feel for the cause of psychosis might influence their understanding. Parents appeared to favour a medical model of understanding when compared to clients and siblings, who seemed to endorse the role of previous events in the development of psychosis. This was interpreted as parents feeling blamed if the development of their child's experience was linked to their upbringing. Conflicting literature has shown that the stigma associated with psychosis has been found to be reduced if it is framed as a meaningful response to adversity (Longdon & Read, 2017). Furthermore, individuals with psychosis are seen as unpredictable and out of control when applying an illness model (Read et al., 2004). This shows the role of who feels to blame and, therefore, experiences stigma, and their subsequent understanding of psychosis.

Given these relational influences on understandings of psychosis, family interventions may be valuable. This has been supported in the literature with "observed family disturbances" being present prior to the onset of experiences of psychosis (Hahlweg & Baucom, 2023). The National Institute for Health and Care Excellence (NICE) guidelines also recommend family interventions for adults experiencing psychosis (NICE, 2015). Open Dialogue (OD) fosters an approach of involving the whole family from the onset and maintaining open communication (Seikkula & Arnkil, 2006) and may help align the varying perspectives, lending to a more cohesive and supportive treatment environment. OD has a strong evidence base for supporting psychosis (Seikkula et al., 2006; Bergström et al., 2018), making it a suitable option for fostering such discussions about families and their collective or individual perspectives of psychosis. Behavioural Family Therapy (BFT) holds a strong evidence base for psychosis (Pharoah et al., 2010; Falloon et al., 1985). BFT enhances communication (Campbell, 2004) to create a more supportive environment and allow differing understandings of psychosis to be brought up and discussed between family members, which may assist in aligning beliefs about the causes of psychosis and improving interactions between family members. Finally, Systemic Family Therapy (SFT) has a strong evidence base for supporting those with psychosis and their families (Anderson et al., 1986; Hahlweg & Baucom, 2023). SFT focuses on the systems surrounding the clients and how we can maintain curiosity (Boscolo et al., 1987), which may allow family members space to consider alternative perspectives on their family members experiences. Holding this research and the present review in mind, services may wish to consider offering such family interventions for those experiencing psychosis.

The final theme, *a lack of understanding of psychosis may lead to confusion and uncertainty in individuals and their families in their understanding of psychosis*, showed that despite participants having a personal relationship, either themselves or through a relative, they still did not have a full grasp on their understanding. This highlighted the need for improvements in communication and support within mental health services to ensure that individuals and families can access accurate information and receive the support they need for recovery and well-being. This is of particular importance with literature showing the influence of clear psychoeducation on schizophrenia on the reduction of clients and their families stress levels (Mubin & Livana, 2020).

Many studies included in this review exhibited similarities to previous research in the area. For example, the dominance of social and biological causes of psychosis has been consistently observed throughout the literature (Read et al., 2013; Link et al., 1999; Cavanagh et al., 2004; Read & Larkin, 2008; Morgan & Fisher, 2007; Stilo et al., 2013; Pearce et al., 2019). Despite the evidence in the wider literature encompassing social influences on the development of psychosis, the present review found biological causes and medical treatments were most widely offered (2, 5, 6, 7, 9, 11). This shows that despite the growth in alternative narratives of psychosis, medical models are still prevalent in services within the locations where the studies were undertaken. However, most of these studies were conducted over a decade ago and might not reflect present day services. This is important considering the promotion of trauma-informed care within services over the last 20 years (Emsley et al., 2022) and the possible influence this may have had on peoples' understanding of psychosis.

Strengths and Limitations

This review had several strengths and limitations. One strength was the diversity of the included studies. By synthesising studies conducted in multiple countries, it allowed a wide range of understandings of psychosis to be considered and presented. However, it was not possible to determine the exact breakdown of the ethnicities of the participants because not all studies reported this information. The search also yielded narratives from clinicians, clients, and family members. Despite the clinicians being the least represented group, their narratives still contributed to the overall findings. A further strength was the in-depth nature of much of the data collected across the studies. Most studies reported interviews lasting hours, which contributed to the richness of the presented data.

The limitations of this review are as follows. Firstly, the interpretation of the qualitative studies was done by the researcher alone, and the synthesis of information is subjective. Considering this, the researcher tried to continuously consider any bias they may have brought to the review and ensured the language presented was representative of the language included in the studies. Secondly, the search terms included to describe the experiences of psychosis had limitations. Due to the non-inclusion of other terms that may have helped to capture experiences of psychosis, for example, “delusions” or “hallucinations”, some studies may have been missed. Similarly, a limitation was the limited specific types of qualitative methodologies used as search terms. It was hoped that by using the terms selected and conducting title and abstract screens, the appropriate studies would be found and included if suitable. However, the inclusion of additional search terms may have led to a wider range of relevant studies being found, which may have contributed to the results. Thirdly, not all aims of the synthesis were able to be addressed. The studies included were unable to speak to the development of the narratives of psychosis and instead focused more on the understanding and beliefs of psychosis. It might be that by using additional search terms, the narratives could have been addressed. Finally, this review only synthesised 11 studies, which may be considered a small amount. It is possible that some important perspectives were not captured, such as a wider diversity of clinicians and partners of people experiencing psychosis, due to the search terms employed or difficulties with accessing all the identified studies.

Clinical and research implications

During the synthesis of the studies, it became apparent that most of the studies concerned the client, carer, or family members. Clinicians' narratives were not as prominent in this review, which may suggest a direction for future research. Previous research into clinicians' understandings and beliefs of psychosis has found a range of findings (Carter et al., 2017), which is not surprising given the diversity of theoretical beliefs and explanatory models that exist within the field of mental health, e.g., biological, psychological or sociocultural explanations. A study showed psychiatrists holding a reluctance towards a medication-free treatment for psychosis due to the lack of evidence (Yeisen et al., 2019). This reluctance in part explains why client participants included in this review were mostly offered medication (2, 5, 6, 7, 9, 11). Byrne and colleagues (2020) reported that only a small number of studies explored clinicians' views of psychological support for psychosis, one of which reported psychology as an "integral, but not first line" intervention (Wood et al., 2019, pg. 554). This again mirrored the experiences of participants being offered minimal or no psychological support in this review. A recommendation for future research based on this review would be for further studies exploring clinicians' views of psychological support. Understanding these diverse perspectives may assist in developing more integrated, client-centred approaches that combine the strengths of various models, promoting comprehensive and holistic approaches to care.

Given that the relationships with family and peers were found to influence an individual's understanding of psychosis, family therapy interventions should be considered within services where possible. Especially with the existing evidence base of the effectiveness of family therapy interventions when supporting people with psychosis and their support networks. It may be beneficial for future research to look at the role family therapy may hold in shaping family understandings of psychosis and the possible role of blame between family members within this.

Finally, it is important for clinicians to ensure they are relaying clear information about psychosis to clients with psychosis and their families and, if possible, not from one discipline’s perspective. For example, if a client were only to speak to a psychiatrist they may hear only a medical perspective, which may influence their understanding. This clearer and more multifaceted explanation may support the individual’s understanding of their experiences and, possibly, help them to make informed decisions about their care and increase their confidence when talking to others about their experiences.

Conclusions

Through a thematic synthesis of qualitative studies, this review expanded the existing literature by enhancing the comprehension of how individuals develop and change their understanding of psychosis. The synthesis revealed the complex interplay of relationships, support received, and a sense of blame in shaping individuals’ understandings of psychosis. There were also findings about what might limit somebody from developing an understanding. Generally, each study had moderate to high quality, so these findings can be accepted with some confidence. The reviews strengths included the diversity of studies across multiple countries and rich data collected through in-depth interviews. However, limitations included the subjective interpretation of the researcher, the restricted search terms, the narrow focus on understanding psychosis rather than its narrative development, and the small sample of 11 studies, which may have excluded important perspectives. This synthesis revealed a focus on clients, carers or families rather than clinicians, highlighting a gap in research on clinicians’ views. This review made suggestions for future research.

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Exploring Beliefs, Narratives, and Understandings of Psychosis: Insights from Literature and Staff Stories Utilising the Power Threat Meaning Framework

Section B: The stories of staffs understanding of psychosis with the use of the Power Threat Meaning Framework

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Abstract

The understanding of psychosis has changed over time to consider the impact of trauma upon people’s experiences. Services are evolving to consider ways to provide trauma-informed care. The Power Threat Meaning Framework (PTMF) has been used to guide team formulation meetings. The study aimed to explore staff who have worked with psychosis, experiences of PTMF team formulation meetings and if they influence their subsequent understanding of psychosis. Ten staff participants from mental health services supporting those experiencing psychosis were recruited and interviewed. Narrative analysis methodology was employed. Five research questions were answered. Within the narratives, most participants spoke of having previously held a medical model understanding of psychosis, which reflects the dominance of this narrative. The PTMF featured in narratives and often appeared to highlight the role of adversity and power in people’s understandings. Participants shared how the PTMF formulation meetings helped to humanise clients. Personal stories of loved ones experiencing psychosis were shared. Clinical implications and recommendations for future research are raised.

Key words: psychosis, power threat meaning framework, team formulation, understanding, narratives

Introduction

The phenomenon referred to as ‘psychosis’ encompasses a range of experiences, such as hearing voices, seeing, smelling, feeling, or tasting things others do not and holding beliefs that others may find unusual. The concept of psychosis was brought into psychiatric literature by Carl Canstatt in 1841, and it was emphasised as a “disease of the brain” (Bürgy, 2008, p.1201). Ever since this introduction in the 19th century, the biomedical model has dominated the narratives surrounding psychosis and has consequently guided its treatment and management (Bentall, 2004).

In the United Kingdom, antipsychotic medication, alongside psychological interventions, is the recommended treatment for episodes of psychosis or ‘schizophrenia’ (National Institute for Health and Care Excellence [NICE], 2015). However, the association between adverse life events and psychosis is well known among researchers (Read & Larkin, 2008; Hardy et al., 2005). This association was perpetuated after the recognition of a dose response relationship with trauma. For example, those who have had three traumas are eighteen times more likely to develop psychosis compared to those who have had five traumas who are 193 times more likely (Shevlin et al., 2007).

Poor mental health is strongly associated with broader social factors such as violence, poverty, and racism (Paradies, 2006; Muralia & Oyebode, 2004). Those using mental health services show higher rates of adverse and traumatic experiences than the general population (Mauritz et al., 2013). Despite the NICE guidelines (2015) also recommending psychological interventions alongside antipsychotics, it is well documented that these are not always offered (Judge et al., 2008). This is a concern, as psychological interventions would provide an opportunity to help clients who have had such adverse and traumatic experiences. The literature demonstrates the need for services and clinicians to consider the impact of adversity and trauma on those they are supporting and the interventions chosen (The NHS Long Term Plan, 2019).

Narratives of psychosis

Mankowsi and Rappaport (2000) proposed a three-tier model of narratives that encompasses individual, group and societal stories. Dominant narratives are produced and reproduced within society and have an influence on both group and individual narratives. With regards to psychosis, the medical model is the primary discourse in society (Lawrence et al., 2021), mental health services (Chadwick & Billings, 2022), and among individuals (Naeem et al., 2016; Judge et al., 2008; Corcoran et al., 2007; Laithwaite & Gumley, 2007), including clinicians (Chadwick & Billings, 2022). There is research showing that the dominant societal, group and individual medical narratives are not always helpful due to their potential to place the blame within the individual and increase stigma (Read et al., 2004).

People with lived experience and mental health professionals have been increasingly suggesting that alternative narratives may offer more possibilities and, in some cases, could have more benefits for people and wider society. For example, May (2004) commented that his own diagnosis of schizophrenia was unhelpful and that a focus on social and psychological recovery would have been beneficial. He commented on his diagnosis, instilling a feeling of learned helplessness within him and his family and a belief that he would always be ill.

There is also evidence demonstrating the usefulness of assessments of psychosis incorporating an understanding of the individual's narrative of their personal experiences and the significance attributed to them, as opposed to just their “acceptance of biomedical model of ‘illness’” (Marriott et al., 2019, p. 75). This is helpful as individual narratives promote a deeper understanding of the client, a holistic view of their entire experience beyond biological factors and enable tailored interventions.

Due to the dominance of the medical model, there is evidence that the narrative embeds itself within the personal stories of people that have experienced psychosis and their family members (Judge et al., 2008; Naeem et al., 2016). This is reinforced by the narratives of psychosis inherent in the explanations given by clinicians, medical interventions offered and sometimes psychosocial support (Corcoran et al., 2007; Laithwaite & Gumley, 2007). Considering the power clinicians have in influencing narratives, it is beneficial to consider their own understanding of psychosis and how these can be shaped by different team practices, including team formulations.

Team formulations

Team formulations have been defined as “the process of facilitating a group of professionals to construct a shared understanding of a service user’s difficulties” (Johnstone & Dallos, 2013, p. 5). The Division of Clinical Psychology (DCP) Good Practice Guidelines recommend all team formulations be trauma-informed (DCP, 2011), therefore, they have often been used to shift the culture of services away from focusing on what is wrong with people to what has happened to them (Cole et al., 2015; Dexter-Smith, 2015). They also aim to facilitate collaborative working amongst team members and have become increasingly popular (DCP, 2011).

Multiple benefits of team formulations have been found, including a greater understanding of risk (Ramsden et al., 2014), increased psychological thinking (DCP, 2011), more confidence in treatment plans (Hartley, 2021) and improved relationships between staff and clients (Berry et al., 2015). A systematic review based on multidisciplinary teams found team formulation meetings enhanced staff's understanding of service users and improved professional confidence and validation (Bealey et al., 2021). An example of this was from a recent qualitative study, where a clinician working on a dementia ward described seeing clients more as “people” and less as “patients” after attending team formulations (Murphy et al., 2013, p. 444).

Team formulations allow staff members to put forward their own ideas, subsequently allowing others to learn from these ideas and impacting their personal narratives on emotional distress. Despite this process, the existing team narrative will typically influence these discussions. For example, if the team holds a medical model understanding of psychosis, they may be more inclined to solely consider interventions in line with that narrative, e.g. medication. Therefore, it would be beneficial to consider using an approach that allows for other narratives to be considered and discussed.

Despite these reported benefits of team formulations, Geach and colleagues (2018) systematic review found weak evidence for team formulations leading to beneficial outcomes in clinical practice or evidence of change found for the service users following the introduction of team formulations. Papers in this review also reported that team formulation meetings were not always collaborative, with some studies reporting the formulation being completed outside of the meeting by psychologists. Staff reported feeling unsupported by colleagues if they had not attended the team formulation meetings and felt they had “unfairly missed out” (Geach et al., 2018, p. 23).

Two papers included in the Geach et al. review (2018) commented on the mixed experiences and benefits associated with team formulation meetings. Clinical psychologists have commented that they felt multi-disciplinary team members valued the team formulation meetings (Chirstofides et al., 2012), whereas staff from other disciplines felt that during the meetings, staff wanted to be right or come across as powerful (Summers, 2006).

The Power Threat Meaning Framework

The Power Threat Meaning Framework (PTMF) created by Johnstone, Boyle and colleagues (2018) offers a non-pathologising approach to understanding mental distress. It serves as a comprehensive framework for identifying patterns of emotional distress, unusual experiences, and troubling behaviour. It offers an alternative approach to ‘psychiatric diagnosis’ and classification and moves the question from asking the individual “what is wrong with you?” to “what has happened to you?”. The framework provides a focus on an individual’s story, and when used in a team formulation meeting, it allows for themes in emotional distress, experiences and behaviours to be identified. The focus of the framework is to provide a lens to view power and adversity and the role these experiences play in people’s difficulties and stories. The PTMF is summarised into four key questions:

1) “What has happened to you? (How is power operating in your life?)”
2) “How did it affect you? (What kind of threats does this pose?)”
3) “What sense did you make of it? (What is the meaning of these situations and experiences to you?)”
4) “What did you have to do to survive? (What kinds of threat response are you using?)”

Two additional questions are set out to help facilitate conversations about what strengths and resources the person/family/group might have, and how to bring this together to create their narrative. These are:

5) “What are your strengths? (What access to power resources do you have?)”
6) “What is your story? (How does all this fit together?)”

Question 6 highlights how the PTMF positions the narrative as carrying the meaning, i.e., the story holds together how power operations pose a threat, what meaning the individual has taken from these experiences, and their survival responses. The PTMF has been applied in a range of clinical and community settings, including service design (Flynn & Polak, 2019; Nikopaschos & Burrell, 2020), one-to-one therapeutic work (Aherne et al., 2019; Sapsford et al., 2023), group formats (Griffiths, 2019; Reis et al., 2019), and staff support in a multi-disciplinary team setting (Akande & Bland, 2023).

While the PTMF is used across a number of different settings, it holds some limitations. Firstly, despite the inclusion of power in understanding human experience, the PTMF does not consider its own production of power in its interpretations of distress (Morgan, 2023). Harper (2023) emphasised this by commenting on critiques the PTMF has received for providing a new overarching framework, which might impose its own rigid structure on understanding mental health distress, thus replicating the limitations it seeks to overcome. Secondly, it was found to only be known by 1% of American psychologists (Raskin et al., 2022), which shows it isn’t as shared a language as diagnostic and medical language. Finally, it has been described as not having much to offer (Aftab, 2023).

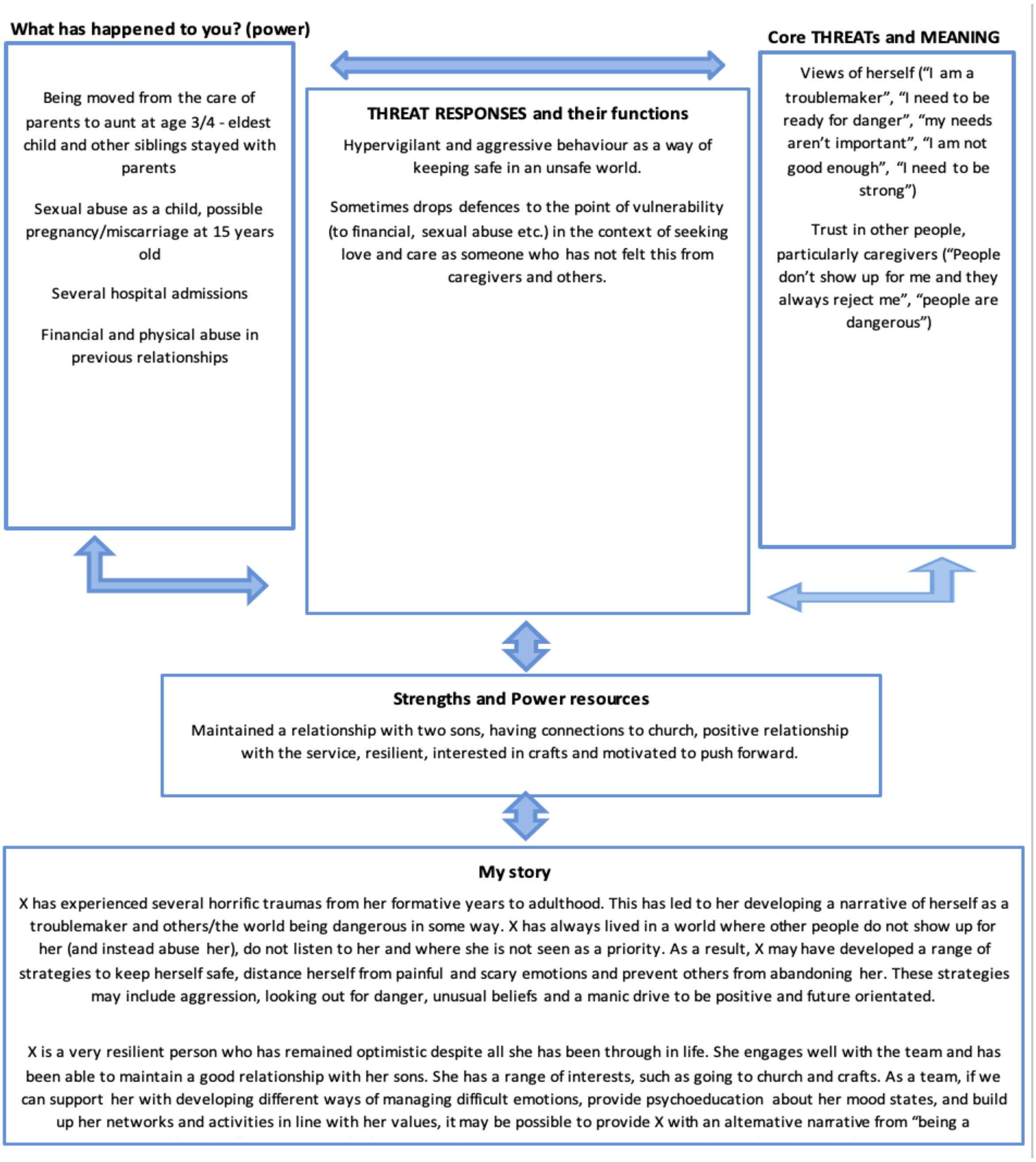
The Power Threat Meaning Framework and team formulations

The use of the PTMF within clinical team formulation meetings is growing (Makwana et al., 2022). A recent study found benefits of using formulation meetings underpinned by the framework in an inpatient setting (Nikopaschos et al., 2023). Findings included: fewer restraints and seclusion measures being used against service users; clients reported the approach supported them to learn new and helpful ways of managing their mental health; and staff developed a better understanding of the relationship between trauma and distress. Another study comparing the impact of describing an individual's difficulties using the PTMF with a medical model found increased stigma when their difficulties were explained using the medical model as opposed to using the PTMF (Seery et al., 2021). For example, participants reported a stronger desire for social distance from others when the diagnosis of schizophrenia was used, compared to when the PTMF formulation was employed.

Using the PTMF may lead to a shift in a team narrative about psychosis by allowing time to consider parts of the client’s narrative that may typically be missed during other meetings. A diagram of how the PTMF may be used in team formulation meetings can be seen in Figure 1. To the researcher’s knowledge, there has been no research on the utilisation of PTMF in team formulation meetings in secondary mental health care services or on the potential influence this may have on staff’s understanding of psychosis.

Figure 1

The PTMF diagram



What has happened to you? (power)

Being moved from the care of parents to aunt at age 3/4 - eldest child and other siblings stayed with parents

Sexual abuse as a child, possible pregnancy/miscarriage at 15 years old

Several hospital admissions

Financial and physical abuse in previous relationships

THREAT RESPONSES and their functions

Hypervigilant and aggressive behaviour as a way of keeping safe in an unsafe world.

Sometimes drops defences to the point of vulnerability (to financial, sexual abuse etc.) in the context of seeking love and care as someone who has not felt this from caregivers and others.

Core THREATs and MEANING

Views of herself ("I am a troublemaker", "I need to be ready for danger", "my needs aren't important", "I am not good enough", "I need to be strong")

Trust in other people, particularly caregivers ("People don't show up for me and they always reject me", "people are dangerous")

Strengths and Power resources

Maintained a relationship with two sons, having connections to church, positive relationship with the service, resilient, interested in crafts and motivated to push forward.

My story

X has experienced several horrific traumas from her formative years to adulthood. This has led to her developing a narrative of herself as a troublemaker and others/the world being dangerous in some way. X has always lived in a world where other people do not show up for her (and instead abuse her), do not listen to her and where she is not seen as a priority. As a result, X may have developed a range of strategies to keep herself safe, distance herself from painful and scary emotions and prevent others from abandoning her. These strategies may include aggression, looking out for danger, unusual beliefs and a manic drive to be positive and future orientated.

X is a very resilient person who has remained optimistic despite all she has been through in life. She engages well with the team and has been able to maintain a good relationship with her sons. She has a range of interests, such as going to church and crafts. As a team, if we can support her with developing different ways of managing difficult emotions, provide psychoeducation about her mood states, and build up her networks and activities in line with her values, it may be possible to provide X with an alternative narrative from "being a

Research aim

The study aimed to explore staff, who have worked with psychosis, experiences of PTMF team formulation meetings and if they influence their subsequent understanding of psychosis. To achieve this research question, five further sub-questions were set:

- How are the participants' earliest understanding of psychosis depicted?
- Did the dominant illness narrative feature in the narratives? If so, how?
- Did the PTMF feature in the narratives? If so, how?
- Do the participants' narratives depict a change in their understanding of psychosis since formulating using the PTMF? If so, how?
- Do the participants' narratives depict any change in their practice with clients?

To gain each participant's understanding of psychosis, narrative interviews were carried out and narrative analysis methodology was employed. Narrative approaches allow in-depth explorations into how individuals construct the sequences of events in their lives and derive meanings from their experiences (Riessman, 2008). This study is relevant to NHS values as it involves capturing the stories of staff who have used the PTMF during a team formulation, which demonstrates the outcome of working together for patients. By staff working together to create and consider the client's story, teams can provide appropriate, thoughtful and individualised care.

Method

Theoretical framework

The underlying epistemology of the study was critical realism. Critical realism suggests that we make sense of the world based on our lived experiences and has been described as "enlightened common sense" (Pilgrim, 2022, p. 84). As such, it allows the analysis of structures that underlie social phenomena, such as power relations, community and cultural norms and adversities. Critical realism also argues that a deeper, underlying reality exists outside of our subjective experiences (Bhaskar, 1978) and acknowledges the material reality of: the lack of services for people in emotional distress; the restrictive nature of interventions; and the way in which services can cause harm. The PTMF employs a critical realist stance and critiques the privileging of ‘scientific’ knowledge and ‘psychiatric’ models to incorporate what has happened to the person. In this way, the meaning of their story is regarded as crucial, and its contribution to their distress is considered.

Design

A qualitative research design was employed, guided by narrative analysis. A narrative analysis approach was used to reveal the participants in-depth and rich stories of their understanding of psychosis (Riessman, 2008). It gives participants freedom in how they tell their story, which may have been restricted had a structured interview approach had been used. Narrative analysis allows contextualisation of individual experiences within their own social, historical and cultural context (Bruner, 1991). Furthermore, narrative analysis has the potential to hear multiple voices making up an individual’s story (Frank, 2012), thus allowing the reproduction of the words of the wider multidisciplinary team (MDT) or other influencing voices to be heard. Participants are empowered by being allowed to share their stories and voices, which may have previously been looked over in traditional research approaches (Chase, 2005).

Reflexivity and quality assurance

I am a white British, female trainee clinical psychologist and I conducted all ten interviews. Prior to the interviews, I reflected upon my own relationship with both the PTMF and psychosis. I have experience co-facilitating PTMF formulation meetings and delivering teachings on the PTMF for different mental health services and audiences. This shows my belief in the PTMF as an effective formulation tool that may act as a source of bias. Due to experiences in my personal and professional life, psychosis caught my attention and led me to want to study psychology and pursue clinical psychology. This was due to experiences in my personal and professional life. I kept a reflexive journal throughout the process to reflect on my own position, for example, personal characteristics, values, and circumstances, and how they may influence the research process, particularly the analysis (Appendix M). Here any potential limitations or challenges encountered during the analytical process were documented. For example, I have a close friend who had similar experiences as those personal stories described in some participants' narratives. Since this later became a heading from the narratives, I wondered if I had felt an emotional response to their stories as it held a likeness to my own experiences. I had previously worked in the same community mental health team (CMHT) with five participants (Table 2). I noted feeling more comfortable and confident using prompts during the interviews with these clinicians. Similarly, I reflected that when these clinicians spoke highly of their experiences of attending PTMF team formulation meetings, they may have felt pressure to do so since I had co-facilitated their team formulation meetings for them. I wonder if they felt an additional pressure to speak positively of this than those clinicians I had not previously worked with.

I sent a synopsis of their interview to each participant to check for accuracy. One participant was unable to respond due to having no access to their professional email address for a year and the researcher did not have consent to contact them in an alternative way. Seven participants responded by confirming that the synopsis was an accurate reflection of their interview and two asked for minor amendments, which were made. An example of an amendment made was to change the word “sympathy” to “empathy”. I consulted with a supervisor at the analysis stage to enhance the quality of the research by discussing narratives and facilitating reflexive stance throughout the research.

Participants

Purposive sampling was employed in the study, which involved identifying and selecting information-rich cases connected to the phenomenon of interest (Palinkas et al., 2013). As such, staff members who had supported clients experiencing psychosis and attended PTMF team formulation meetings were sought and included. An email was sent to MDTs in a mental health NHS trust where some services conducted PTMF team formulation meetings and potential participants were invited to contact the researcher if they were interested in taking part. The inclusion criteria can be seen in Table 1. Participant demographic information has been shown in Table 2.

Table 1

Inclusion criteria

Inclusion criteria
• NHS staff members
• Have previously or currently working with individuals with psychosis

- Have attended power threat meaning framework team formulation meetings

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Table 2

Participant demographics

Participant*	Gender	Age range	Ethnicity	Job role	Relationship to researcher
Sarah	Female	25-35	White British	Trainee clinical psychologist	Known prior to research
Fiona	Female	25-35	Any other White Background	Trainee clinical psychologist	Not known prior to research
Ade	Female	50-65	Black African	Cognitive behavioural therapist & nurse specialist	Known prior to research
Naomi	Female	25-35	White British	Occupational therapist	Known prior to research
Indira	Female	25-35	Any other Asian Background	Assistant psychologist	Known prior to research
Ishaan	Male	36-50	Any other Asian Background	Clinical psychologist	Not known prior to research
Mary	Female	50-65	White British	Occupational psychologist	Not known prior to research
Louise	Female	36-50	Black British	Consultant psychiatrist	Not known prior to research
Johan	Male	36-50	Black African	Team lead, mental health nurse	Not known prior to research

				background	
Aysa	Female	25-35	Any other Asian Background	Trainee clinical psychologist	Known prior to research

* Names changed to protect anonymity

Ethics

The study was reviewed by the Research Ethics Committee (REC) and granted approval on 25th May 2023 (Appendix D). Capacity and capability approval was given by the appropriate NHS trust research and development team prior to recruitment (Appendix E). As instructed, the researcher informed the research and development team when recruitment was completed. Each participant was given the study's information sheet (Appendix F) to read and following this, gave their written consent using a consent form (Appendix G). These documents were reviewed by an Expert by Experience (EbE) prior to them being distributed. The EbE had a previous diagnosis of psychosis and had received support from their local CMHT. The researcher had worked with the EbE during her doctorate course, and he agreed to review the above documents to support this project. Arrangements for interviews then took place. Transcripts were generated from audio recordings using transcription software and subsequently manually adjusted to correct inaccuracies. The audio recordings were deleted once the transcripts were completed and anonymised. They were securely stored on an encrypted drive.

Data collection

In line with a narrative approach, all participants were asked the same single open-ended question, which invited them to tell their story without interruption: "Tell me the story of your understanding of psychosis from as far back as you can remember.” Prompts were used to further explore areas associated with the study’s research questions. These were derived from the pre-planned interview schedule (Appendix I).

Nine of the interviews were conducted online over Microsoft Teams (participants confirmed being in confidential spaces during their interview) and one was conducted in person. All interviews were audio recorded and transcribed. The length of the interviews ranged from 12 minutes to one hour and 44 minutes. The participant whose interview lasted only 12 minutes commented on having a very busy day but wanted to make time for the interview. Since they were unable to reschedule the meeting, it was agreed that the interview would go ahead. It might be the case that, as a cognitive behavioural therapist who has experience running team formulation meetings in a service, she felt passionately about team formulations and therefore agreed to the interview despite not having the time. This connects to social identity theory (Tajfel & Turner, 1979), which discusses in-group and out-group theory. This suggests people are more likely to align with those they see as part of their ‘in-group’. As a member of the psychology team, the participant may have felt pressure to participate to align with her professional group’s values and by participating, she reinforces her in-group identity.

Identifiable features were anonymised. Each participant completed a demographics questionnaire prior to their interview (Appendix H). The interviews were conducted between October 2023 and February 2024.

Analytical approach

There are no set guidelines for narrative analysis, thus enabling a bespoke analytical approach best suited to answer the research question (Butina, 2015). In the present study, the researcher incorporated structural (Labov, 1972; Labov &

Waletsky, 1967), content (Denzin, 1989; Riessman, 2008) and relationship (Mankowsi & Rappaport, 2000) narrative analysis approaches. Structural narrative analysis looks at how the person is telling their story. Labov and Walestky (1967) detail six elements in a story that are summarised in Table 3. It is not necessary for all six elements to be present in a narrative and they may not present in the exact order shown. Content narrative analysis looks at what the participant is saying within their narratives and if there are any themes or contradictions across the different participant stories. Finally, relationship narrative analysis looks at the relationship between the participant's personal story and the wider societal narratives, e.g. the dominant medical model, personal narratives, wider group narratives or their own community narratives, e.g. the MDT's narratives around a particular client.

The analysis was not a linear process, the researcher went back and forth between steps as the analysis progressed. Each transcript was read and re-read to allow the researcher to become familiar with the narratives. As the transcripts were read, the structural elements were identified using Labrov and Waletsky's (1967) framework. This allowed an analysis of how the person was telling their story and elements such as turning points (Wieslander & Löfgren, 2023) to be considered. The content of each participant's story was explored. Consideration was taken of the relationships between the story presented in the participants' narrative and wider dominant narratives in society or in services. An annotated interview transcript can be seen in Appendix J and analysis development in Appendix L.

Table 3

Labov and Waletsky (1967) six elements in a story

Part of the story	Description
Abstract	Refers to the introduction of the narrative,

	aims to attract the listener to want to hear the rest of the story
Orientation	Narrator sets the scene for the narrative
Complication Action	Actual events of the narrative, events that move the narrative forward
Evaluation	Refers to why the narrative is being told
Conclusion or resolution	The conclusion of the narrative
Coda	Narrator communicates the relevance of the story by connecting it to present life or events falling outside of the narrative given

Results

The results have been displayed below with insights from content, structural and relational narrative analysis approaches. A synopsis of each narrative has been provided in Table 4. An interpreted synopsis can be seen in Appendix K.

Table 4

Synopsis of narratives

Participant	Synopsis
Sarah	Sarah began by highlighting her interest in psychosis influencing her pursuit of a career in mental health. At the beginning of her narrative, she pinpointed seeing people's experiences of psychosis in a documentary, which caused her to reflect upon how "wild" it was to her that others can have such a different experience of reality. Her narrative led on to studying psychology at university. Psychosis grabbed her attention and evoked a response in her, despite it not

	being focused on throughout teaching. She described psychosis as a “mystery” as it was not discussed during teaching. As her narrative progressed, she described how joining the NHS led to her working with and talking about the experiences of people with psychosis. Sarah went on to discuss a family friend who had experiences of psychosis, which she now considered to have been drug-induced as he had been away in India and used substances. She spoke of working with psychosis on a placement during her clinical psychology training and recognising that these individuals had “gone through stuff”. Sarah described how her previous understanding of psychosis had fitted a the “prominent”, medical explanation (e.g. drug-induced psychosis, genetics, etc.) but how this had shifted during her placement to thinking “a trauma perspective makes so much more sense”.
Fiona	Fiona started at the point where she had begun working in mental health settings within a deprived area with a large population of people from minoritized ethnic backgrounds. Her narrative returned to her friend who had an episode of psychosis, and she said this friend had a “chaotic kind of tough life”. She spoke about wanting to know more about psychosis and seeking more information about the phenomena by listening to podcasts. Fiona commented that she had heard clients at work and people on the podcast talk about their experiences of psychosis in a positive light. She described how people said psychosis had taken them to interesting and meaningful

places. She felt the response in her workplace was over medicalised with people being put in seclusion and restrained. Fiona discussed her friend who had a difficult life and how this was similar to other people she met in the service with psychosis, and she was learning the importance of trauma in psychosis despite us “brandishing it a medical problem and a disease”. Fiona moved onto starting the doctorate in clinical psychology and her more recent placement in a CMHT. She reflected how formulation models influenced her understanding, including the power threat meaning framework “what you’ve been through, the effect that had on you… the way you understood that… the way that you very understandably responded to that”. Fiona reflected that the PTMF did not initially always “land well” with the rest of her colleagues, however, it grew to become valued. She commented that the PTMF highlighted how important people’s life history and experiences are to their experiences of psychosis and gave real-life examples of this. For example, she spoke about a woman who was experiencing “unusual beliefs about the police”. However, when the team stopped and thought about this woman, they connected this with her past experience of having the police come into her home and be involved in “the removal of her children”. With experience, Fiona said her understanding of the framework progressed and that she felt on occasions the team realised how they could support the client in a more helpful way and ways they could reduce unhelpful things they were doing (e.g. sectioning people or other restrictive interventions). Towards the end of her narrative, Fiona concluded that her understanding of psychosis had been influenced by the PTMF team formulation meetings and she felt she had a clearer understanding of how to work with and support people with psychosis.

Ade

Ade began by explaining that psychosis is a difference in opinion of what is reality, and that if we agree with the person, they are "normal" and if we do not, they have an "illness". She emphasised how this is determined by professionals. She then gave an example of a client and how her experiences were labelled as psychosis were clearly linked to her past trauma. She also mentioned that medication was given to this female service user despite her not wishing to take medication. Ade told me that because "we feel" she is "psychotic" we have chosen to give her this and less focus is on her trauma. She went on to say that this woman had been through "a lot of trauma in her marriage" and her husband's family were not kind to her. Ade then explained how, following a PTMF formulation meeting about this client, the team had space to go through her story and identify that the problem was trauma and not psychosis. Ade highlighted that the PTMF applied in team formulation meetings has been valuable to her team as they come together and take time to understand the client. Ade felt the PTMF had led people to feel more empathic with clients and understand things more from the client's point of view. She ended her narrative quite abruptly by saying that treating trauma does not need medication. This ties in with the example of the lady she was working with earlier on in her narrative.

Naomi

Naomi began her story with her first impression of psychosis having been from horror films and, as a result, she previously understood it as a "possessed spiritual type experience". When studying psychology, she felt an emphasis was placed on the significance between neuroscience and mental health difficulties. Naomi did share her thoughts on her undergraduate course focusing on these models. During occupational therapy training, different placements came with different understandings of psychosis (e.g. medical models and drug induced psychosis). Naomi told me that this was mostly the case during her inpatient placements. She reflected on being mindful of the language used in client reports e.g. using less medicalised language. Following conversations with a cousin who was a "holistic therapist", who did not agree with terms such as "delusion" or "hallucination", she began to consider what the client had been through before labelling their experiences as these. Through working in community mental health teams, Naomi's perspective on psychosis had changed from being more medical to more trauma informed. The power threat meaning framework changed her perspective, not only on psychosis but the general role of power in an individual's difficulties. She did share with me a specific client example but emphasised the role in power professionals hold on those with "forensic histories or even LD (learning disabilities)". Naomi reflected on her own freedom

	compared to those she works with and how clients have decisions made on their behalf. At the end of her narrative, Naomi said she was surprised at how few people were given the opportunity to talk through their experiences and the meaning they had made.
Indira	Indira started at the time of her undergraduate psychology degree, where psychosis appeared in an “abnormal psychology” module. This led Indira to want to hear people’s own experiences of psychosis, which led to completing a Master’s degree with a psychosis focus. Indira described psychosis as “a unique experience” and her current understanding as someone struggling to get “a concept of what is real and what is not”. Indira reflected upon “systemic issues” and “systemic racism” towards people from “African, Caribbean and Sub Saharan” backgrounds being more likely to be “diagnosed with psychosis” in comparison to white people. Indira finished by highlighting the importance of trauma when understanding psychosis and how this had come to light for her as she worked in her current role in a CMHT. It is with this CMHT that Indira attends PTMF team formulation meetings, which may have reinforced the consideration of trauma in distress.
Ishaan	Ishaan described a shift in his understanding from the perspective of his cultural and religious background to his understanding now working in mental health services. He began by saying Islamically, what he now understands to be psychosis was not given a term but

	was understood to mean a person had been possessed. He commented on the word “fagol” in his language, which referred to somebody “who’s mentally unwell”. Ishaan then moved on to describe how psychosis was understood in his culture, which was not to ask “what’s wrong with this person?” but asking “what’s happened to this person?... What’s happened in their life?”. Following this, Ishaan discussed the dominance of a medical understanding during his study of psychology during A-Levels, which he struggled to agree with and led him to question “what is psychosis?”. He then developed a psychological understanding of people who have certain experiences, which may link back to distressing events from their past. Ishaan mentioned how some experiences associated with psychosis may be a protective mechanism (e.g. suspiciousness and paranoia). He gave a powerful example of being paranoid in some white spaces, which serves to help keep safe. Then he spoke about the power that we have as professionals to determine what is normal and what is not. He concluded by saying that a part of his role as a psychologist has meant he has stepped away from using labels such as “psychosis or schizophrenia” and asks himself what experiences are troubling this person and how he can work with them to manage this.
Mary	Mary began with an example of a school friend who people in her town considered “mad” as she “behaved in a very unusual way with very unusual thoughts”. Mary did not share an example of these

“unusual thoughts” with me. She also described several boys at her college who were sectioned. Mary said that at this time it was referred to as “mental illness”, not psychosis, and that she did not really understand it. She said that working in mental health meant her understanding was always shifting as she had different experiences working with different people. Mary mentioned that the PTMF had changed her understanding of psychosis and that she found it a helpful framework in expanding her thinking. It led Mary to see psychosis as a reaction to life and trauma “how you can become unwell as a reaction to an experience” rather than “for any other reason”. Towards the end of her narrative, Mary said that the PTMF enabled the team to really think and understand the person and their experiences. She reflected that the PTMF had broadened her mind and that it was a new way of thinking for her. An example that shone through her narrative was considering the role of a person’s past on their present emotional distress.

Louise

Louise began with telling a story about a family member having schizophrenia but not having an awareness of the details of it as it was not talked about. At a similar time in her life, Louise saw the word psychosis in news articles, “you might see… the terrible things that people have done when they’ve been mentally unwell”. During medical school placements, Louise described meeting people experiencing psychosis and hearing their explanations (e.g. spiritual, chemical imbalance in the brain, drug related) whilst gaining a more medical understanding of psychosis from her training. Through studying medical anthropology, Louise began to gain alternative understandings away from the medical model and to challenge this way of thinking. For example, considering how “mental illness can be portrayed in different communities and different cultures” and how something to us might look unusual but would be culturally normal to that person. She reflected that using medication to treat psychosis limited opportunities to consider the client’s past traumas and experiences. Louise included the importance of keeping the individual's understanding as a part of their care plan, rather than solely focussed on medication. Louise described her current understanding of psychosis as a broad spectrum and not having a single idea of its cause or someone’s experiences. Following this, Louise discussed the PTMF formulation meetings and said they have been helpful to gain the full context of a person, their past and what they are experiencing now rather than just labelling it as psychosis. She gave an example of a client they had discussed during a PTMF formulation meeting who was “verbally aggressive” when they came into the team base. She said that by using the PTMF they could see the role this client’s experience of childhood abuse had led her to behave in this way “almost [to] reinstate themselves and let others know actually you can’t just walk all over me, you can’t bully me”. This led to an open conversation with the client and an improvement in the relationship between the client and the team. Louise said using her medical background, current research, and remembering the past traumas or spiritual aspects a person brings allows her to try to meet the person where they are at and support them in the best way possible.

Johan

Johan started his story from when he was a young boy and heard the word psychosis in a “demeaning context” as a part of name calling. He jumped in time to discuss how his understanding had shifted since working in mental health services and now he sees psychosis on a spectrum of mental wellness. Johan emphasised how the word needs to be used appropriately and not carelessly due to the associations with the word psychosis being “quote unquote mad”. He viewed these words as an insult towards the individual.

Johan said the PTMF team formulation meetings had given him a “fresh pair of eyes” to come to understand where the person has come from and consider factors leading to the development of psychosis and that the conversations give the individual a “human face”. He discussed using the PTMF formulation meetings to inform care plans and considered curiously how the team may move forward with the person. This included asking each other “what can we do going forward?”, “what can we do more of?” and “what can we do less of?”. Johan described not having the client in team formulation meetings as a disadvantage because they could not hear from them directly, but that the team would bring their voice alive. He said that the word ‘psychosis’ does not get used much during the formulation meetings and the focus is on what the person was

	experiencing at the time and what the team could do to support them. Johan told me, it is important to advocate for those with psychosis and educate other people in the community on how to support people experiencing psychosis. Johan finished by commenting that the PTMF was a very effective formulation tool to help understand the person and understand what the team is doing well to support them and what they were doing that might be harmful. He gave an example of using the word psychosis outside of the PTMF team formulation with the client and between professionals.
Aysa	Aysa began by telling me about the first time she had heard the word psychosis, which was during her psychology undergraduate degree and across the news. She commented on psychosis being taught at undergraduate under a module termed “abnormal psychology” and the module included the “history of institutions, mania, crazy people and bizarre behaviours”. During Aysa’s Master’s, psychosis was spoken about in “dehumanising” and “degrading” ways that “shunned them from society”. Aysa linked this to the “institutionalisation of people” and highlighted how medication and biological narratives were focused on during teaching. Aysa then jumped to her current doctorate training and starting a placement in a CMHT working with people with psychosis. Aysa said that her family had concerns about her safety in relation to the placement, however she did not share these fears and instead felt excited. Aysa commented on the CMHT’s medicalised approach, which she would

have previously supported, however found that it was something she felt uncomfortable with during the placement. Aysa told me this discomfort was because clients were often reduced to a diagnosis that did not capture their wider experiences and “symptoms” being discussed. Aysa gave two examples of her experiencing the team talking with a medical lens. One example she shared with me was an instance of medication being used in a “coercive way” as the client did not understand what his medication was or how it was supposed to be helping him. Aysa noticed a shift in the team’s discussions when more psychology staff joined the MDT and when they started using the PTMF as a team formulation tool. For example, she noticed that discussions about trauma and psychological perspectives were brought forward more often. Aysa reflected that discussions in the PTMF team formulation meetings had less of a medical lens and a client’s difficulties were spoken more as a response to adverse life events or how power was operating in their life. It felt to Aysa like the client was thought more about as a person compared to a diagnosis, which allowed the team to “bring a lot of the human side of people to the discussions”. However, in MDT meetings there was limited time for a client’s past or present experiences to be considered. At this point of her narrative, she told a personal story of a “distant aunt” who was described by others in the community as “mad” and “crazy”. Her aunt had lost a child and found out that her husband had another family. She summarised by reflecting on how her narrative of psychosis had changed from a medical story to

> seeing psychosis as a trauma response, which was a learning process. She worried that medicalised narratives might be hard for other professionals to unlearn and that psychologists could have a role in helping their colleagues to consider alternatives.

Research aim: to explore staff, who have worked with psychosis, experiences of PTMF team formulation meetings and if they influence their subsequent understanding of psychosis.

The narrative analysis sought to answer five further sub-questions. These will be discussed below.

How are the participants' earliest understanding of psychosis depicted?

The participants' earliest understanding of psychosis varied from a medical model, influenced by early education (e.g. A-levels or undergraduate degrees), personal stories, a trauma-informed understanding or understandings based upon cultural or religious communities. The understandings explained by medical models varied from the neurochemical, genetic, neurostructural and drug-related hypotheses: "*The medical model and thinking about dopamine and glutamate and things like that" (Louise).* The earliest understandings of clinicians tended to orientate their stories.

Four narratives were initially associated with medical models. For example, Sarah began by sharing her initial understanding, which aligned with this model: *"I think the like biological explanations that more prominent mm hmm mm hmm… Or kinda like drug induced explanations for why some cases was kind of more understandable at first".* As her narrative went on, this changed: *"I connect a lot more now with just traumatic experiences".* Sarah finished her narrative with a concluding statement: *"So yeah, I think it's definitely shifted from where I thought it was, which is probably more biologically mm hmm before".* Her narrative being summarised in this way emphasised her journey and highlighted how her understanding had shifted. Sarah was a trainee clinical psychologist, so this may have highlighted the significance her further training had on her understanding. This correlated with other participants from a psychology training background (Aysa and Fiona).

Three participants started their narratives with their personal stories (Mary, Louise and Fiona). Mary began her narrative by talking about a close friend: *"My first experience of um psychosis um was a close friend who I'd been who'd I'd grown up with and who I was at school".* Where personal stories orientated the narratives, empathy and compassion was a common feature. For example: *"It just seemed really sad and, like, and being very aware that they had had a um such a hard life" (Fiona).* Empathy and compassion were especially apparent when comparing narratives with a medical understanding or psychosis. These narratives focused on intellectualising psychosis and holding an emotional distance to their understanding: *"When I did my undergraduate in psychology that I may have paid attention to a little bit… Umm yeah, I think maybe it was then where I and start to sort of notice that word" (Aysa).*

Ade started her story by highlighting the role of mental health professionals in diagnosing psychosis if they do not agree with what the client's perception of *"normal"* is*:*

"*If the majority and the patient themselves agree what has happened is normal there will be no psychosis. If our view, especially the professionals, if what we think is different from the patient's view about their feelings we will call that psychosis so it seems that whatever we don't understand has to be illness and so we diagnose that."*

Her narrative encompassed a trauma-informed understanding from the very beginning. Ade conveyed passion throughout her narrative and used examples of clients' distress mirroring traumas they have encountered: *"She's hearing voices and these voices are for those people, the relatives who made her leave the marriage, and because she's hearing these voices, we are calling it psychosis".*

It was striking that Ishaan was the only participant to share his initial understanding of psychosis based on his cultural and religious influences. He said these influences would be *"a good place to start"*, which acted as a strong abstract to his narrative and set the scene. He spoke about the word *"Fagol"* which in his first language refers to *"someone who's mentally unwell but it essentially means crazy person"* and how this would be used rather than words such as psychosis. He compared his religious understanding of psychosis to his own cultural understanding: *"we understand it as Islamically like they've been possessed. Uh so somebody's happened to them kind of like a jinn has possessed them".* Alternatively, it can be seen that his cultural understandings of psychosis are in accordance with the PTMF and, perhaps, challenge the dominant illness narrative in services and wider society:

> *"We think about it it's like differently, kind of like if someone very stressed out or something's going on in their life, we we kind of asked like what's happened to this person, which is quite interesting. Instead of saying what's wrong with the person, be like, oh, what's happened to this person? What's happened in their life? That's got to this point that this person is like this I'm so, yeah. So that's the contrast between the two".*

Did the dominant illness narrative feature in the participants' narratives? If so, how?

The dominant illness model of psychosis frequently featured in participants' narratives of psychosis. Seven participants commented on holding, or previously holding, a medical model understanding of psychosis. The dominance of this model had mostly stemmed from early education or training: *"then I had a more and medicalised understanding of like hearing voices and looking at new brain images and I guess very basic neuroscience around it" (Naomi).* The explanations within the narratives varied from the dopamine hypotheses, genetics, neurological and drug-induced psychosis. For example: *"Like an imbalance of chemicals in the brain umm whether they might have thought it was drug related or something like that"* (*Louise).*

Participants commented on the simplicity of the dominant medical model: *"the very medicalised context of psychosis that was a lot easier to understand"* (Aysa). Mary similarly implied that the medical model was simple and that it pointed to an obvious intervention: *"Then we just called it mental illness and that person had been sectioned".* These ideas may suggest the participants found it easier to submit to a simpler dominant narrative rather than forging their own ideas. Aysa spoke of being younger when she held the medical model: *"I think when I was younger and I and learning about psychosis, then I didn't see a problem with that before...Uh... Working within very medicalised frameworks not accounting for difference you know"*. This again may speak to it feeling easier to accept learnt explanations of psychosis and working within frameworks associated with it.

Some participants showed anger towards the medical model after further exposure to it in services. Aysa spoke of interventions that services employed associated with the medical model being forceful and restrictive: *"then this history of being hospitilised and and sectioned and and and, you know experience like it's lots of restrictive and quite oppressive services".* Fiona also commented on the restrictive interventions used when treating psychosis within medical model frameworks: *"I had like a big thing of like, oh, this is wrong, this is over medicalized and it was hard seeing people being restrained, seeing people being put in seclusion".* The emphasis on it being hard to see shows Fiona's emotional response to such interventions. Fiona went so far as to describe professionals diagnosing psychosis as *"brandishing it a medical problem".* "*Brandishing*" implies a weapon, suggesting that Fiona may view the medical model as threatening and harmful to clients.

Following a conversation with a *"holistic therapist"*, who commented on their preferences of language in client notes, Naomi said she was careful of what she wrote in clinical notes and avoided using medicalised language. She felt it was unfair for her to label a client's experience with medical language such as *"delusions"*:

"I've really stopped and paused before I've written like delusions and hallucinations because I find it quite like…umm, I suppose I I do kind of question like how almost like the fairness of me to kind of come to that conclusion".

Ishaan, Ade and Indira did not mention any influence of the medical model on their understanding of psychosis. For example, Ishaan said that, despite learning about the medical model, he had not felt like he understood it:

"I remember being taught about schizophrenia and psychosis as a brain disease and I remember we had a lecture and they were showing the brain, and it was talking about dopamine. And then it became this biological, physical entity, and I could never really understand it, to be honest with you".

It seemed that alternative understandings away from the medical model were only offered in higher education. While this was mostly seen to be offered on psychology trainings, Louise also spoke of later trainings in psychiatry offering different perspectives. Fiona spoke of learning about the significance of trauma and being encouraged to question dominant models during her clinical psychology doctorate training:

"I feel like the ideas around psychosis that we had in training were very much. Umm, you know this is seeing it in a way as a response to life events and to trauma. Umm and to experiences, experiences of exclusion and discrimination and racism. Umm and questioning that medical model."

Did the PTMF feature in the narratives? If so, how?

The PTMF appeared in eight narratives (Mary, Naomi, Aysa, Ade, Johan, Fiona, Louise and Ishaan). Participants appeared to have been on a gradual journey with regards to their understanding of psychosis. It seemed that participants came across different influences throughout their lives that influenced a slow change or understanding. However, the influence of the PTMF formulation meetings seemed to be a turning point in some narratives. In Mary's narrative, she positioned the PTMF as the reason her understanding shifted and conveyed a passion for it by commenting that it was why she made time for the interview:

"*The power threat meaning framework, I do know that that has changed my understanding… That's partly why I agreed to make time for this interview… Understanding that psychosis is more a reaction to life and and trauma and life the experiences in life rather than… for any other reason".*

Similarly, Louise commented on the influence of the PTMF:

"I think that's where the power threat meaning framework, which we now use in our formulation sessions have been really helpful just to give a full context of who is this person, what have their experience has been, what has happened to them umm

and what has contributed to umm some of their experiences now that we might label as psychosis”.

The PTMF tended to appear towards the end of most participants’ narratives. In comparison to other understandings presented, participants provided examples connecting the PTMF to present life. This was often an example of a client who had been discussed during a PTMF formulation meeting and how this had changed how staff considered the client’s experiences. For example, Louise shared an example of a client who was described as *“verbally aggressive”* and by using the PTMF, the team could see how this client’s childhood abuse had led her to behave in this way: *“almost reinstate themselves and let others know actually you can’t just walk all over me, you can’t bully me”.* The PTMF often featured in participants’ concluding statements.

However, Ade positioned the PTMF near the start of her narrative by using the PTMF to orientate her narrative. It set the scene for her story, which focused solely on the trauma lens of psychosis. The PTMF featured in her complication action, evaluation and conclusion (Labrov & Waletsky’s, 1967). Sarah and Indira did not directly mention the PTMF but similarly reported a journey and felt they presently held a trauma-informed understanding of psychosis.

Johan shared how he felt the PTMF formulation meetings could be made better with the inclusion of a client:

“Maybe what will would also benefit the discussion or maybe make make it even better or more and enrich the discussion will be to get to the service user if he or she agrees to be part of the discussion would have been to be very, very good, unfortunately, we don't have them, but we bring their voice alive”.

Do the participants' narratives depict a change in their understanding of psychosis since formulating using the PTMF? If so, how?

Where the PTMF featured in narratives, it was depicted as a catalyst for a change in understanding of psychosis (Mary) or a framework that supported or consolidated a change in participants' understanding (Naomi, Aysa, Ade, Johan, Fiona, Louise and Ishaan).

Five participants commented on the PTMF as a team formulation, allowing the participants to have an appreciation for the humanity of the clients. Johan spoke of the PTMF formulation meetings allowing an individual's "*flesh*" to develop from their "bare bones" and that the conversations gave clients a "*human face*". This metaphor provided a strong image of a client being rehumanised during the PTMF formulation meetings, following the medical model dehumanising them. Later in his story, Johan spoke of the uniqueness of the PTMF as it humanises the client: *"Oh wow was it this person you know in humanises the patient in a way that was in the way that I I I think would be different with the other tools".* In this way, the staff depicted a change in their understanding of psychosis as a human response to adversity and trauma, which challenged the dominant medical model. Additionally, in multiple stories, there was a development in the language used. It moved away from labelling clients as a "*patient*", or grouping them as "*people*", to using humanising language such as "*person*" or "*human being*".

Ishaan further emphasised the naturalness of having responses to trauma as human beings: *"I suppose I kind of think about it in terms of the fact that we are we as human beings have experiences and some of those experiences can be quiet distressing".* He later spoke about being able to relate to experiences that would be labelled as 'paranoia' in services:

"There's times when I become very suspicious when I'm in white spaces in sense of harm that could come to me as well. Is that paranoia, is that psychosis? It's not. It's a... it's a mechanism in a way, to kind of let me know that potentially I could be in danger, physical danger or some kind of social danger… Is it helpful for me? Yeah".

This is a powerful statement as Ishaan comments on the power relationship between white dominance and minoritised ethnicities in society. This part of Ishaan's narrative came after discussing the implementation of the PTMF in his team. These conversations seemed to come more to light during the PTMF team formulation meetings as teams took time to consider the significance of power throughout clients' lives' and living in a society that created the need for clients to have responses to keep them safe. It also allowed for consideration of the role of power in their own lives. This resonates with Naomi's narrative commenting on the freedom she held as a white British woman: *"Yeah, I guess I didn't realise how much freedom maybe I perceive I have".* These comments highlighted that the use of the PTMF went beyond having an influence on their narratives of psychosis but on their own life stories and how they related to themselves alongside their clients.

Do the participants' narratives depict any change in their practice with clients?

Some participants shared concerns about how the PTMF team formulation meetings may not lead to changes in how they or the team would support the client. For example, Fiona shared her difficulty with moving the work with clients beyond the formulation meeting:

"My own uh struggles to move on to more like move on beyond that kind of formulation stage, I didn't necessarily feel like I knew or had much more of a clearer

understanding of how to support people and how to yeah work, work with people going beyond this".

This may reflect the dominance of the medical model in determining treatment and the neglect of psychological and social approaches to working with psychosis. This reflection came at the end of Fiona's narrative, which may mirror the afterthought of implementing the PTMF formulations into care planning.

In contrast, Johan, who was a service team lead, spoke highly of the PTMF informing clients' care plans:

"The objectives of the formulation is to give us insight you know and to to be able to sort of think through, uh, different approaches in caring for the patient effectively so there's a direct relationship with what what is considering formulation and how that is fed into the care plan".

For example, Johan spoke of the PTMF allowing the team to consider the client's strengths and help support the client to nurture them while holding their goals for treatment in mind:

"Because now you got the history, you know where he excelled, he or she what she excels in you know? And the kind of lifestyle or the ambitions and hopes that the person has for him or herself and he is here".

Discussion

The current research used narrative analysis to explore staff, who have worked with psychosis, experiences of PTMF team formulation meetings and if they influence their subsequent understanding of psychosis. There was additional focus on five sub-questions. The findings will be discussed in relation to the research aim, research questions and previous literature. Participants' initial understanding of psychosis often reflected a medical model, shaped by education, personal experiences, and cultural or religious influences. The dominant illness narrative was prevalent, particularly among those with early medical training. However, engagement with the PTMF was noted to shift their perspectives, fostering a more trauma-informed and humanising understanding of psychosis. While some participants felt that the PTMF led to a more compassionate approach to client care, others expressed concerns about translating these insights into practical changes in client support. These findings will be discussed alongside the study’s strengths and limitations, clinical implications, and suggestions for future research.

Seven participants said they had previously held a medical model understanding of psychosis, reflecting the dominance of this narrative. This is in line with Bentall (2004), who found that the medical model dominates how psychosis is understood and subsequent interventions offered by services. In the narratives, this understanding stemmed from early education or training, and a range of medical influences on the development of psychosis were discussed (e.g. the dopamine hypothesis, genetics and neuroscience). However, two participants (Ade and Indira) did not mention the medical model and Ishaan stated he had not ever understood the significance of it. These participants held religious, cultural and/or trauma and adversity understandings throughout their stories, starting from the very beginning. This aligns with the literature highlighting the growth in the understanding of the role of trauma, adversity, and discrimination on psychosis (Read & Larkin, 2008; Hardy et al., 2005; Shevlin et al., 2007). All three of these participants came from a psychology background and, therefore, may have had emphasis on the role of life experiences on mental health during their training. Aysa and Fiona spoke about the restrictive interventions the medical model can lead to, and, in contrast, Nikopaschos and colleagues (2023) found a reduction in the use of restraints and seclusion measures on a ward following the introduction of the PTMF in formulation meetings alongside other changes to embed trauma-informed care approaches. This demonstrates the possible benefits of implementing the PTMF in other services, particularly around shifting interventions offered and reducing staff concerns around the use of restrictive practices.

Some participants commented on the PTMF causing the clients to be discussed in a way that brought out their humanity. There was a development in the language used in the narratives, which moved away from labelling clients as a “patient” ‘or grouping them as “people” to using humanising language such as “person” or “human being”. This finding aligns with previous research on the impact of team formulation meetings, leading a participant to view the client discussed as more of a “person” and less of a “patient” (Murphy et al., 2013). Additionally, Geach et al’s (2018) review reported increased empathy towards clients following team formulations as being a frequent theme amongst studies included. However, there is evidence to suggest that not all staff members show an increase in empathy following team formulation meetings, with some staff describing formulation as an excuse for a client’s behaviour (Summers, 2006).

Johan commented on how the PTMF formulation meetings could be enhanced by the presence of the client during them. In a first-person account of psychosis, Fox (2021) commented on the value of “user-led models of care” (p. 1516), which highlights the importance of accessing the lived experience of the service user through their own knowledge and relationship to their experiences. By including the client in the formulation meetings, as Johan suggested, the outcome may benefit from a more holistic understanding of the individual's experiences and needs.

Six participants referred to having known friends and family members who had experienced psychosis. This showed that the development of an understanding of psychosis arises from personal experiences, as well as professional. All but one participant identified contextual difficulties in relation to the experiences of their friends and/or family members. Some examples included relationship difficulties and a “chaotic” life. Sarah referenced a medical understanding of her friend’s experiences by commenting on her friend’s drug use at the time. The personal aspect of participants’ stories often featured at the beginning of narratives. There was an observed contrast of the presence of empathy and compassion when the narratives started with personal stories compared to a medicalised understanding, which focused on intellectualising psychosis and holding emotional distance. Similarly, literature has commented on the influence of how medical professionals are taught to memorise facts and knowledge, which may lead to emotional distancing from clients (Yakeley et al., 2014).

Early education, such as A-levels and undergraduate degrees, narrowed understandings of psychosis by providing an explanation rather than allowing people to see the whole person. These explanations were mostly medical in nature. Encouraging people to think outside of professional or educational boundaries seemed to enable the endorsement of trauma as an explanatory model.

Some participants reflected upon the power in their professional roles and how this influences clients. These comments seem to have been a result of the attending PTMF formulation meetings and subsequently considering their professional power and the role this can play in people’s difficulties and stories (Johnstone & Boyle, 2018). Despite this reflection of professional power being shown to be useful in the participants narratives, there has been critique towards the PTMF for not acknowledging the power that exists to be in the position to make interpretations about individuals’ (Morgan, 2023) and possibly use such interpretations to underpin support.

Although the PTMF formulation meetings were described in a generally positive way by participants, some clinicians mentioned that they rarely led to a change in the intervention the client received. This is seen in the wider literature, with Geach and colleagues (2018) reporting that team formulation meetings don’t always lead to subsequent changes in the clients care plans. Additionally, research has found that team formulations can lead to staff experiencing an increase in powerlessness or hopelessness (Buckley et al., 2021). It is plausible that this hopelessness could be contributing to the feeling of the meetings feeling ineffective. Buckley et al. (2021) advised that facilitators should prepare staff for the possibility of feeling this way and support them to work through such powerlessness.

In contrast, Nikopaschos and colleagues (2023) found that imbedding a wider trauma-informed approach, including PTMF team formulation meetings, led to reduced use of restraints and seclusion measures on the ward. Similarly, Johan did speak of the PTMF formulation meetings translating into clients’ care plans, which mirrors previous research (Hartley, 2021).

As previously mentioned, the participants in this study mostly came from a psychology background (trainee clinical psychologists, assistant psychologists, cognitive behavioural therapists and qualified clinical psychologists). The findings may be a result of staff members with psychology backgrounds holding a bias towards the benefits of team formulation meetings given how they promote psychological thinking (DCP, 2011) and with them often being facilitated by clinical psychologists (Health and Care Professions Council, 2015). This vested interest may be amplified given the study was specifically looking at the PTMF as a formulation tool, which has received growing interest within psychological professions (Makwana et al., 2022). Additionally, psychology staff may self-select themselves for research in this area due to feeling confident and knowledgeable when talking about team formulations and the PTMF.

The literature shows that staff from different disciplines may have different perspectives on team formulations, most notably clinical psychologists reporting that staff value team formulation meetings (Christofides et al., 2012) and other staff members feeling during team formulation meetings, colleagues are seeking to seem powerful or right (Summer, 2006). This highlights the possible impact having the majority of participants coming from a psychology background may have on the findings and the need for further studies to better centre other staff perspectives. Similarity, a psychiatrist commented that the PTMF has been reported to not having a lot to offer (Aftab, 2023) and could be seen as a threat to their discipline with its anti-diagnostic nature (Morgan, 2023). Although it should not be assumed that all psychiatrists will hold the same views about the PTMF.

Strengths and limitations

The study had several strengths and limitations. The narrative style of the interviews allowed participants to tell their own story freely. This freedom may have been restricted if a structured interview approach had been used. The use of content, structural and relational narrative analysis approaches allowed for an in-depth analysis of the data and provided extensive insights.

There were limitations with the gender diversity within the sample, with only two male participants. Narratives of empathy and compassion were emphasised in the study, which aligns more with femininity and caregiving approaches towards emotional distress. It is likely that narratives more fitting with traditional views of masculinity, such as holding back emotions, may have been missed. Secondly, as discussed above, it was difficult to recruit participants from a wide range of training backgrounds, with most participants from this study having a psychology background. This may have led to the emphasis of trauma-informed understandings of psychosis and anger that was shown towards the medical model. Having more participants from a medical background, such as psychiatrists and mental health nurses, may have provided more reflections on the benefits of the medical model and a different perspective on the PTMF. A third limitation was the length of two interviews. The researcher had not conducted narrative style interviews before and may have initially not been using enough prompts, meaning that the stories recounted in some interviews were not fully explored. However, participant recruitment continued to ensure sufficient rich data was collected. A final limitation of the study was that some participants previously worked with the researcher in a clinical capacity and within this, had attended PTMF team formulation meetings she co-facilitated. It is possible that these participants may have felt they had to be positive about their experience of PTMF team formulation meetings for fear of it reflecting badly on the researcher.

Clinical and research implications and recommendations

The study findings suggest that the PTMF can support clinicians in developing an alternative understanding of psychosis away from dominant medical model understandings. What the formulation meetings might be lacking is how to translate these understandings into care plans and future work with clients. Additionally, the narratives showed that allowing staff to think outside of their professional or educational relationship with psychosis may lead to an endorsement of a more trauma-informed narrative. For example, staff members who spoke of personal relationships to psychosis were able to freely attribute contextual factors to their friend or family members experiences. The promotion of spaces for services to stop and think about the people they work with and the lives they have lived will allow for these conversations and reflections to be had.

Future studies should look to include clients who have been the focus of a formulation meeting using the PTMF to explore their experience of care within their service and any changes in their understanding of distressing experiences. To the researcher's knowledge of work across clinical services, there are limited PTMF team formulation meetings that take place with the client present. Services may wish to work towards enhancing the client's voice and move towards collaborative formulations, providing a meaningful care plan that holds the client's strengths and goals in mind. Additionally, due to the over-representation of participants with a psychology background, it would be beneficial to gain a wider understanding of other professionals' narratives of psychosis following their attendance at PTMF formulation meetings, such as social workers, nurses and other non-psychology staff members.

Additionally, future research could look at using alternative research designs than the cross-sectional qualitative narrative analysis approach used within this research study, for example longitudinal and pre-post measures designs. Integrating the timings of research assessments would provide a nuanced understanding of both immediate and long-term impacts of PTMF team formulation meetings on staff experiences and understanding of psychosis. This combined approach may allow for capturing both the initial shifts in understanding and the sustainability and evolution of these changes over time. This could be implemented by conducting baseline and post-team formulation meeting interviews to capture immediate changes and conducting longer-term follow-ups with the same participants to observe long-term changes and developments. Additionally, comparisons in client care plans before and after PTMF team formulation meetings may allow for the investigation of the influence of the formulation meetings on client support going forward. Since this was presented as a criticism of the PTMF formulation meetings in this study and, as discussed above, of team formulation meetings in wider literature, it is of high importance and may hold important clinical implications of how services can adapt care plans where appropriate. Such alternative designs were not implemented here due to the aims of the qualitative research not suiting this type of design. Qualitative research is mostly concerned with meaning making by eliciting descriptive accounts and does not aim to compare two time points to explore causal relationships, unlike some quantitative designs (Pietkiewicz & Smith, 2012).

Finally, qualitative approaches rely on self-report, which may mean participants could make errors, including in their language, which might point to the usefulness of the inclusion of quantitative measures alongside qualitative methodologies.

Conclusion

This study used a narrative analytic approach to explore staff, who have worked with psychosis, experiences of PTMF team formulation meetings and if they influence their subsequent understanding of psychosis. Overall, the study found positive associations with the clinicians’ experience of using the PTMF as part of a team formulation and their subsequent understanding of psychosis. The benefits outlined in the narratives show that the PTMF is an effective framework and should be used more widely across services as a formulation tool. Future research may wish to focus on clients’ understandings of psychosis to gain a deeper understanding of the PTMF’s influence on psychosis narratives. Additionally, it would be interesting to see if clients notice a difference in their care from their service following the team using PTMF team formulation meetings to think about their case.

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Appendices

Appendix A
Development of codes

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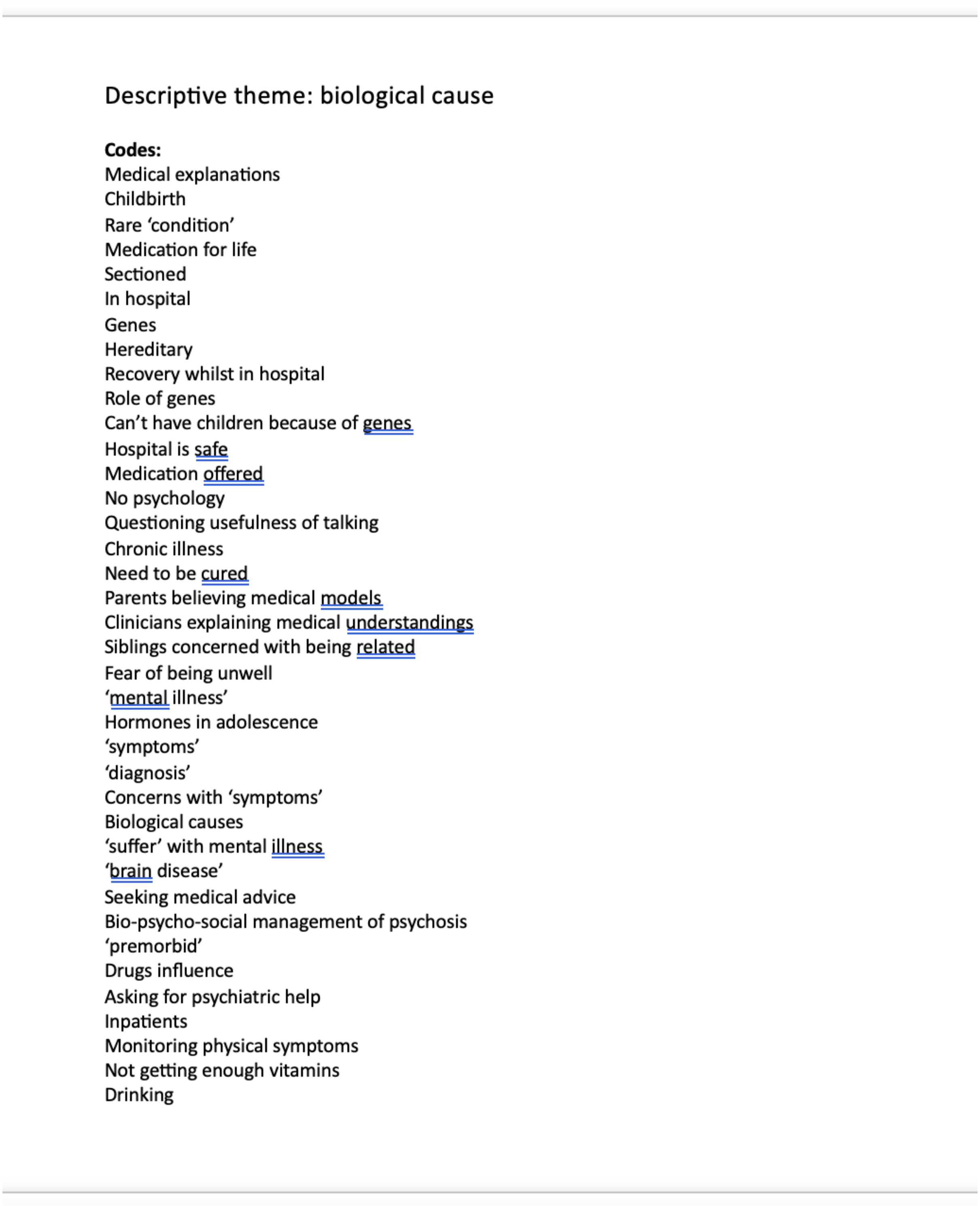
Appendix B

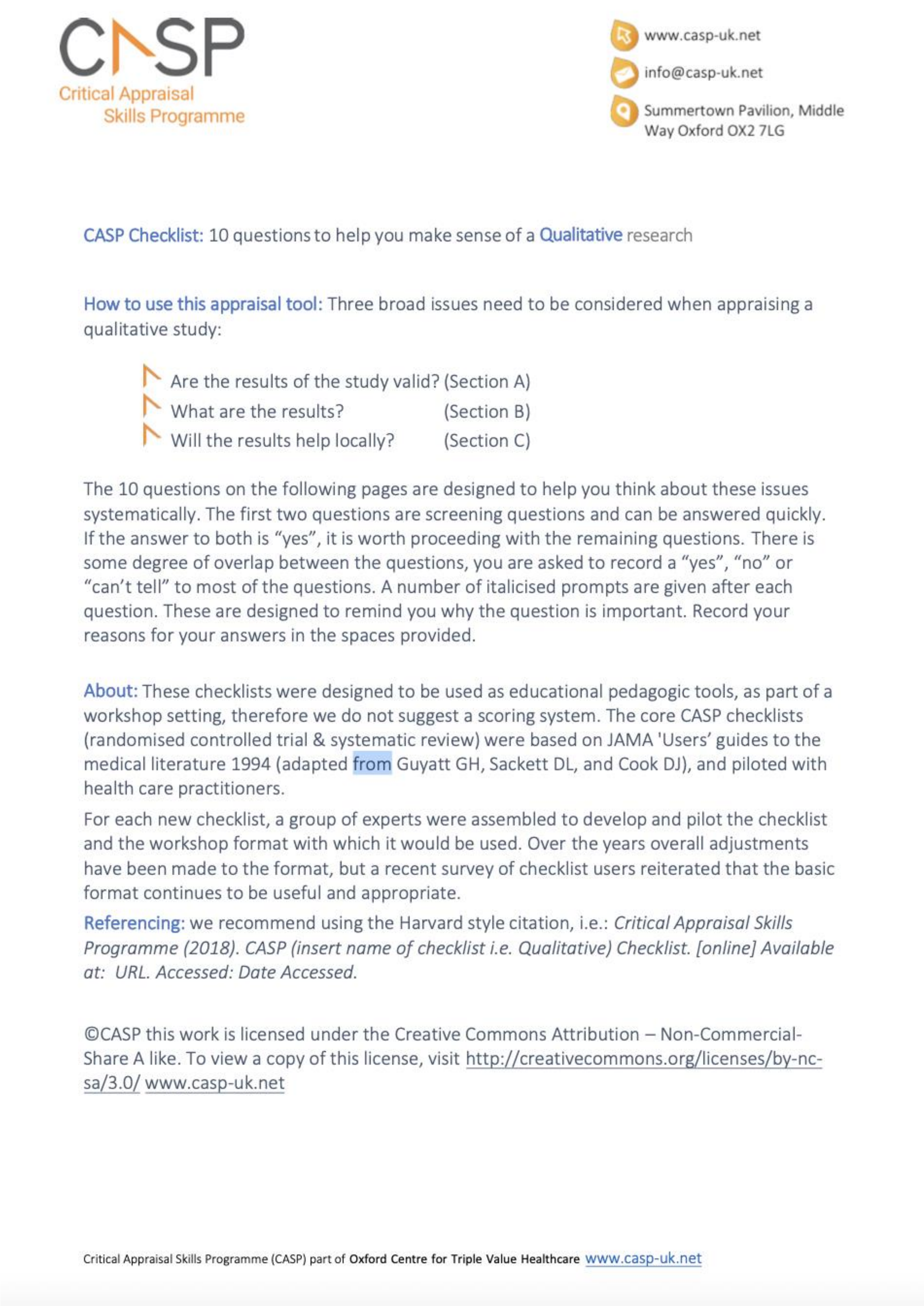
Development of descriptive themes



Descriptive theme: biological cause

Codes:
Medical explanations
Childbirth
Rare ‘condition’
Medication for life
Sectioned
In hospital
Genes
Hereditary
Recovery whilst in hospital
Role of genes
Can’t have children because of genes
Hospital is safe
Medication offered
No psychology
Questioning usefulness of talking
Chronic illness
Need to be cured
Parents believing medical models
Clinicians explaining medical understandings
Siblings concerned with being related
Fear of being unwell
‘mental illness’
Hormones in adolescence
‘symptoms’
‘diagnosis’
Concerns with ‘symptoms’
Biological causes
‘suffer’ with mental illness
‘brain disease’
Seeking medical advice
Bio-psycho-social management of psychosis
‘premorbid’
Drugs influence
Asking for psychiatric help
Inpatients
Monitoring physical symptoms
Not getting enough vitamins
Drinking

CASP Quality Assessment Tool



Critical Appraisal
Skills Programme

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle
Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

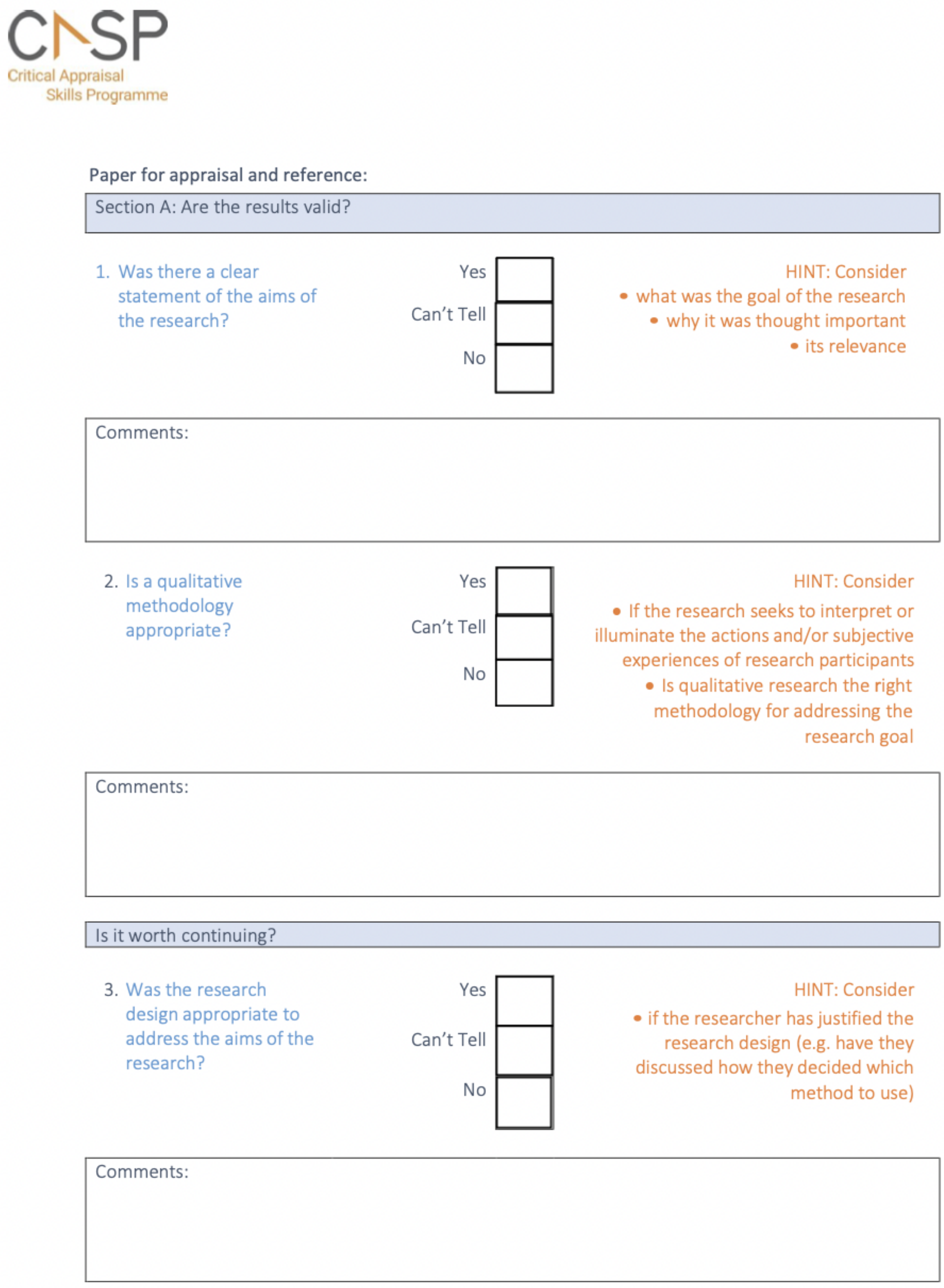
The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

Critical Appraisal Skills Programme (CASP) part of **Oxford Centre for Triple Value Healthcare** www.casp-uk.net



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Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

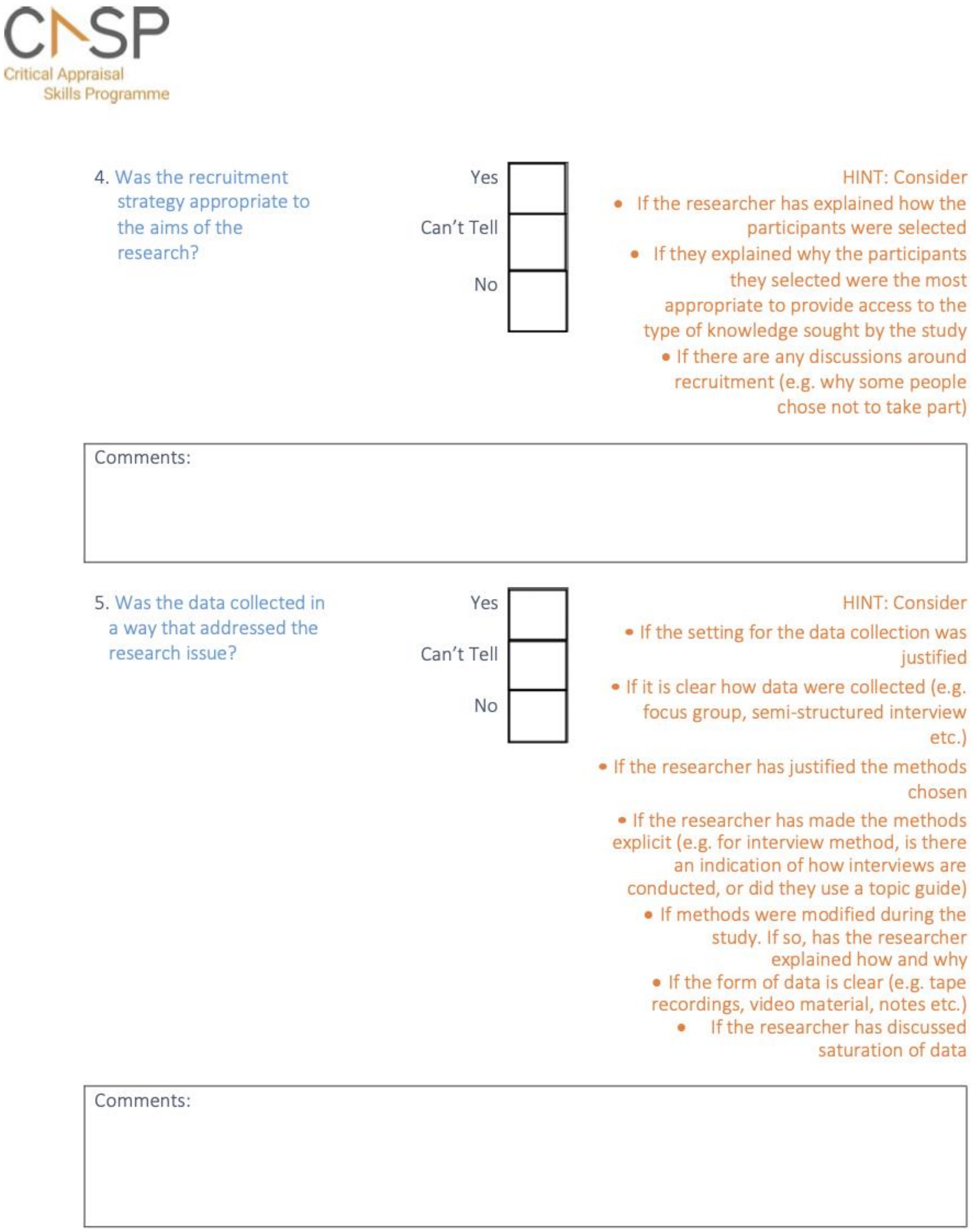
Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:



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Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

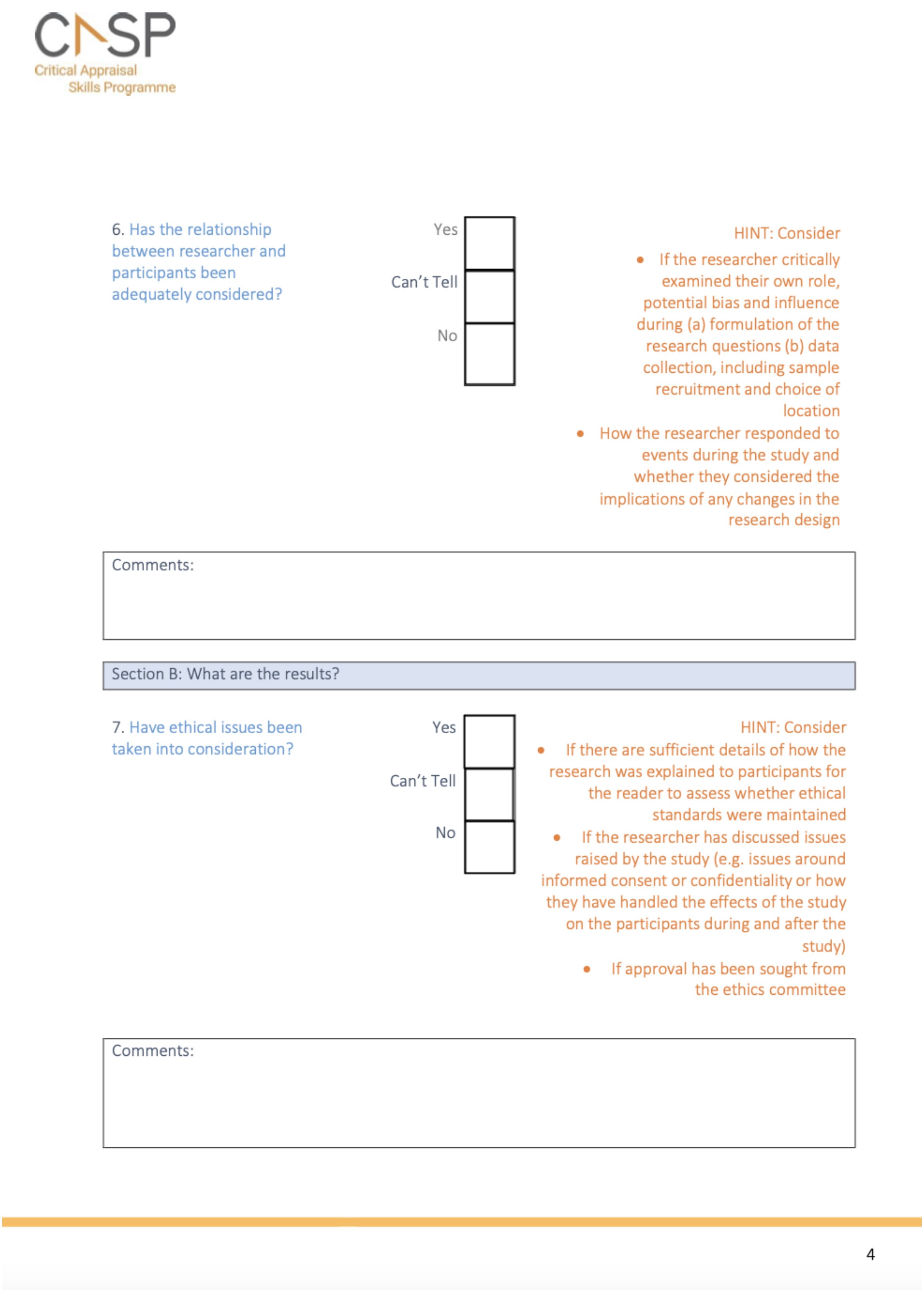
Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:



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6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

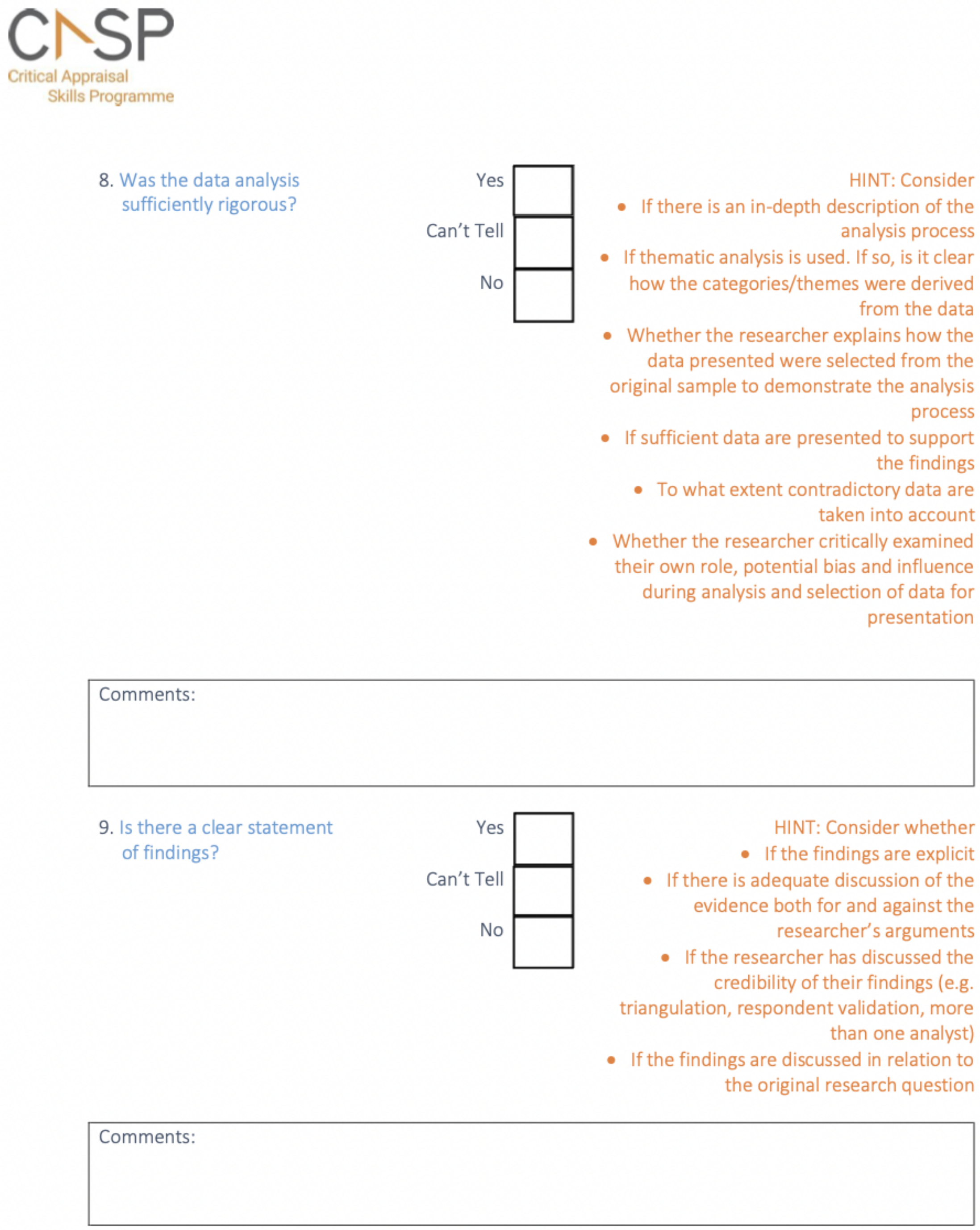
Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:



CASP
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8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

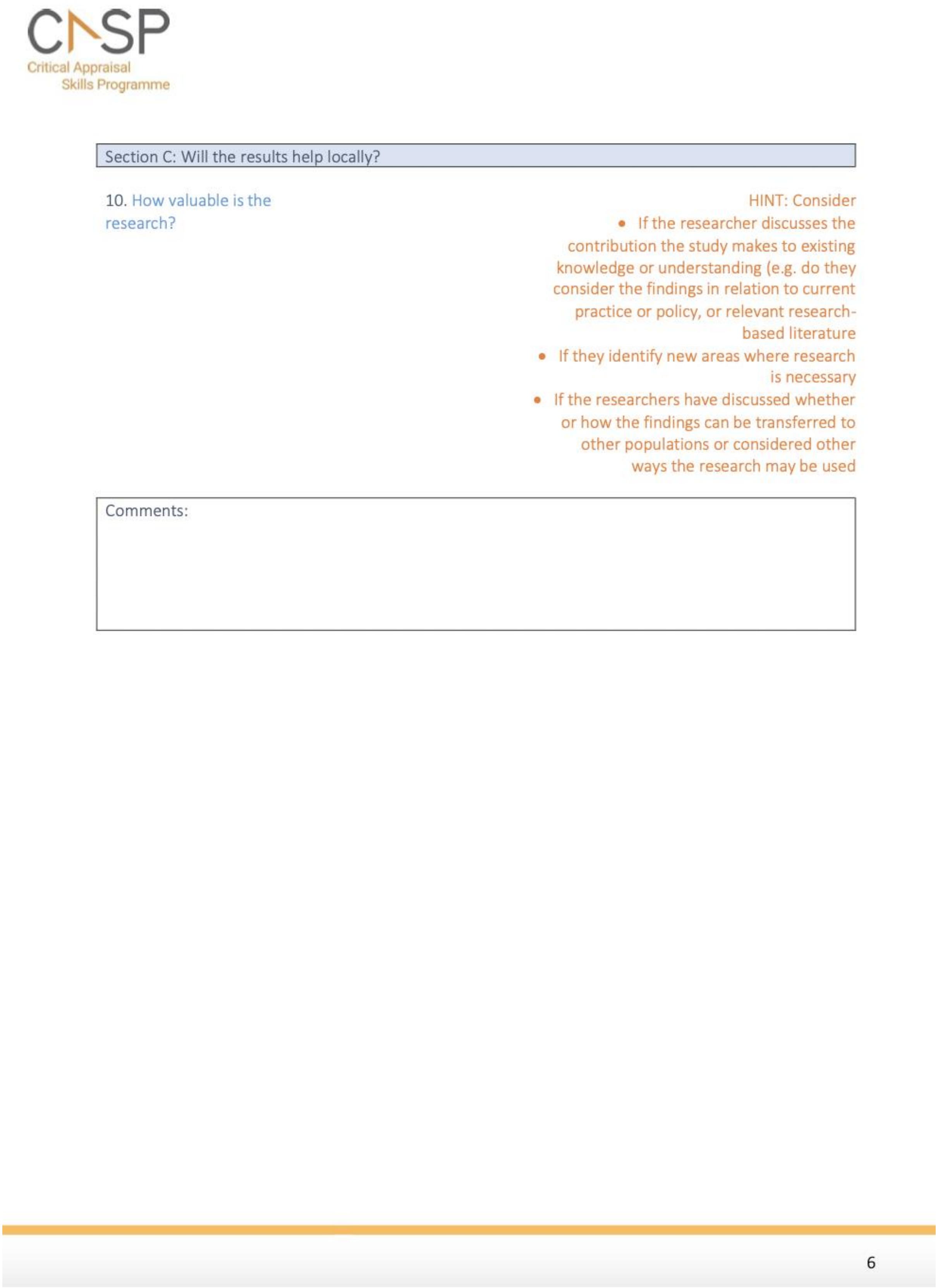
Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:



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Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

6

Appendix D
HRA and HCRW approval
This has been removed from the electronic copy

Appendix E
NHS trusts confirmation to conduct research through their organisation
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Appendix F
Participant information sheet

Canterbury Christ Church University

Salomons Institute of Applied Psychology
One Meadow Road,
Tunbridge Wells,
Kent T
N1 2YG
www.canterbury.ac.uk/appliedpsychology

Participant Information Sheet – for staff

The Power Threat Meaning Framework and the understanding of psychosis.

Lead Researcher: Megan Bland, Trainee Clinical Psychologist.

m.bland1456@canterbury.ac.uk

Co-Workers: Dr Susannah Colbert, Clinical Psychologist and Senior Research Lecturer, Email: Susannah.colbert@canterbury.ac.uk, Dr Isaac Akande, Clinical Psychologist, isaac.akande@slam.nhs.uk and Kirstie Wright, Cognitive Behavioural Therapist, kirstie.wright@slam.nhs.uk.

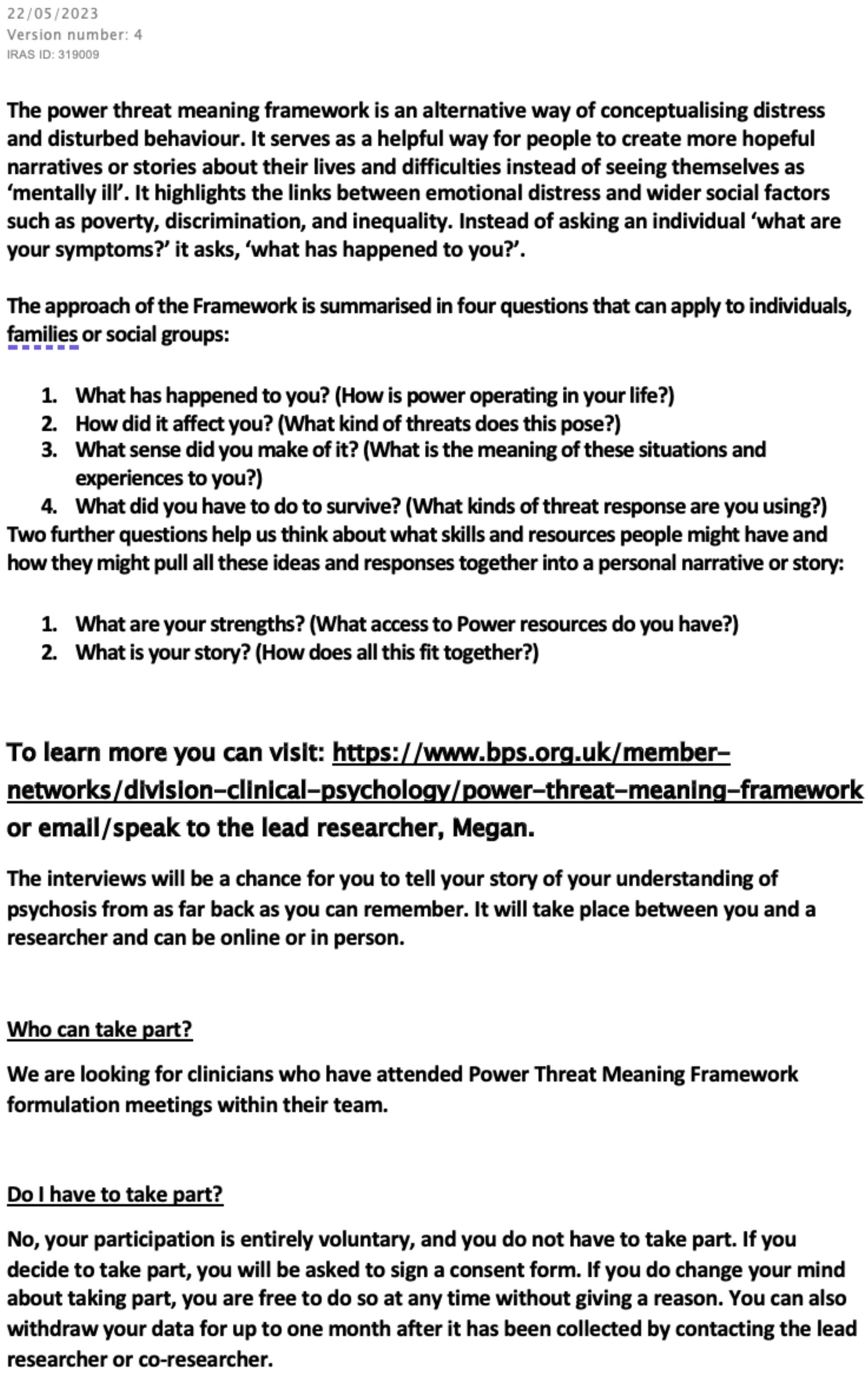
We would like to invite you to take part in a research study being conducted across NHS Trusts. This research is being undertaken as part of a 3-year doctoral training programme at the Salomons Institute for Applied Psychology and is sponsored by Canterbury Christ Church University. Before you decide you need to understand why the research is being done and what it would involve. Please take time to read the following information carefully. If anything is not clear or if you would like more information, please contact me (see above details).

You are being invited to take part as you have attended Power Threat Meaning Framework formulation meetings within your team.

What is the purpose of the study?

The purpose of the study is to explore how the Power Threat Meaning Framework may impact how clinicians and clients understand psychosis.

The power threat meaning framework is an alternative way of conceptualising distress and disturbed behaviour. It serves as a helpful way for people to create more hopeful narratives



22/05/2023
Version number: 4
IRAS ID: 319009

The power threat meaning framework is an alternative way of conceptualising distress and disturbed behaviour. It serves as a helpful way for people to create more hopeful narratives or stories about their lives and difficulties instead of seeing themselves as 'mentally ill'. It highlights the links between emotional distress and wider social factors such as poverty, discrimination, and inequality. Instead of asking an individual 'what are your symptoms?' it asks, 'what has happened to you?'.

The approach of the Framework is summarised in four questions that can apply to individuals, families or social groups:

1. What has happened to you? (How is power operating in your life?)
2. How did it affect you? (What kind of threats does this pose?)
3. What sense did you make of it? (What is the meaning of these situations and experiences to you?)
4. What did you have to do to survive? (What kinds of threat response are you using?)

Two further questions help us think about what skills and resources people might have and how they might pull all these ideas and responses together into a personal narrative or story:

1. What are your strengths? (What access to Power resources do you have?)
2. What is your story? (How does all this fit together?)

To learn more you can visit: https://www.bps.org.uk/member-networks/division-clinical-psychology/power-threat-meaning-framework or email/speak to the lead researcher, Megan.

The interviews will be a chance for you to tell your story of your understanding of psychosis from as far back as you can remember. It will take place between you and a researcher and can be online or in person.

Who can take part?

We are looking for clinicians who have attended Power Threat Meaning Framework formulation meetings within their team.

Do I have to take part?

No, your participation is entirely voluntary, and you do not have to take part. If you decide to take part, you will be asked to sign a consent form. If you do change your mind about taking part, you are free to do so at any time without giving a reason. You can also withdraw your data for up to one month after it has been collected by contacting the lead researcher or co-researcher.

What will happen if I agree to take part?

In the first instance, you will be invited to complete an Informed Consent Sheet, which means that you are happy to take part in the study and fully understand the terms of your participation. You can still change your mind about being involved after signing and will have an opportunity to ask the researcher any questions.

On the interview day, I will invite you to complete a brief demographic questionnaire (e.g. age, gender, professional background). You will then sit with me for up to an hour and a half for the interview which will be recorded. These recordings will be used to make a written transcript of the conversation, which will be used to build up an understanding of the possible impact of the framework through summarising alongside other participants' narratives.

The recordings will be deleted as soon as the transcriptions have been written up and all transcriptions will be anonymous. The transcriptions will be stored securely.

The interviews will take part online via Microsoft Teams or at your NHS services team base. This is completely up to you. If the interview takes place at the team base you can be reimbursed £10 for your travel expenses.

During the interview you will be able to request breaks if needed. This would be arranged by simply letting me know you would like to take a break and the recording will be paused.

Following the interview, you will have the option of being sent your transcribed interview via email or post if you wished to look through it and discuss it further with the researcher. You will not be able to make any changes to the interview.

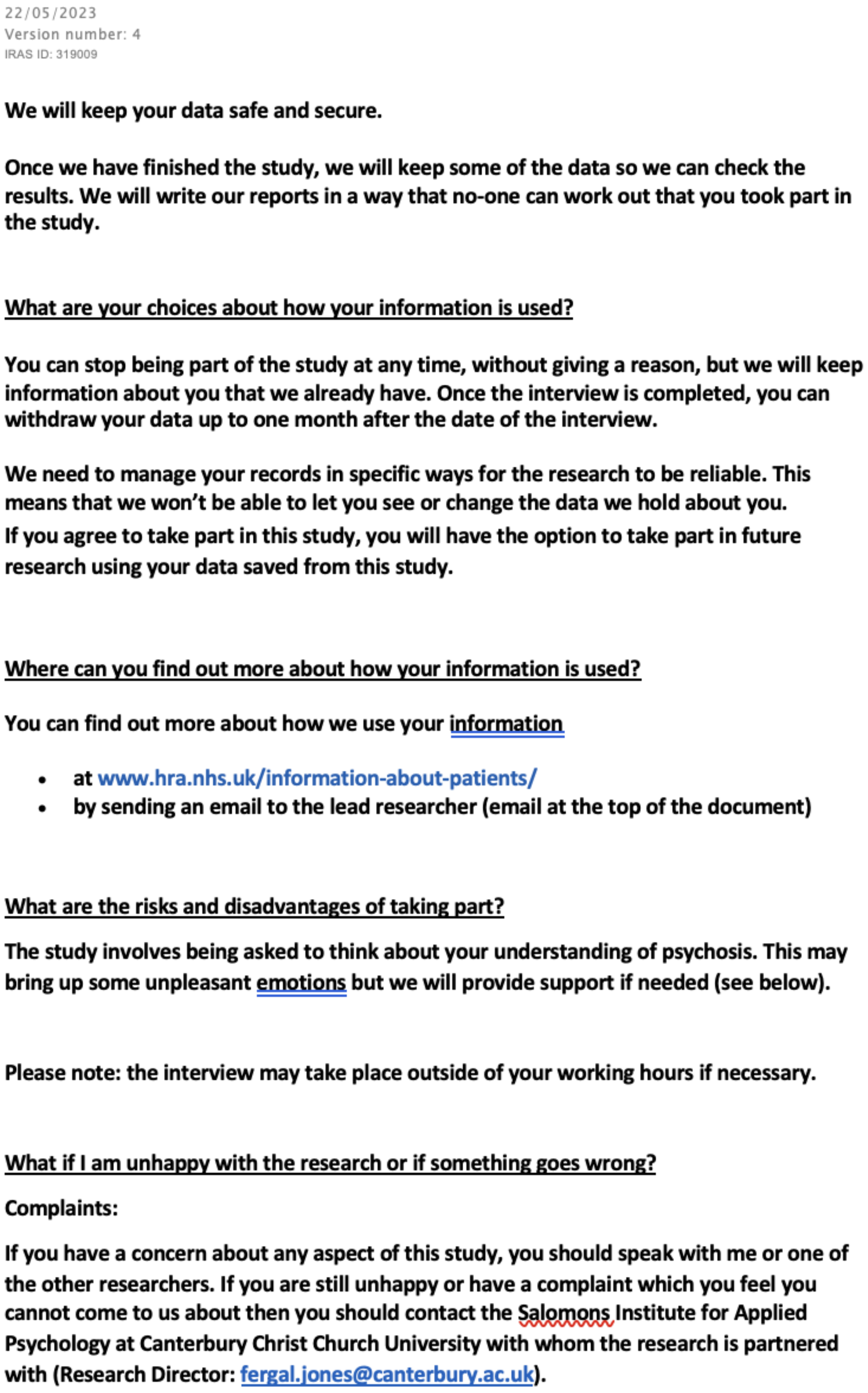
If it is of interest, there will also be the option to receive a copy of the lay summary of the project.

How will we use information about you?

We will need to use information from you for this research project.

This information will include your name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.



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We will keep your data safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. Once the interview is completed, you can withdraw your data up to one month after the date of the interview.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.
If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- **at www.hra.nhs.uk/information-about-patients/**
- **by sending an email to the lead researcher (email at the top of the document)**

What are the risks and disadvantages of taking part?

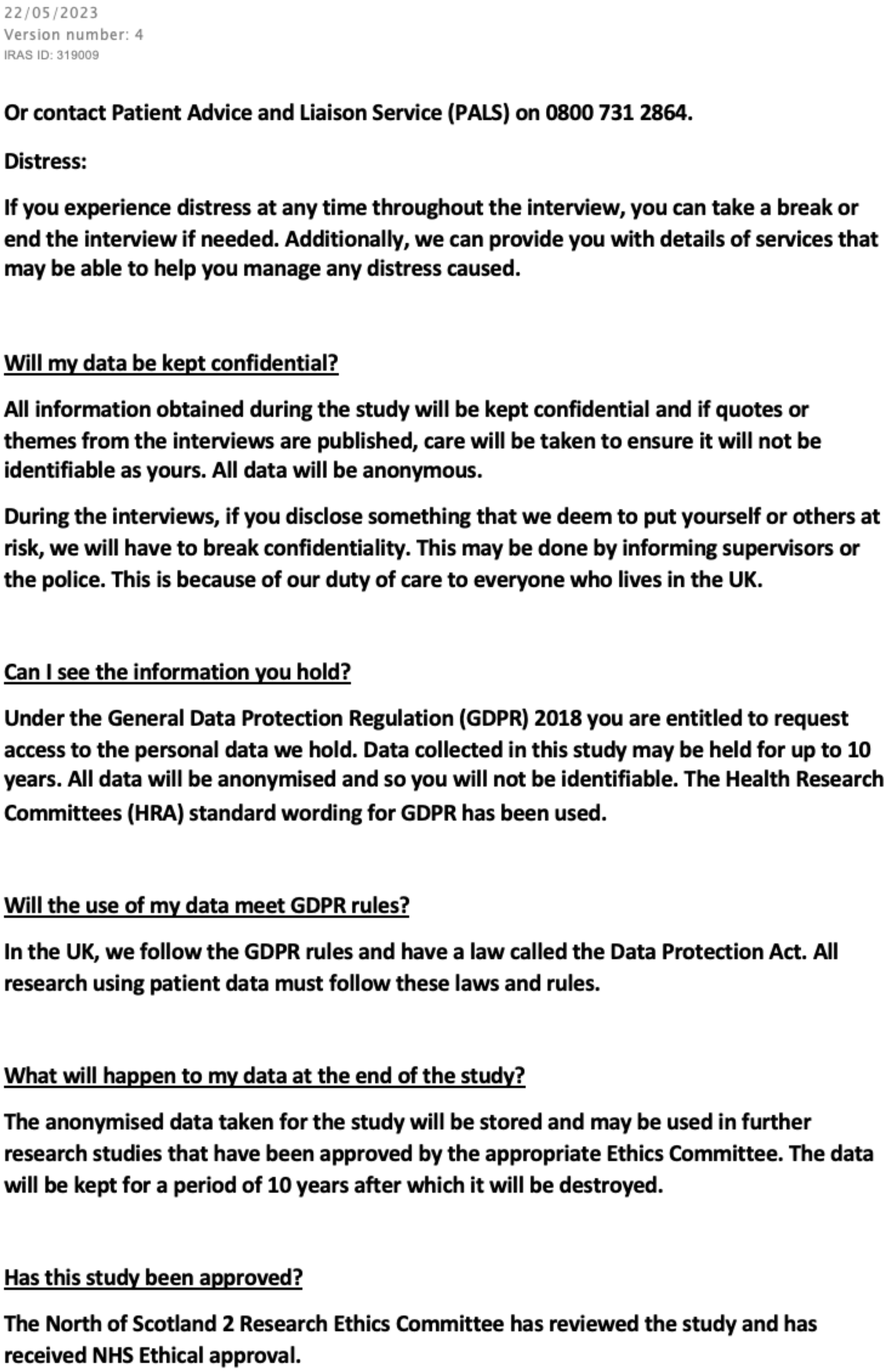
The study involves being asked to think about your understanding of psychosis. This may bring up some unpleasant emotions but we will provide support if needed (see below).

Please note: the interview may take place outside of your working hours if necessary.

What if I am unhappy with the research or if something goes wrong?

Complaints:

If you have a concern about any aspect of this study, you should speak with me or one of the other researchers. If you are still unhappy or have a complaint which you feel you cannot come to us about then you should contact the Salomons Institute for Applied Psychology at Canterbury Christ Church University with whom the research is partnered with (Research Director: fergal.jones@canterbury.ac.uk).



Or contact Patient Advice and Liaison Service (PALS) on 0800 731 2864.

Distress:

If you experience distress at any time throughout the interview, you can take a break or end the interview if needed. Additionally, we can provide you with details of services that may be able to help you manage any distress caused.

Will my data be kept confidential?

All information obtained during the study will be kept confidential and if quotes or themes from the interviews are published, care will be taken to ensure it will not be identifiable as yours. All data will be anonymous.

During the interviews, if you disclose something that we deem to put yourself or others at risk, we will have to break confidentiality. This may be done by informing supervisors or the police. This is because of our duty of care to everyone who lives in the UK.

Can I see the information you hold?

Under the General Data Protection Regulation (GDPR) 2018 you are entitled to request access to the personal data we hold. Data collected in this study may be held for up to 10 years. All data will be anonymised and so you will not be identifiable. The Health Research Committees (HRA) standard wording for GDPR has been used.

Will the use of my data meet GDPR rules?

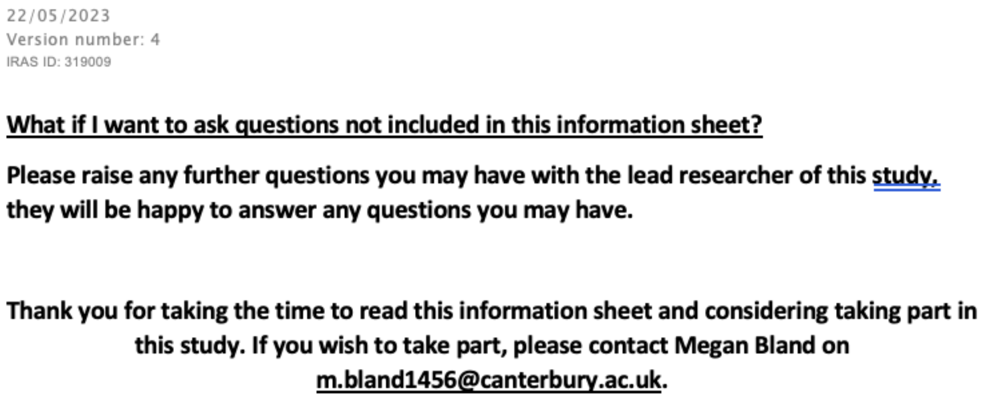
In the UK, we follow the GDPR rules and have a law called the Data Protection Act. All research using patient data must follow these laws and rules.

What will happen to my data at the end of the study?

The anonymised data taken for the study will be stored and may be used in further research studies that have been approved by the appropriate Ethics Committee. The data will be kept for a period of 10 years after which it will be destroyed.

Has this study been approved?

The North of Scotland 2 Research Ethics Committee has reviewed the study and has received NHS Ethical approval.

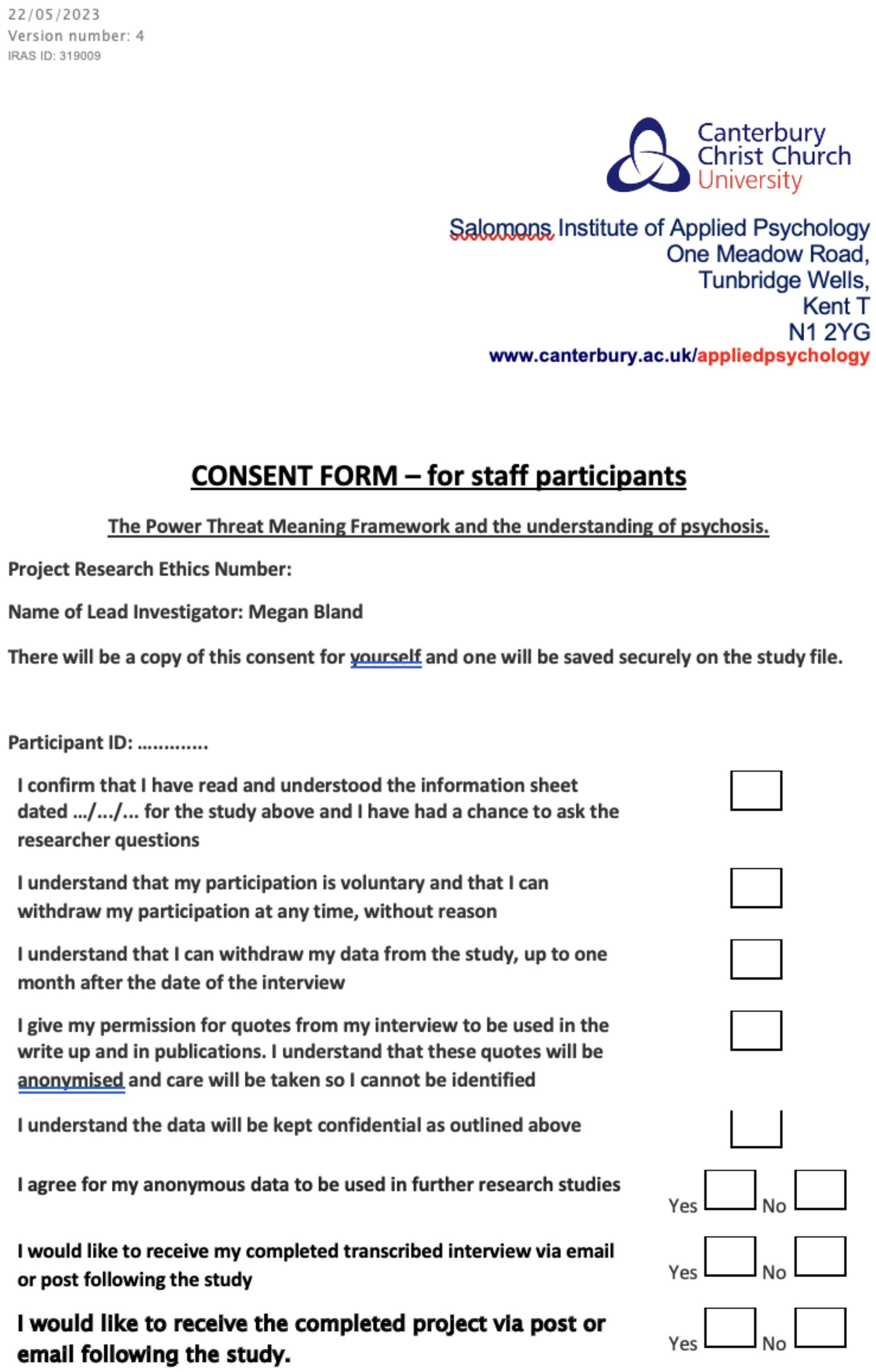


What if I want to ask questions not included in this information sheet?

Please raise any further questions you may have with the lead researcher of this study. they will be happy to answer any questions you may have.

Thank you for taking the time to read this information sheet and considering taking part in this study. If you wish to take part, please contact Megan Bland on m.bland1456@canterbury.ac.uk.

Appendix G
Study consent form



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Canterbury
Christ Church
University

Salomons Institute of Applied Psychology
One Meadow Road,
Tunbridge Wells,
Kent T
N1 2YG
www.canterbury.ac.uk/appliedpsychology

CONSENT FORM – for staff participants

The Power Threat Meaning Framework and the understanding of psychosis.

Project Research Ethics Number:

Name of Lead Investigator: Megan Bland

There will be a copy of this consent for yourself and one will be saved securely on the study file.

Participant ID: ....

I confirm that I have read and understood the information sheet dated .../.../... for the study above and I have had a chance to ask the researcher questions ☐

I understand that my participation is voluntary and that I can withdraw my participation at any time, without reason ☐

I understand that I can withdraw my data from the study, up to one month after the date of the interview ☐

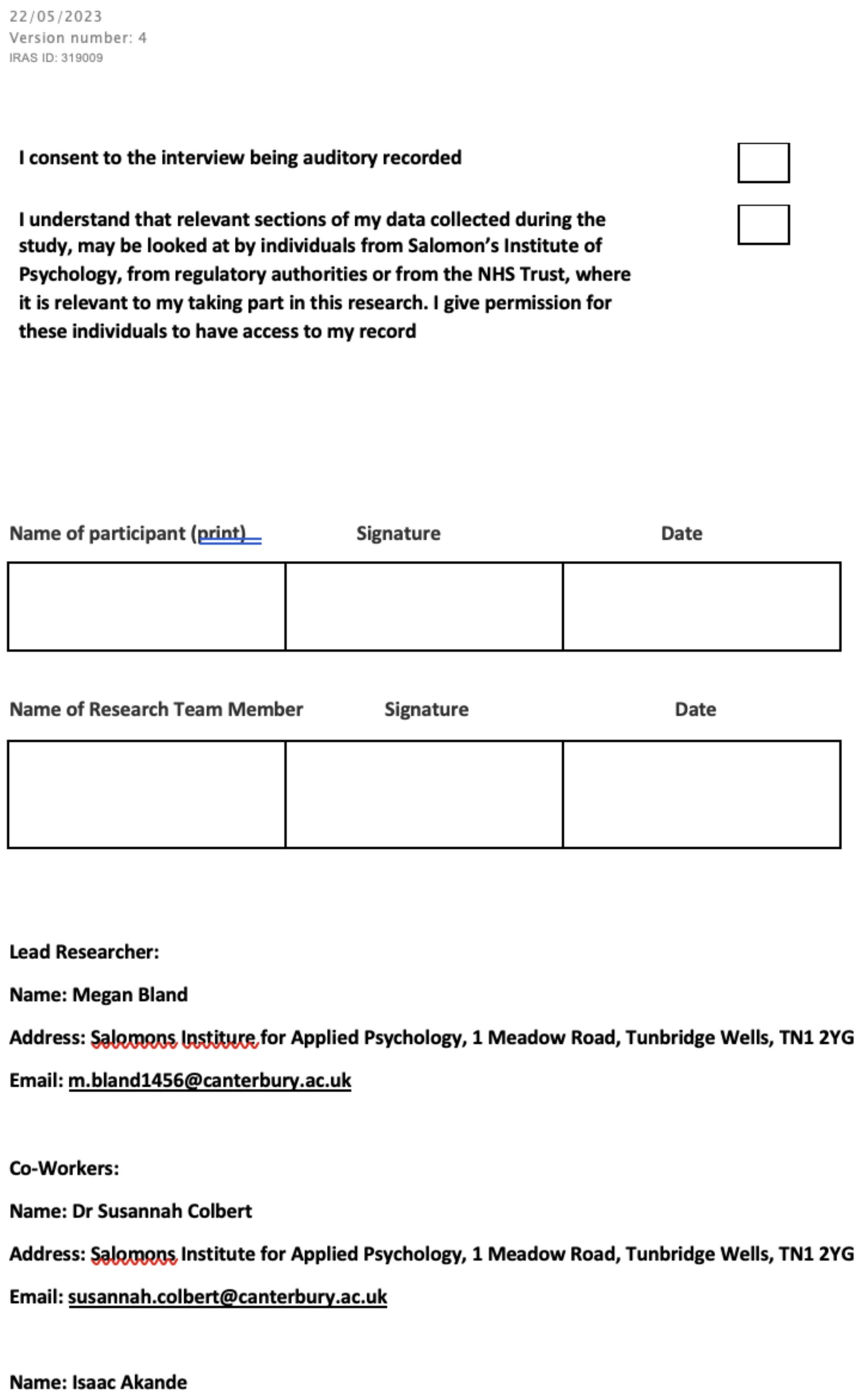
I give my permission for quotes from my interview to be used in the write up and in publications. I understand that these quotes will be anonymised and care will be taken so I cannot identified ☐

I understand the data will be kept confidential as outlined above ☐

I agree for my anonymous data to be used in further research studies Yes ☐ No ☐

I would like to receive my completed transcribed interview via email or post following the study Yes ☐ No ☐

I would like to receive the completed project via post or email following the study. Yes ☐ No ☐



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Version number: 4
IRAS ID: 319009

I consent to the interview being auditory recorded ☐

I understand that relevant sections of my data collected during the study, may be looked at by individuals from Salomon's Institute of Psychology, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my record ☐

Name of participant (print)	Signature	Date

Name of Research Team Member	Signature	Date

Lead Researcher:

Name: Megan Bland

Address: Salomons Institute for Applied Psychology, 1 Meadow Road, Tunbridge Wells, TN1 2YG

Email: m.bland1456@canterbury.ac.uk

Co-Workers:

Name: Dr Susannah Colbert

Address: Salomons Institute for Applied Psychology, 1 Meadow Road, Tunbridge Wells, TN1 2YG

Email: susannah.colbert@canterbury.ac.uk

Name: Isaac Akande

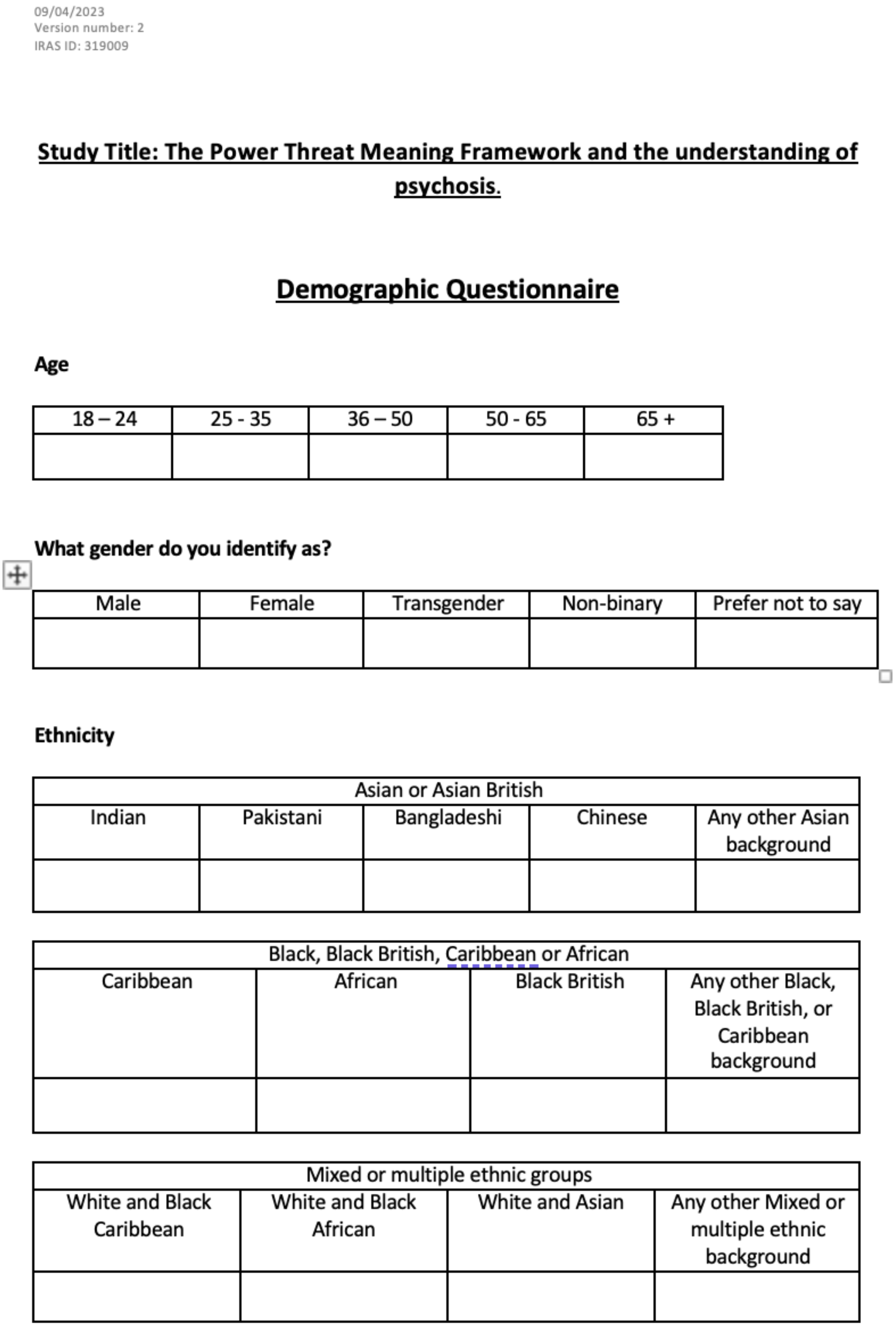
Email: isaaac.akande@slam.nhs.uk

Name: Kirstie Wright

Address: St Giles House, St Giles Road, London, SE5 7UD

Email: kirstie.wright@slam.nhs.uk

Appendix H
Study demographic questionnaire



09/04/2023
Version number: 2
IRAS ID: 319009

Study Title: The Power Threat Meaning Framework and the understanding of psychosis.

Demographic Questionnaire

Age

18 – 24	25 - 35	36 – 50	50 - 65	65 +

What gender do you identify as?

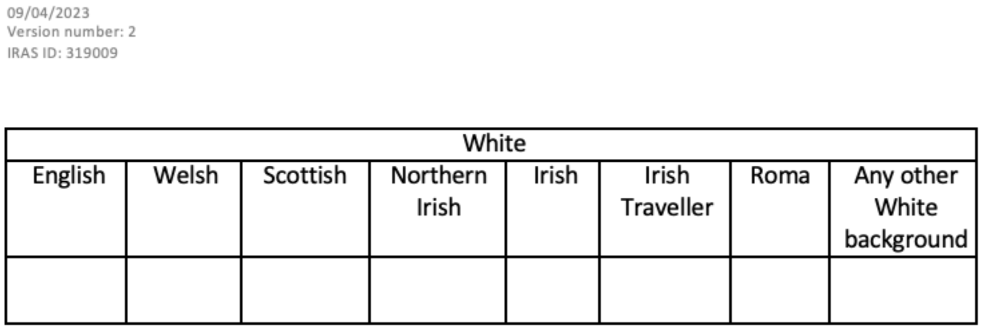
Male	Female	Transgender	Non-binary	Prefer not to say

Ethnicity

Asian or Asian British				
Indian	Pakistani	Bangladeshi	Chinese	Any other Asian background

Black, Black British, Caribbean or African			
Caribbean	African	Black British	Any other Black, Black British, or Caribbean background

Mixed or multiple ethnic groups			
White and Black Caribbean	White and Black African	White and Asian	Any other Mixed or multiple ethnic background



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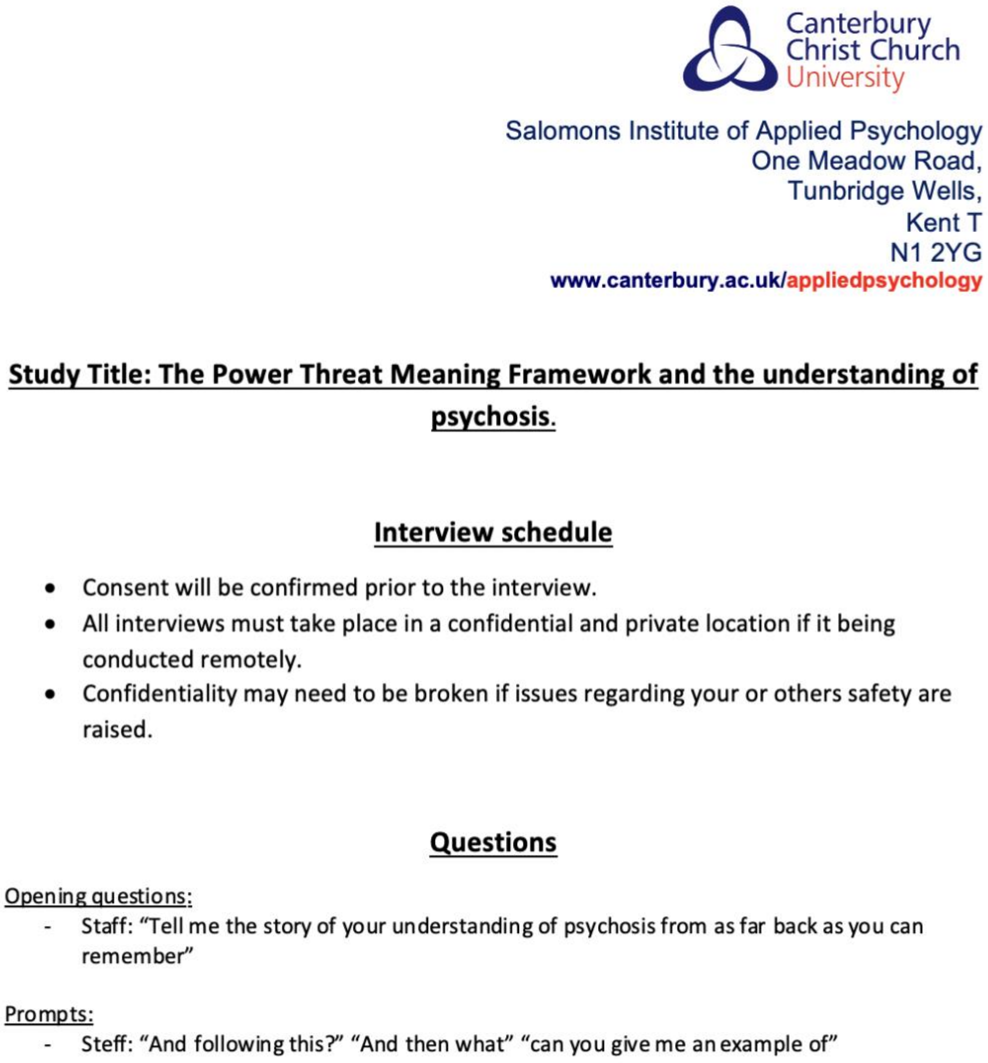
Version number: 2
IRAS ID: 319009

White							
English	Welsh	Scottish	Northern Irish	Irish	Irish Traveller	Roma	Any other White background

Appendix I
Interview schedule



Canterbury
Christ Church
University

Salomons Institute of Applied Psychology
One Meadow Road,
Tunbridge Wells,
Kent T
N1 2YG
www.canterbury.ac.uk/appliedpsychology

Study Title: The Power Threat Meaning Framework and the understanding of psychosis.

Interview schedule

- Consent will be confirmed prior to the interview.
- All interviews must take place in a confidential and private location if it being conducted remotely.
- Confidentiality may need to be broken if issues regarding your or others safety are raised.

Questions

Opening questions:

- Staff: "Tell me the story of your understanding of psychosis from as far back as you can remember"

Prompts:

- Steff: "And following this?" "And then what" "can you give me an example of"

Appendix J

Annotated interview transcript

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Appendix K
Interpreted narrative synopsis
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Appendix L
Analysis development
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Appendix M

Extract from research diary

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Appendix N

Confirmation of the NHS trust R&D team closing the study upon completion and receiving the end of study report/information

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Appendix O
Email confirmation of notifying IRAS REC committee study upon completion
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Appendix P
Form attached to the above email notifying IRAS REC committee study upon completion
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Appendix Q
End of study information form sent to IRAS
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Appendix R
IRAS acknowledgement of declaration of end of study form email
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