WHICH WOLF TO FEED? EXPLORING CLINICIANS' EXPERIENCES OF HOPE AND RECOVERY WHILST WORKING WITH INDIVIDUALS WITH FIRST EPISODE PSYCHOSIS

By

Rose Christopher

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Department of Clinical Psychology

School of Psychology

The University of Birmingham

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Thesis Overview

This thesis contains the academic work submitted by the author as part of the DClinPsych program and is made up of two volumes. Volume One contains a review of the literature regarding staff attitudes towards psychosis and the potential impact of these, an empirical paper investigating clinicians' experiences of recovery from psychosis whilst working in Early Intervention for Psychosis, using an Interpretive Phenomenological approach and public dissemination document surmising the findings of the above.

Volume Two consists of four written clinical practice reports and a summary of a verbal presentation exemplifying the applications of psychological theory and skills in practice. The first clinical practice report illustrates the formulation of a 24 year old male with a learning disability from a systemic and behavioural perspective. Secondly, a service evaluation of community behavioural support team for adults with a learning disability is presented. Third, a leadership and consultancy clinical practice report of delivering clinical supervision to a nursing colleague. The fourth clinical practice report utilises a single case experimental design to evaluate the effectiveness of cognitive behavioural intervention for anxiety in an older adults inpatient setting. The final clinical practice report is the abstract from an oral presentation of working with a female adult client from a dialectical behavioural perspective.

*All names and identifiable information have been changed to maintain client and participant anonymity.

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Contents

Volume One

4. **Appendices**

Volume Two

6. Appendices

Volume One

List of Illustrations

1. **Literature Review**

Volume One

List of Tables

1. **Literature Review**

2. **Empirical Paper**

3. **Public Dissemination Document**

1. Literature Review: A Systematic Review of Staff Members’ Attitudes Towards Psychosis and Schizophrenia and The Impact on Care Delivered

1.1. Abstract

Introduction: A service user-led recovery movement, cognitive theories and trauma research have challenged the traditional chronic disease model of psychotic symptoms. It is unclear whether these different conceptualisations have impacted on clinical staff’s perceptions of psychosis. The care delivered by mental health professionals is likely to be influenced by their knowledge, beliefs and attitudes about psychosis. This review aimed to investigate attitudes of clinicians working directly with psychosis and the implications of these.

Method: A systematic search was conducted of the databases PsycINFO, Embase, Medline, CINAHL and Web of Science, in order to locate articles relating to staff attitudes to psychosis and schizophrenia. Twenty- three papers were included and methodological quality was assessed using Kmet, Lee and Cook (2004).

Results: The studies reviewed found a range of attitudes held by clinicians working with individuals experiencing psychosis with regards to the aetiology of experiences, treatment efficacy, potential outcomes and stigma. This review suggests that culture, professional background, area of practice and age may contribute to the development of different attitudes towards individuals with psychosis.

Discussion: There is a lack of theoretical understanding of the factors that may influence staff attitudes. It is not clear why the many theories used to understand patients’ attitudes and behaviours have not been applied to clinical staff. The clinical implications and limitations of the findings are discussed.

1.2. Introduction

Traditionally psychotic experiences have been synonymous with a diagnosis of schizophrenia and thus conceptualised as a life-long chronic condition. This stems from the work of Kraepelin and Bleuler whereby improvement from such symptoms was not expected, and those treating the individual would anticipate a slow decline into illness (Kelly & Gamble, 2005). This chronic disease interpretation of psychotic experiences dominated treatment options for many decades. The definition of a good outcome was analogous to a ‘cure’ and would be indicated by a decrease in symptoms and hospitalisation (McGuire, 2000). McGorry, Killackey and Yung (2008) argue that it is conceptual error to infer “that a true disorder could be validly defined by its (poor) outcome” (p. 148). They observe that this error has resulted in pessimism, stigma and neglect, toxically restricting therapeutic efforts and care.

In recent years, alternative conceptualisations have emerged. The service user-led recovery movement has presented an important perspective on psychotic experiences, arguing that these should no longer be considered as merely symptoms of a biological illness but as meaningful interpretations of past experiences (Romme & Escher, 2013: Longden, 2013: Corstens, Longden, McCarthy-Jones, Waddingham, & Thomas, 2014). First-hand accounts of recovery from individuals who have experienced psychosis describe it as a more complex, idiosyncratic, non-linear process, involving movement towards a meaningful life and personal growth, regardless of the presence of symptoms (Deegan, 1988; Leete, 1989; Lovejoy, 1982 & Unzicker, 1989).

Additionally, cognitive theories of psychosis have highlighted a role for stressful life events (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001) and many professionals endorse a stress-vulnerability model (e.g. Nuechterlein et al., 1994), whereby biological and genetic factors interact with environmental stimuli resulting in developing psychotic symptoms. Traumatic events, and associated diagnoses, have been theoretically linked with psychosis (Morrison, Frame, & Larkin, 2003). Furthermore, it has been acknowledged that for some individuals experiencing such symptoms, there are known organic causes, such as dementia or other neurological structural changes (Lautenschlager & Förstl, 2001). The chronic disease-based model has not been replaced by any one particular conceptualisation but these approaches are used interactively in an attempt to best understand psychotic experiences.

Whilst these conceptual arguments have been well documented in the theoretical and academic literature, these often contrasting conceptualisations of psychotic experiences have implications for mental health services seeking to treat or support individuals experiencing such difficulties. Many of the recovery movement’s values have influenced the design of services, such as Early Intervention for psychosis Services (EIS), which aims to ‘maximise optimism, engender hope and ensure service delivery in low-stigma settings’ (Singh & Fisher, 2005, p.72). In order to be able provide appropriate recovery-focused support at an earlier stage in individuals’ care, it is advocated that a shift in thinking about psychotic experiences from a pessimistic inevitable decline to a more fluid and malleable process is required (McGorry et al., 2008). It is recognised that for many individuals experiencing distressing psychotic experiences, services and professionals play an important role. Social networks often reduce as a consequence of experiencing psychotic symptoms, placing greater importance on the relationships with staff and services (Randolph, 1998). However, Allott, Loganathan and Fulford (2009) draw attention to a tension between the values of the survivor recovery movement and traditional service implementation, stating fears of empowered service users leading to disempowered professionals, as they experience difficulties in giving up some of their authority. They argue that, although professionals and services may no longer have “power over” individuals, it is important that they are empowered to support recovery collaboratively on equal terms with service users.

It is important to investigate whether these different theoretical conceptualisations are apparent in the way that mental health professionals perceive psychotic experiences and illnesses, and whether these views impact on the approach they take to working with individuals experiencing psychosis. The approaches undertaken by mental health professionals are likely to be influenced by their knowledge, beliefs and attitudes about psychotic experiences and working with these individuals.

Mental health professionals’ attitudes towards mental illness more generally have received increased interest in literature (Jorm, Korten, Jacomb, Christensen, & Henderson, 1999). A review of this literature by Wahl and Aroesty-Cohen (2010) suggested that the majority of attitudes held by professionals were positive in nature and more positive than attitudes found to be held by the general public. Chambers and colleagues (2010) found that nurses generally demonstrated positive attitudes towards mental health but there were some notable cross-cultural differences, signifying that wider social, cultural and organisational factors are likely to impact. However, some studies have illustrated more negative attitudes, such as believing people with mental health problems are dangerous (Lauber, Nordt, Braunschweig, & Rössler, 2006) and should not have children (Magliano, Fiorillo, De Rosa, Malangone, & Maj, 2004). There is some evidence to suggest that biogenetic disease models of mental illness are associated with more stigmatising views (Read, Haslam, Sayce, & Davies, 2006).

These findings raise concerns about the impact of negative attitudes on patient care. Such attitudes may perpetuate stigmatising views and limit the clinician's ability to build effective therapeutic relationships or respond to individuals' needs in a beneficial way. Furthermore, Wahl and Aroesty-Cohen (2010) highlight that attitudes may differ towards different disorders, with attitudes towards diagnoses such as schizophrenia and borderline personality disorder being less accommodating. They suggest that further research is needed to better understand attitudes towards specific disorders. Studies highlight that the general public associate schizophrenia with dangerousness, violence and unpredictability (Angermeyer & Matschinger, 1996). Therefore, it is important to look at staff attitudes toward psychotic experiences and associated diagnoses specifically and to explore how these may impact on the care received by these individuals.

It has been recognised that there is a gap between what is recognised as effective mental health treatment and what is actually delivered in actual clinical practice (Drake et al., 2001; Ganju, 2003; Mueser, Torrey, Lynde, Singer, & Drake, 2003) despite these evidence-based recommendations being widely disseminated. Perkins and colleagues (2007) identified that there is little research investigating how to change clinicians' behaviours, despite there being a large number of empirical and theoretical studies about behaviour change for patients or individuals. Many of these theories, such as the theory of planned behaviour (TPB) and theory of reasoned action (TRA) (Ajzen, 1985, 1991; Madden, Ellen, & Ajzen, 1992), highlight a key role of attitudes in behaviour change. It has been found that different attitudes adopted by clinical staff can lead to different advice. Domenech, Sánchez-Zuriaga, Segura-Ortí, Espejo-Tort and Lisón (2011) found that when physical therapy students received training in biopsychosocial or a biomedical model of lower back pain, they demonstrated significantly different beliefs and attitudes, which resulted in endorsing different clinical advice that they would give to patients experiencing lower back pain. Those trained in a biopsychosocial model were more likely to follow the relevant clinical practice guidelines for lower back pain. Thus, in order to effectively implement evidence-based care for individuals experiencing psychosis, it is imperative to understand the attitudes held by professionals providing that care.

The aim of the review is to examine existing literature investigating the attitudes of clinicians working directly with psychosis and the implications of these attitudes. This review seeks to summarise research on the attitudes of mental health staff, focusing on those delivering direct care to individuals experiencing psychosis. Attitudes are defined as an evaluation, often positive or negative, of objects, ideas, event or activities (Fishbein & Raven, 1962). Within the literature, these evaluations can be termed beliefs, perceptions and appraisals, as well as attitudes. These terms are often used interchangeably and essentially are referring to a thought process or evaluation about a particular concept. This review aims to focus on clinicians' cognitive representations of people with psychotic symptoms and associated diagnoses and, therefore, will include studies investigating beliefs, perceptions, appraisals and attitudes.

1.3. Search Strategy

A systematic search was conducted of the databases PsycINFO, Embase, Medline, CINAHL and Web of Science, in October 2015 in order to locate articles relating to staff attitudes to towards psychosis and schizophrenia. The search terms (Table 1) were mapped on to subject headings and combined using the Boolean operator AND. This search returned a high number of inappropriate articles and, therefore, a further keyword search for attitudes (Attitud* OR Perception* OR Belief* OR Appraisal*) within the title or abstract was included. This search returned 571 records. Duplicates were removed to leave 551 articles for abstract review. Records were screened using the criteria in Table 1.

Research Question	What are the attitudes of clinicians towards psychosis and the implications of these attitudes?		
Research Concept	Clinical staff	Working with individuals experiencing psychosis or schizophrenia	Attitudes
Search terms	Clinician* OR Professional* OR Staff*	Psychosis* OR Schizo*	Attitud* OR Perception* OR Belief* OR Appraisal*
Inclusion Criteria	• Peer-reviewed papers. • Studies investigating attitudes of clinicians or staff members working directly with individuals experiencing psychosis or with a diagnosis of schizophrenia. • All dates were included, as a review in this specific area had not been completed before.		
Exclusion Criteria	• Papers not available in English. • Studies investigating general healthcare professionals attitudes, such as GP's or pharmacists, as the area of interest was clinicians involved directly in the treatment and recovery process. • Studies investigating the attitudes of nursing/medical/healthcare professional students. • Studies investigating attitudes or beliefs regarding general severe mental illness, dementia or at risk mental state rather than psychotic experiences or illnesses specifically. • Studies focusing solely on attitudes to specific medications were also excluded as these were deemed to be evaluating the medication rather than the conceptualisation of psychotic illness.		

Table 1: Research concepts and associated search terms

Twenty-six articles were identified as meeting the inclusion criteria from reviewing abstracts. However, full texts were unable to be accessed for two of these articles. The reference lists of the 24 articles were examined and eight further relevant papers were identified. A further four papers were excluded whilst reading the full texts; in one the staff sample used was from a study assessing their views towards severe mental illness rather than psychosis specifically, one was a non-systematic review article, one looked staff rejection rather than attitudes and one was deemed not to meet a high enough quality standard to be included. It was decided to focus on papers that investigated the attitudes held by staff and any impacts of these, rather than any evaluations of interventions designed to change attitudes, and therefore a further six papers were excluded. A total of 22 papers were included in the current review. This process is presented diagrammatically in a PRISMA flow chart (Liberati et al., 2009, Figure 1).

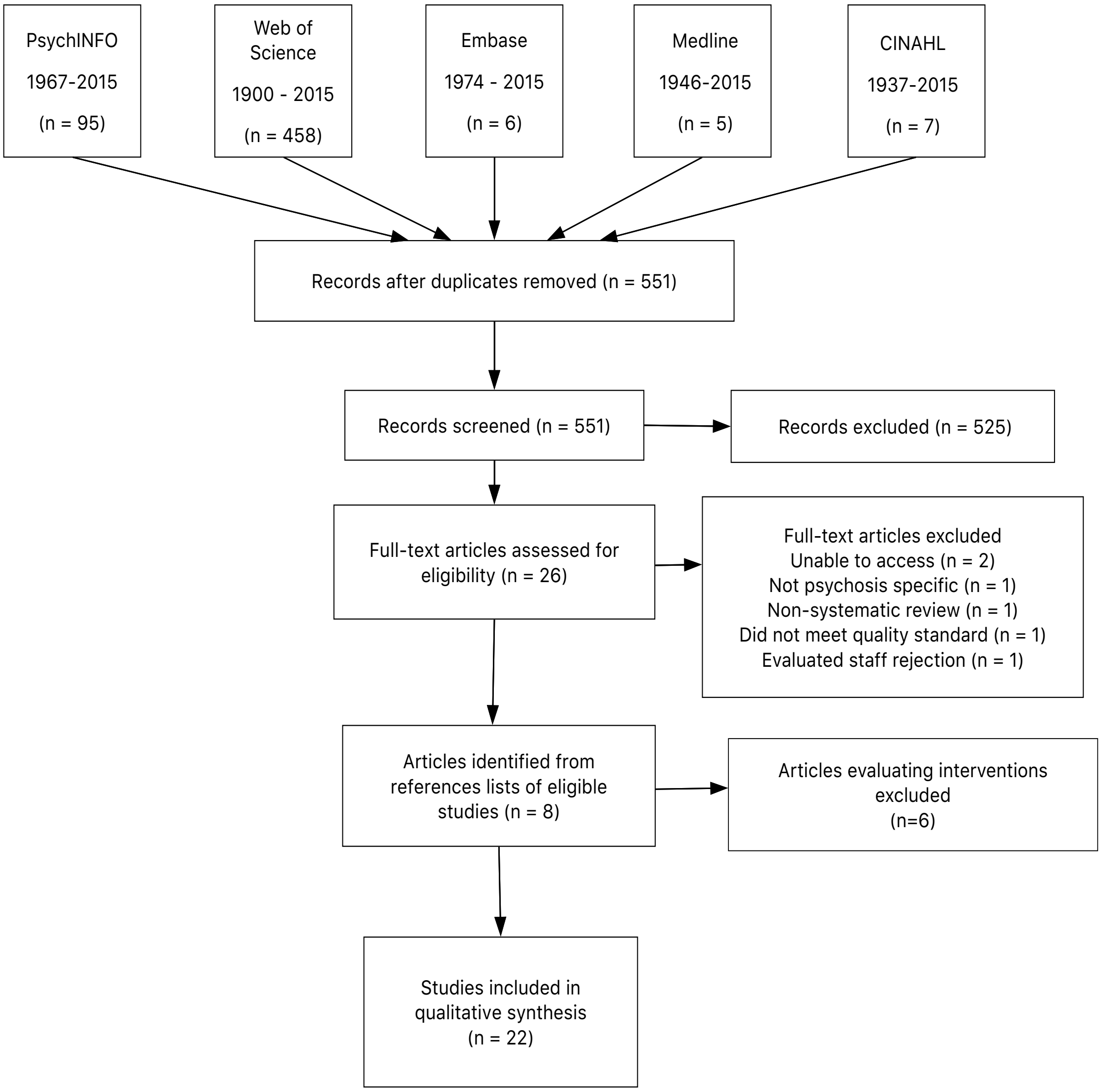

Figure 1: PRISMA flow chart

1.4. Review of Methodological Quality

In order to ascertain the methodological quality of research in this area, the papers identified were assessed using the standard quality assessment criteria developed by Kmet, Lee and Cook (2004). The results of this are presented in Tables 2 and 3, including the overall quality scores for each of the studies. The authors suggest that quality scores can be used to define a minimum threshold for inclusion in systematic reviews and that this threshold should be determined based on the range of the scores and the constraints of the study (Kmet et al., 2004). Considering the range of scores found for the papers included and that no previous reviews have been completed in this area, a liberal cut off score of 0.5 was allocated. Following this, one paper (Woodside et al., 1994) did not meet this cut off score and, thus, was excluded. The framework is also designed to provide information about the quality of the studies in the research area in question, to aid with synthesising results from a systematic review. A brief summary of the quality of the literature overall was derived from the assessment criteria and is presented below.

The majority of the research investigating the attitudes held by staff utilised survey designs, often in comparison to members of the general public or relatives. The main limitation of these studies was the range of different measures used to evaluate attitudes, many of which were devised by the study authors. There was little consideration of the validity and reliability of these measures presented in the studies. Therefore, variations in findings may also be due to differences in assessment tools used, rather than differences in attitudes per se.

The range of questionnaires was often underpinned by different conceptual understandings of psychotic experiences. For example, some of the questionnaires referred to the diagnosis “schizophrenia” whereas others made specific reference to symptoms and behaviours associated with psychotic experiences, which means that there are difficulties integrating the results of the studies. Furthermore, the interpretation of the results, and the conclusions drawn, appear to be influenced by the researchers' *own* attitudes, as framed by their professional backgrounds. For example the studies by Magliano and colleagues (Magliano, De Rosa, et al., 2004; Magliano, Fiorillo et al., 2004) did not reflect on the potential implications of their participating professionals adopting a biomedical model rather than alternative models cited by relatives.

Very few of the studies considered confounding variables in their statistical analysis of attitudes held by staff members, such as professional background, age, culture or length of time in job. These limitations must be considered when interpreting the findings from the different studies.

The studies included in this review were conducted in a number of different countries. Each of these countries is likely to have different cultural expectations and assumptions underlying the mental health care provision, as well as structural and organisational differences in how these services are provided. Thus, this must be taken into account when synthesising the findings of the studies, and homogeneity of samples should not be assumed.

Only one qualitative paper was included in the review (Prytys, Garety, Jolley, Onwumere, & Craig, 2011). It was felt it was important to include this paper, as it was the only study that explicitly investigated clinician impact of attitudes on their clinical practice and contributed a more in-depth exploration of attitudes. It is important to note that the findings of one qualitative study cannot be readily generalised due to small, specific sample size however the findings do provide some further insight to the difficulties of implementing interventions.

A brief summary of each of the papers reviewed is provided in Table 4.

Study Reference	Question / objective sufficiently described?	Study design evident and appropriate?	Method of subject/comparison group selection or source of information/input variables described and appropriate?	Subject (and comparison group, if applicable) characteristics sufficiently described?	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement / misclassification bias? means of assessment reported?	Sample size appropriate?	Analytic methods described/justified and appropriate?	Some estimate of variance is reported for the main results?	Controlled for confounding?	Results reported in sufficient detail?	Conclusions supported by the results?	Quality Score
Caldwell & Jorm (2000)	1	1	2	2	1	2	2	2	2	2	2	0.9
Carr et al. (2004)	2	2	2	2	1	1	2	2	0	2	2	0.8
Grausgruber, Meise, Katschnig, Schöny, & Fleischhacker (2007)	2	1	1	2	1	NA	2	2	1	2	2	0.8
Hansson, Jormfeldt, Svedberg, & Svensson (2011)	2	2	2	2	2	1	2	2	2	2	2	1.0
Hori, Richards, Kawamoto, & Kunugi (2011)	2	1	1	2	1	1	2	2	2	2	2	0.8
Ishige & Hayashi (2005)	1	1	2	2	2	2	2	2	2	2	2	0.9
Jorm, Korten, Jacomb, Christensen, & Henderson (1999)	0	2	2	1	1	2	1	1	1	1	1	0.6
Jorm, Korten, Jacomb, Rodgers, Pollitt, Christensen, & Henderson (1997)	1	2	2	1	1	2	1	0	0	1	1	0.5
Kukulu & Ergün (2007)	1	2	2	2	1	NA	1	0	NA	2	1	0.7
Lesinskiene, Jegorova & Ranceva (2007)	1	2	2	2	1	NA	1	0	NA	2	1	0.7
Magliano et al. (2004)	2	2	2	2	2	2	2	2	1	2	1	0.9
Magliano, De Rosa, et al. (2004)	2	2	2	2	2	2	2	2	2	2	2	1.0
Marwaha, Balachandra, & Johnson (2009)	2	2	2	2	1	NA	2	NA	NA	2	2	0.9
Mittal et al. (2014)	2	2	2	2	2	2	2	2	2	2	2	1.0
Nordt, Roessler, & Lauber (2006)	1	2	2	2	1	1	2	2	1	1	2	0.8
Ono et al. (1999)	1	2	1	1	1	2	2	2	NA	1	1	0.7
Tiffin & Gasparyan (2009)	2	2	2	1	1	1	2	2	0	1	2	0.7
Ucok, Polat, Sartorius, Erkoc, & Atakli (2004)	2	2	2	1	1	NA	2	2	NA	2	1	0.8
Van Dorn, Swanson, Elbogen, & Swartz (2005)	2	1	2	2	1	1	2	2	0	2	1	0.7
Vendsborg et al. (2013)	2	2	1	2	2	NA	2	2	NA	2	2	0.9
Wahass & Kent (1997)	2	2	1	2	1	NA	2	2	0	2	2	0.8
Woodside et al. (1994)	1	0	0	1	1	2	1	1	0	0	0	0.3

Table 2: Standard quality assessment criteria quantitative results (Kmet et al., 2004)

Study Reference	Question / objective sufficiently described?	Study design evident and appropriate?	Context for the study clear?	Connection to a theoretical framework / wider body of knowledge?	Sampling strategy described, relevant and justified?	Data collection methods clearly described and systematic?	Data analysis clearly described and systematic?	Use of verification procedure(s) to establish credibility?	Conclusions supported by the results?	Reflexivity of the account?	Quality Score
Prytys, Garety, Jolley, Onwumere, & Craig, (2011)	2	2	2	2	2	2	2	2	2	2	1

Table 3: Standard quality assessment criteria qualitative results (Kmet et al., 2004)

Study Authors	Date	Design	Sample (n)	Measures used	Main Findings	Limitations
Caldwell & Jorm	2000	Survey	Public (n=982) Psychiatrists (n=564) Clinical psychologists (n=228) GPs (n=424) Mental health nurses (n=324)	Devised own questionnaire including vignette.	Mental health nurse significantly more optimistic than other professional groups however still less than public.	Data collected using different methods for different groups. Professionals commented on lack of information in vignettes. Research question not clear.
Carr et al.	2004	Survey	GP's (n=192) Community Mental health staff (MHS) (n=50) Patients (129)	Devised own questionnaire.	MHS and GPs less likely to rate family as important than patients. GP ranked regular employment as important more than MHS and patients. MHS rated psychological treatments as more helpful than GPs and patients.	Smaller group of MHS. Did not control for confounding variables.
Grausgruber, Meise, Katschnig, Schöny, & Fleischhacker	2007	Survey	Public (n=1035) Staff (n=1479) Relatives (n=385)	Devised own questionnaire. No reliability data.	Perceived causes differed between groups. Staff indicated a more multi-causal understanding. Staff more likely to perceive schizophrenia as treatable and less likely to perceive as dangerous.	Low response rate (30%) for staff and relatives. Study design not explicit. Selection method for staff and relatives not described.
Hansson, Jormfeldt, Svedberg, & Svensson	2011	Survey	MHS (n=140) Patients (n=141)	Perceived Devaluation-Discrimination Questionnaire	Staff members working with psychosis or inpatient settings demonstrated more negative attitudes.	Low response rate (59%).

Table 4: Summary table of papers

Hori, Richards, Kawamoto, & Kunugi	2011	Survey	Public (n=197) Psychiatric staff (n=100) Physicians (n=112) Psychiatrists (n=36)	Web-based questionnaire based on Uçok et al. (2006).	Identified three factors of attitudes using factor analysis of public sample; stigma, underestimation of abilities and scepticism about treatments. Psychiatrists scored significantly lower on stigma. Psychiatric staff scored lower on underestimation of abilities. All groups desired social distance.	Limited information collected about how much time spent working with psychosis specifically.
Ishige & Hayashi	2005	Survey	Psychiatric Nurse (n=261) Public Health Nurse (n=83) Non-psychiatric care workers (n=80) Welfare commissioners (n=75) Probation officers (n=58) Non-care workers (n=229)	Developed own evaluation scale using semantic differential technique. Modified Social Rejection Scale (Trute, Tefft, & Segall, 1989)	Public health nurses and psychiatric nurses demonstrated more affective accepting attitudes. Psychiatric nurses significantly less socially accepting attitudes than public health nurses.	Introduction and rationale not given in depth.
Jorm, Korten, Jacomb, Christensen, & Henderson	1999	Survey	Public (n=2031) Psychiatrists (n=1128) Clinical psychologists (n=454) GPs (n=872)	Devised own questionnaire including vignette.	Public rated positive outcomes more likely and negative outcomes less likely than all professionals. Clinical psychologists more positive than GPs and psychiatrists. GPs rated positive outcomes more likely than psychiatrists.	Research question not clearly expressed. Variance statistics not reported. Difference between groups not addressed using theoretical basis.

Table 4: Summary table of papers

Jorm, Korten, Jacomb, Rodgers, Pollitt, Christensen, & Henderson	1997	Survey	Public (n=2031) Psychiatrists (n=1128) Clinical psychologists (n=454) GPs (n=872)	Devised own questionnaire including vignette.	Professionals rated medication, compulsory admission and psychiatrists as more helpful than public. Discrepancies between professional groups and public views.	Professionals commented vignettes did not include information about social context. No room to capture views about differences of helpfulness of interventions at different stages. Variance statistics not reported. Did not control for confounding variables.
Kukulu & Ergün	2007	Survey	Psychiatric Nurses (n=543)	Devised own questionnaire. No reliability data.	93% believed schizophrenia was an illness present from birth. Majority viewed schizophrenia as a treatable illness but 84% thought recovery was not possible. The greater closeness of relationship, more likely increased social distance.	Variance statistics not reported. Only descriptive statistics presented. Study design not well described.
Lesinskiene, Jegorova & Ranceva	2007	Survey	Psychiatric Nurses (n=152)	Devised own questionnaire. No reliability data.	Found nurses' concerns about working with patients experiencing psychosis; - Personal and patient safety. -Difficulties in establishing a contact. - Non-compliance with treatment plans. - Forced medication	Only descriptive data presented. Conclusions based on little data.

Table 4: Summary table of papers

Magliano, Fiorillo, et al.	2004	Survey	Public (n=714) Mental Health Professionals (n=465) Relatives (n=709)	Questionnaire About Opinions on Mental Illness (no reference given) Reliability data provided.	Professionals more like to attribute illness to heredity. Less likely to endorse psychosocial treatments. Only 2% of professionals endorsed complete recovery is possible. Difference between groups about beliefs about civil rights for patients.	Little reflection about the implications of professionals' beliefs and it appears the underlying assumption is that biomedical perspective is "correct".
Magliano, De Rosa, et al.	2004	Survey	Nurses (n=109) Psychiatrists (n=110) Relatives (n=709)	Questionnaire About Opinions on Mental Illness (Magliano et al., 1999)	Nurse and psychiatrists more frequently attributed schizophrenia to heredity, stress and family conflict. Relatives attributed to stress, trauma and love breakdown.	Little reflection about the implications of professionals' beliefs and it appears the underlying assumption is that biomedical perspective is "correct".
Marwaha, Balachandra, & Johnson	2009	Survey	Mental health professionals (n=91)	Devised own questionnaire. Some assessment of face validity and acceptability.	Viewed only a small percentage of caseload (average 11%) as being able to work. Rated potential benefits highly. Rated stigma and additional stress leading to relapse as biggest barriers to employment.	Wide range of values means that views may not be uniform across the group. Lack of analysis of demographic variables e.g. professional background.
Mittal et al.,	2014	Survey	Mental health nurses (n= 67) Psychiatrists (n=62) Psychologists (n=76) Primary care nurses (n=91) Primary care physicians (n=55)	Characteristics scale (Olmsted & Durham, 1976), Attribution questionnaire (Corrigan et al., 2002) Social distance scale (The National Data Program for the Sciences & University of Chicago, 2013), Vignette	When the vignette was labelled with schizophrenia, primary care providers had significantly more negative attitudes. No effect for MHS. All participants showed desire for increased social distance.	Findings may not generalise outside service provider (Veterans Affairs). Low response rate (50%).

Table 4: Summary table of papers

Nordt, Roessler, & Lauber	2006	Survey	Psychiatrists (n=201) Psychologists (n=66) Nurses (n=676) Other therapists (n=116) Public (n=253)	Devised own questionnaire including vignette. Administered as telephone interviews.	No difference between negative stereotypes endorsed by MHS and public. Psychiatrists endorsed most stereotypes. Public endorsed more restrictions than MHS. All groups desired greater social distance from schizophrenia vignette than depression vignette.	Large gap (5 years) between public and professional samples data collection.
Ono et al.	1999	Survey	Psychiatrists (n=110)	Devised own questionnaire. No reliability data.	Only 7.3% of respondents always inform patients of diagnosis. 51.9% on a case-by-case basis. Perceive Japanese term for Schizophrenia to sound negative and create despair.	Group characteristics not well described. Study aims not clear.
Prytys, Garety, Jolley, Onwumere, & Craig	2011	Qualitative	CMHT care coordinators (n=20)	NA	Medication viewed as having essential role. Pessimistic attitudes towards outcomes. Positive attitudes about guidelines but doubts about applicability.	Limited generalisability of findings outside of particular sample.
Tiffin & Gasparyan	2009	Survey	CAMHS (n=26) and Adult Psychiatrists (n=71)	Devised own questionnaire. No reliability data.	CAMHS psychiatrists hold more pessimistic view of prognosis than adult psychiatrists.	Mainly focused on prescribing habits.
Uçok, Polat, Sartorius, Erkoc & Atakli	2004	Survey	Psychiatrists (n=60)	Devised own questionnaire. No reliability data.	Majority did not inform patients of diagnosis: - Would not understand diagnosis. - Would drop out of treatment. Believed schizophrenia to be most severe diagnosis and use in a pejorative manner by public.	Relatively small sample size. Group characteristics not described

Table 4: Summary table of papers

Van Dorn, Swanson, Elbogen & Swartz	2005	Survey	Consumers (n=104) Relatives (n=83) Public (n=56) Clinicians (n=85)	Interviews with consumers, relatives and public. Devised own questionnaire for clinicians. Both included a vignette. No reliability data.	Clinicians found to be less likely to endorse likelihood of violence than other groups. Clinicians less likely to attribute cause to stressful circumstances. Clinicians more likely to adopt biomedical model. Negative views about risk of violence lowest in clinician group but still present.	Did not control for confounding variables. Limited description of group characteristics.
Vendsborg et al.	2013	Survey	Psychiatric unit staff (n=548)	Mental Illness Clinicians' Attitudes (Kassam, Glozier, Leese, Henderson, & Thornicroft, 2010)	Staff found to agree recovery is possible and individuals with schizophrenia pose a low risk. View schizophrenia as chronic disorder caused by biological or biological and social factors. Suggests less stigmatising attitudes than previously found.	Selection method for participants not described.
Wahass & Kent	1997	Survey	Psychologists UK (n= 70) Saudi Arabia (n=70) Psychiatrists UK (n= 85) Saudi Arabia (n=70)	Devised own questionnaire. No reliability data.	UK staff more likely to believe brain damage, childhood experiences, environmental factors and stressful life events have aetiological significance. UK staff endorsed a wider range of factors. Psychiatrists believe psychologist have important input for small minority. Psychologists believe they have important input for larger proportion.	Did not control for confounding variables. Selection method for participants not described.

Table 4: Summary table of papers

1.5. Results

1.5.1. Attitudes towards Individuals Experiencing Psychosis or Diagnosed with Schizophrenia

The majority of the research found in this review investigated attitudes towards the diagnosis of schizophrenia rather than the experience of psychotic symptoms per se. Studies conducted with the general public have found high levels of stigmatising attitudes towards schizophrenia, e.g. believing they are dangerous, believing they should have certain rights removed or not wishing to socialise with individuals (e.g. Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Many of the studies aimed to compare public attitudes to those held by staff members. As it has been found that contact under the right conditions with individuals experiencing mental health difficulties reduces stigmatising attitudes (Couture & Penn, 2003), many of the authors hypothesised mental health professionals would express less stigmatising attitudes than public samples. However, little consideration was given by the authors as to what conditions clinicians do have contact with individuals experiencing psychosis and the degree to which these conditions vary dependent on factors such as area of work and healthcare culture. The attitudes ranged from views on the aetiology of the difficulties, the effectiveness of different treatments, expected outcomes and willingness for social contact. The findings from the papers included have been organised by topic for the purpose of this review.

1.5.1.1. Aetiology of difficulties.

Several studies investigated mental health staff’s perceptions of the possible causes of schizophrenia and how these differed from the views of general public, service users and relatives. It has been found that clinicians are more likely to attribute the illness to heredity and genetic causes than are family members, service users and the general public (Van Dorn, Swanson, Elbogen & Swartz, 2005; Magliano, Fiorillo et al., 2004; Magliano, De Rosa, et al., 2004). Van Dorn et al. (2005) found that clinicians were significantly more likely to endorse an explanation based upon chemical imbalance and less likely to endorse stressful circumstances and upbringing as causes of illness, than service users and family members. Kukulu and Ergün (2007) found that 93% of a sample of Turkish nurses supported the idea that schizophrenia was an illness present from birth, and 51% agreed that social problems caused schizophrenia. Vendsborg et al. (2013) found that the majority of multi-disciplinary staff regarded schizophrenia as a chronic disease caused by biological factors or a combination of biological and social factors. Grausgruber, Meise, Katschnig, Schöny, and Fleischhacker (2007) found that staff endorsed more multi-causal understanding of schizophrenia. The majority of studies indicated that clinicians were likely to adopt a biogenetic model of schizophrenia.

Culture may influence beliefs about causal factors involved in the development of psychotic difficulties. In a comparison between the UK and Saudi Arabia, UK psychologists and psychiatrists were found to be more likely to believe that brain damage, childhood experiences, environmental factors and stressful life events play significant roles in aetiology. The same study suggested that UK clinicians were likely to draw upon a wider range of aetiological factors than professionals in Saudi Arabia (Wahass & Kent, 1997). These findings must be applied with some caution as there were differences in gender distribution between the two samples and the levels of education are not directly comparable.

We might also expect that the professional background and model of training (e.g. biomedical, psychological) will impact on clinicians' understanding of the aetiology of psychotic experiences. However the studies that compared the attitudes of different clinical staff groups' towards treatments or stigma, did not evaluate or compare staff groups' understanding of the *development* of these experiences.

1.5.1.2. Effectiveness of different treatments.

Several of the studies reviewed found discrepancies in attitudes about the helpfulness of different interventions. Some studies suggest that professionals place less value on lifestyle interventions (e.g. counsellors, impact of family and close friends, physical activity) and more value on more traditional psychiatric interventions such as medication, admission to hospital and access to psychiatrists (Jorm, Korten, Jacomb, Rodgers, Pollitt, Christensen, & Henderson, 1997; Magliano, Fiorillo et al., 2004; Kukulu & Ergün, 2007; Hori, Richards, Kawamoto & Kunugi, 2011). Contrary to this, Carr et al. (2004) found that mental health staff and patients tended to rank similar activities and treatments as helpful. Mental health staff viewed psychological treatments and recreational activities as more helpful than GPs and patients, which the authors suggest may reflect great awareness of these interventions and the evidence for them. It is important to recognise that these studies were conducted in different countries and healthcare settings, and therefore, contextual factors (e.g. such as access to different treatment options or to evidence-based treatment guidance) may have a role in explaining these differences.

It has been acknowledged by several studies that the role of psychology and talking therapies is often evaluated to be appropriate for only a small number of individuals with psychosis (Prytys et al., 2011; Ucok, Polat, Sartorius, Erkoc, & Atakli, 2004; Wahass & Kent, 1997) . Wahass and Kent (1997) found that both Saudi Arabian and UK psychiatrists believed that psychologists only had valuable input for a small minority of service-users, whereas psychologists believed they had valuable input for a larger number. Overall there was less faith in psychological treatments than in pharmacological treatments. A qualitative study

(Prytys et al., 2011) investigating community mental health staff's opinions about implementing recommendations for psychological therapies found that participants viewed medication as "an essential aspect of treatment, stabilising symptoms before talking therapies could be considered" (p.54). Furthermore, staff expressed pessimistic views of individuals with schizophrenia highlighting a need for ongoing support and felt that improvements made with psychological therapy would not be sustained. Despite these findings, no studies explicitly addressed how different attitudes towards the development of psychotic experiences may influence which treatment options are viewed as effective.

1.5.1.3. Expected outcomes.

The findings regarding views of potential outcomes for individuals experiencing psychosis vary and there appear to be different standpoints from different authors as to whether the aim is recovery, rehabilitation or management. Kukulu and Ergün (2007) found that the majority of psychiatric nurses viewed schizophrenia as a treatable illness but that 84% thought recovery was not possible. However, it is not reflected within the paper what recovery might mean to the nurses sampled, only that viewing it as a "treatable illness" is a positive indicator. Ucok and colleagues (2004) found that 56% of psychiatrists agreed that rehabilitation was possible, but again it was not discussed what rehabilitation meant. Magliano, De Rosa, et al. (2004) reported that only 2% of professionals believed complete recovery was possible. However the question within this study was asked as "People can recover from this disorder" with a choice of completely true, partly true or not true, with 87% selecting partly true. This is presented in a misleading manner in the results section as the question was not phrased in terms of whether complete recovery is possible, but in terms of whether they believed that it was 'completely true' that people do recover. However, 35% of the lay public thought it to be completely true that people recover suggesting a less negative view of recovery than the one held by professionals. One other study also found that, compared with professionals, the general public tend to rate positive outcomes as more likely and negative outcomes as less likely (Jorm et al., 1999).

More positively, Vendsborg et al. (2013) found that the majority of staff surveyed agreed recovery was possible for individuals with schizophrenia, and cited this was due to Denmark moving to a more recovery-oriented service structure. Prytys et al. (2011) found both positive and negative views were expressed about individuals' abilities to achieve social and occupational goals. Overall the picture with regard to potential outcomes varies immensely even within samples. It is not explored by the papers reviewed here, but it is likely that different groups hold different understandings of what 'recovery' means. By not acknowledging this within the interpretations of the data, the degree to which staff attitudes about outcomes can be understood is significantly limited.

It has been identified that lack of employment is common for individuals who experience psychotic symptoms and that staff attitudes may be a contributing factor. Marwaha, Balachandra and Johnson (2009) investigated clinicians' attitudes towards the employment of people with psychosis and found that clinicians only rated a small minority (average 11%) of their caseload as being capable of working full time and 40% of not being capable to work at all. Clinicians appeared to support the perceived advantages of employment, however, this appeared to be overridden by concerns about clients experiencing stigma in the workplace and the belief that work stress could lead to a relapse. It was concluded that clinicians do not have high occupational expectations for service users and possibly underestimate the type of work suitable for clients. On the other hand, studies have found that psychiatric staff scored significantly lower on underestimation of abilities than the general public (Hori et al., 2011) and are more likely to believe somebody with schizophrenia can work than relatives (Magliano, De Rosa, et al., 2004). It appears that staff attitudes concerning the degree to which individuals are capable of working are mixed and that these are likely to be influenced by their understanding of psychosis; however this has not been investigated.

There have been a number of studies suggesting that professional background may impact on attitudes with regard to the patient outcomes predicted by staff. Jorm et al. (1999) found that clinical psychologists rated positive outcomes as more likely and negative outcomes as less likely than psychiatrists and GPs. The authors argue that clinical psychologists may see clients with less severe difficulties. However, it has also been recognised that professionals have often undervalued psychosocial interventions. Caldwell and Jorm (2000) compared these findings with mental health nurses' attitudes and found that they were significantly more optimistic about recovery than other professional groups, but still less optimistic than the public sample. These studies highlighted that psychiatrists were most likely to hold negative beliefs about outcomes and least likely to think positive outcomes would occur. Contrary to this, Magliano, De Rosa, et al. (2004) found that psychiatrists were more likely to disagree that there was little to be done for people with this disorder than nurses, both doctors and nurses were significantly less likely to disagree than relatives. Findings suggest that area of work may also influence clinicians' beliefs about potential outcomes. Tiffin and Gasparyan (2009) found CAMHS psychiatrists to have a mildly more pessimistic view of prognosis than adult psychiatrists, which they argue may have a basis in reality as some evidence suggests earlier onset may lead to poorer outcomes. As contact under the right conditions has been shown to be an important factor in the development of attitudes (Couture & Penn, 2004; Pettigrew 1998), the type of contact experienced by different professions may contribute to understanding different professionals attitudes towards potential outcomes. Psychiatrists are likely to hold a more supervisory role with less contact with individual patients. It could be hypothesised that they are less aware of the more day-to-day indications of positive outcomes and progress made, and this might influence their views about potential recovery.

Overall, the literature suggests there is a range in the degree to which clinical staff believe positive outcomes are possible for individuals experiencing psychosis and that a number of factors may influence these attitudes. What is not clear is *how* these factors influence the attitudes held about potential outcomes and which attitudes are most effective in supporting individuals to reach their full potential.

1.5.1.4. Stigmatising beliefs and willingness for social contact.

In the public perception, individuals diagnosed with schizophrenia are often represented as violent, dangerous or aggressive, despite this being largely unsubstantiated (Swanson, Holzer, Ganju, & Jono, 1990). It has been shown that the public hold stigmatising opinions about the civil rights of individuals experiencing psychosis. An increased desire for social distance (for example not wanting to live next to, socialise or marry individuals with psychosis) has also been found. It has been suggested that because clinicians have more knowledge about and more contact with psychosis and schizophrenia, they would recognise these perceptions to be unwarranted (Van Dorn et al. 2005).

The studies reviewed here indicated that clinicians were less likely than the general population to endorse the likelihood of violence from people with schizophrenia (Vendsborg et al., 2013; Grausgruber, Meise, Katschnig, Schöny, & Fleischhacker, 2007; Van Dorn et al. 2005). Nevertheless, there was evidence that between a quarter (Grausgruber et al., 2007) and 76% (Kukulu & Ergün, 2007) of staff believed individuals diagnosed with schizophrenia to be violent, indicating that levels of stigmatising beliefs may vary within staff groups.

It has been highlighted that staff may hold more stigmatising attitudes when working with those diagnosed with schizophrenia than when working with other mental health diagnoses. Hansson, Jormfeldt, Svedberg and Svensson (2011) found that staff primarily working with individuals experiencing psychosis held more stigmatising attitudes. However, the questions used to assess stigmatising attitudes here appeared to be about how ‘most people’ would act and, therefore, may not mean that staff necessarily *hold* these attitudes, but are simply aware that others may hold them.

Despite many studies illustrating that psychiatric staff are less likely to endorse stigmatising attitudes when compared to the general public or other care staff (Hori et al. 2011; Nordt, Roessler & Lauber, 2006, Van Dorn et al. 2005; Ishige & Hayashi, 2005; Mittal et al., 2014), often professionals still show a similar or greater tendency for social distance. Nordt et al. (2006) found that staff showed a desire for greater social distance towards schizophrenia when compared to depression. The exception to this was the public health nurses (community-based mental health nurses) in Ishige and Hayashi's (2005) study who did not show a less socially accepting attitude when compared to other staff groups. The authors suggest this can be attributed to increased opportunities for community staff to see individuals engaging in full lives in the community. Again, cultural context may influence the preference for social distance. For example, professionals in the UK report less social distance than Saudi Arabian colleagues (Wahass & Kent, 1997), suggesting the development of attitudes is likely to be influence by a range of factors.

A higher level of education has been suggested to decreased desired social distance (Grausgruber et al., 2007). Kukulu and Ergün (2007) found that the greater closeness of contact needed, the more likely that nurses were to desire increased social distances, for example 63% would rent their homes to an individual with schizophrenia, 57% believed they could work with an individual with schizophrenia, and 43% would not be bothered about having a neighbour with schizophrenia, but 92% would not marry somebody with schizophrenia.

Largely, the evidence suggests that mental health professionals hold stigmatising attitudes to varying degrees. Although the studies here found evidence that clinicians are less likely to hold stigmatising attitudes to the general public, there is still some evidence of stigmatising beliefs. It appears that these beliefs are likely to be influenced by the type of contact and area of work. Furthermore, there may be biases in the way that many of the questions used to assess stigmatising attitudes were presented which limit the validity of the findings. There appear to be a number of factors that influence the attitudes held and the desire for social distance (such as culture, education, and opportunities to see positive examples) but again, a relationship between them has not been established. From the studies reviewed here, although professionals may hold less stigmatising attitudes, many still have a desire for increased social distance from individuals experiencing psychosis.

1.5.1.5. Summary.

The evidence above raises awareness that contextual factors are likely to impact on the attitudes held by staff members, as many of the studies found differing attitudes. Vendsborg et al. (2013) found less stigmatising attitudes than previous studies and they attribute this to Danish healthcare moving to a recovery-based model. From the studies reviewed here, the factors that may impact on attitudes held are: culture of country, professional background, area of practice (e.g. inpatient vs. outpatient, child vs. adult) and age of clinician. The process by which these factors may influence attitudes needs further investigation. Whilst it seems intuitive that different professional training might lead to different understandings of the aetiology of psychotic experiences, and that the causal and conceptual models that professionals have learned may influence the perceived effectiveness of different treatment options, there is a lack of coherence in the literature about this. Further research is needed to establish how the different attitudes about aetiology, treatment effectiveness, potential outcomes and stigma link together.

The results above appear to indicate that mental health staff generally endorse a more biological, illness view of psychotic experiences, in particular the diagnosis of schizophrenia. Although some studies state that ascribing to biomedical or genetic model leads to less stigmatising beliefs (Van Dorn et al., 2005), others suggest that a more biologically focused approach is linked with increased social distance (Wahass & Kent, 1997). The majority of studies highlighted that this differed from the psychosocial factors to which the general public, relatives and service users attributed these experiences. The studies differed in the conclusions drawn from these findings, often depending on the professional background of the authors. For example, the Magliano papers (Magliano, De Rosa, et al., 2004; Magliano, Fiorillo et al., 2004) say very little about the implications of the biomedical beliefs held by professionals. It appears that as the authors take these to be the “correct” beliefs. Conversely, relatives’ lack of endorsement for heredity explanations, and their tendency to favour a more psychological model, was attributed to feelings of guilt associated with [a presumed] genetic transmission. However, in the Jorm studies (Caldwell & Jorm, 2000; Jorm et al., 1997; Jorm et al., 1999), the authors highlight that these difference in beliefs needs to be bridged in order to promote engagement with services but do not suggest which set of attitudes need to be targeted. Further research is required to establish the conceptualisation of psychosis, and the associated beliefs about likelihood of behaviours, that promotes the least stigmatising attitudes and most effective way of engaging service users and families.

The majority of the research presented contradicts the assumptions made by many of the authors that increased contact with mental health automatically decreases stigmatising beliefs and highlights the complexity of attitudes (Hori et al., 2011; Caldwell & Jorm, 2000; Jorm et al., 1999). Several authors consider whether attitudes about outcomes have a basis in reality, as mental health staff have increased contact with more chronic, unwell individuals (Nordt et al., 2006; Caldwell & Jorm, 2000; Jorm et al., 1999). However, many of the authors cite concerns about the beliefs found being contradictory to research evidence (e.g. Marwaha et al., 2009; Van Dorn et al., 2005) it is important to understand how clinicians may be subject to a number of biases that influence the decision making process (Harding, 2004). It argued that when making predictions, individuals do not follow statistical theory but are reliant on limited heuristics (Kahneman & Tversky, 1973). If clinicians have experienced statistically rare events, such as individuals with psychosis being violent, they are more likely to base future predictions about behaviour on this experience than on the research evidence that this is statistically unlikely.

Furthermore, the findings suggest that, although clinicians hold less negative and stigmatising attitudes towards individuals experiencing psychosis, they still have a desire for social distance from them (Hansson et al., 2011; Hori et al., 2011). As social inclusion has been shown to be a key part of recovery from psychosis (Kelly & Gamble, 2005), it is important that clinicians hold attitudes that allow them to be role models and demonstrate inclusive behaviours towards individuals with psychosis.

1.5.2. Impact of Attitudes on Care Delivered

It is important to note that the presence of negative beliefs do not necessarily lead to discriminatory behaviour (Mittal et al., 2014) but the care delivered by staff working with individuals experiencing psychosis is likely to be influenced by their attitudes. Many of the above studies addressed the potential impact of attitudes found on engagement with services, underestimation of abilities and implementation of interventions in the discussion sections of their papers. Despite this, only three studies were found in this review that directly evaluated factors associated with care delivered. A summary is presented below of the areas that attitudes could impact on care identified by the studies, followed by the findings from the three studies evaluating aspects of care.

1.5.2.1. Areas for further research identified.

1.5.2.1.1. Engagement with services.

Several papers found staff to endorse a more biologically based model, whereas relatives, service users and the public preferred to hold a more psychological causal model. It was highlighted that differences in beliefs may have a potential impact on individuals seeking help, treatment engagement and adherence, and could result in conflict between individuals and services (Van Dorn et al., 2005; Magliano, De Rosa, et al., 2004; Jorm et al., 1997). It has been suggested that this difference needs to be addressed with health education campaigns (Jorm et al., 1997) and increased training in family psychosocial interventions (Magliano, De Rosa, et al., 2004). However, it is important to note here that these interventions are designed to help professionals target the attitudes of the public and relatives, rather than necessarily address professionals' conceptualisations and beliefs.

1.5.2.1.2. Underestimation of abilities.

Studies highlighted that staff may underestimate the ability of individuals diagnosed with schizophrenia to function socially. Marwaha et al. (2009) acknowledged that staff attitudes about capacity might impact on what information clinicians collect, the needs they identify and which interventions are offered. Several studies argue that mental health staff need to be aware of any negative beliefs that they hold as this can have a detrimental effect on interventions offered, and may thus affect outcomes; a low expectation for recovery may become a self-fulfilling prophecy (Caldwell & Jorm, 2000; Jorm et al., 1999).

1.5.2.1.3 Implementation of interventions.

Staff members holding negative beliefs about potential outcomes for schizophrenia could discourage nursing efforts, reduce ambitions for recovery, induce pessimism and hopelessness, and delay access to, or implementation of, potentially helpful evidence-based interventions. This is likely to have a knock-on effect for outcomes as delays in intervention has been shown to lead to poorer outcomes (Hansson et al., 2011; Caldwell & Jorm, 2000; Jorm et al., 1999). If staff believe specific services (e.g. supported employment agencies) to be ineffective, then they may be less likely to refer to potential organisations that may be beneficial (Marwaha et al., 2009). In particular, it was noted that negative attitudes about psychological interventions might contribute to lack of access to these, despite evidence that they are effective. Wahass and Kent (1997) argue that the implementation of psychological interventions is dependant on professional interest and confidence; if staff believe they are not effective, they are less likely to implement them. Additionally, Prytys et al. (2011) identified that biologically based models of psychosis can present a barrier for integration of psychological interventions into clinical care. However despite these concerns being discussed, further research is needed to investigate empirically the effects of beliefs on practice.

1.5.2.2. Studies evaluating aspects of care impacted.

1.5.2.2.1. Informing individuals of diagnosis.

Two of the studies reviewed here investigated psychiatrists’ attitudes towards schizophrenia and the impact of these on sharing the diagnosis with service users and families. Ucok et al. (2004) surveyed Turkish psychiatrists and found that only 40% always informed patients of their diagnosis and that they were significantly less likely to inform patients of a diagnosis of schizophrenia compared to mania, depression and delusional disorder. The most common reason endorsed was that patients could not understand the meaning of “schizophrenia.” Other reasons included believing that the patient would drop out of treatment, get demoralised or that the diagnosis would not be helpful to them.

Similarly, Ono et al. (1999) found that only 7% of Japanese psychiatrists always informed their patients of a diagnosis of schizophrenia, and that 52% did this on a case-by-case basis. The reasons cited were the perception that the term sounds negative and believing that this diagnosis would throw them into despair. The authors concluded that the assumptions psychiatrists hold about schizophrenia, and their negative impression of the term, are why the diagnosis is not always shared with patients. They argue that there is strong paternalism in the doctor-patient relationship and that not informing individuals stems from a desire to protect patients. They suggest that a new term that better sums up the disease and facilitates an easier understanding would be beneficial. It is important to bear in mind that the authors make reference to the specific Japanese term ‘Seishin Bunretsu Byou’ (meaning disease of the splitting of the mind) and how this can be misconstrued due to the structure of the Japanese characters and, therefore, caution must be used when generalising these findings.

1.5.2.2.2. Implementation of guidelines.

The National Institute for Clinical Excellence (NICE) in the UK publish guidelines providing evidence-based recommendations for care. Despite psychological interventions such as CBT for psychosis and family interventions (FI) being consistently identified as effective, Berry and Haddock (2008) identify that the routine implementation of them remains low. Prytys et al. (2011) conducted qualitative interviews with community mental health staff in order to identify any staff attitudes,which affect the implementation of NICE guidelines for psychological therapies. Staff expressed a mixture of views about psychological therapies. Some expressed views that CBT and FI do not work for individuals with psychosis. Whether a client was believed appropriate for referral for psychological work was not found to be based on research evidence. The authors concluded that pessimistic views about outcomes for schizophrenia and an ambivalent attitude to the possibility of recovery might constitute a barrier to implementation of interventions.

1.5.2.3. Summary.

The different attitudes held by staff members found may well influence the care delivered in a number of ways. It seems intuitive that differing beliefs between professionals and wider society, including those experiencing psychotic symptoms, may impact on when and where they are likely to seek help from. As early intervention with such difficulties has been show to promote better outcomes (Marshall & Rathbone, 2011), a key part of effective care and services is to conceptualise these difficulties in a way that resonates with those individuals experiencing them. The expectations that clinicians hold for their clients are likely to shape the care developed for individuals. If these expectations include underestimations of clients' abilities, preconceptions about prognosis, or misconceptions about treatability, then this could have serious implications for individuals experiencing psychosis. As 'hopefulness' has been shown to be a key factor in recovery from psychosis, it is important that clinicians hold attitudes that engender hope for clients and their families rather than hold them back (McCann, 2002). Furthermore, as clinicians' beliefs about the efficacy of different treatment options are likely to shape the interventions offered to individuals, this could limit the range of treatment options made available, excluding potentially beneficial ones. The research suggests that this may be particularly true of staff endorsing a biomedical model and not recognising the effectiveness of psychosocial interventions (Fowler, Garety & Kupiers, 1998).

However, as this review identified, empirical evidence is need to substantiate the relationship between attitudes and care delivered.

The evidence found here suggests that the expectations and preconceptions of the diagnosis, schizophrenia, impacts on the degree to which psychiatrists are willing to share this with service users and the implementation of psychological interventions. The findings that psychiatrists are not routinely sharing this diagnosis calls in to question the usefulness of the label, if sharing it is perceived to impede recovery rather than inform it. As it has been identified that evidencing and recommending specific interventions for psychosis has not been sufficient for them to be routinely implemented (Berry & Haddock, 2008), the findings of Prytys et al., (2011) suggests there is a role for improving clinicians attitudes towards them in order to further allow individuals with psychosis access to evidence based interventions.

1.6. Discussion

The studies reviewed above found a range of attitudes held by clinicians working with individuals experiencing psychosis with regards to the aetiology of experiences, treatment efficacy, potential outcomes and stigma. The finding that mental health staff hold negative and stigmatising beliefs has been identified in numerous other studies of psychiatric staff attitudes (e.g. Lauber, Nordt, Braunschweig, & Rössler, 2006; Schulze, 2007; Wahl & Aroesty-Cohen, 2010) The range of attitudes found supports findings that the development of staff attitudes about psychosis is complex and likely to be impacted by a number of factors (Hori et al., 2011). This review suggests that culture, professional background, area of practice and age may contribute to the development of different attitudes towards individuals with psychosis. Professional background and culture have been found to be contributing factors in previous reviews of the attitudes of mental health staff (Ucok, 2007; Des Courtis, Lauber, Costa, & Cattapan-Ludewig, 2008; Chambers et al., 2010; Wahl & Aroesty-Cohen, 2010). However, *how* these factors relate to the development of staff attitudes towards psychosis has not been clearly addressed within the literature thus far. It is apparent from the studies reviewed here that just increasing contact with individuals with mental health difficulties is not sufficient in reducing negative attitudes in staff teams (Nordt et al., 2006; Ucok, 2007). There is some evidence to suggest that some staff members, such as inpatient or probation workers, hold more stigmatising attitudes due to increased contact with individuals with more complex difficulties, and therefore the context of interactions must also be taken into account. The findings of this review illustrate the complexity of attitudes towards psychotic experiences and match previous studies that demonstrate that contact alone, and/or theoretical education, is not enough to reduce negative attitudes in mental health staff (Ucok, 2007). Theoretically, the contact hypothesis would predict these findings, which highlights that contact has to be under the right conditions to reduce out-group prejudice (Pettigrew, 1998). Furthermore, reviews of contact studies suggest that not enough is understood about the factors that are needed for contact to be effective at reducing stigmatising attitudes (Couture & Penn, 2003).

The literature investigating the impact of different attitudes held by staff members is sparse. This review only found three studies looking at the impact of attitudes on care, such as not informing individuals of their diagnosis or not implementing evidence-based interventions. Although many of the studies hypothesised how negative or stigmatising belief and attitude might impact on staff members' behaviours, this review found little empirical evidence about this process. This has implications for any interventions that have been designed to change staff attitudes.

Initial small-scale exploratory studies have suggested promising findings that interventions may be successful at helping staff to develop more positive attitudes about individuals experiencing psychosis. Research suggests that negative and stigmatising attitudes have an affective component, which needs to be considered in order to address any changes in attitudes (Addison & Thorpe, 2004). As increased knowledge about psychosis and contact with service users have not been shown to automatically eliminate negative attitudes in staff teams, there may be a role for reflective and experiential learning in order to shape more positive attitudes. Berry, Barrowclough and Wearden (2009) found that supporting staff to draw together psychological formulations helped staff to adopt more benign appraisals of problem behaviour when working with individuals experiencing psychosis. McLeod et al. (2002) found significant improvements in staff attitudes following a three-day CBT training course with specific exercises designed to increase understanding of experiencing hallucinations and delusions. It has also been found that training inpatient staff in a recovery-oriented cognitive therapy (CT-R) can have a positive effect on staff beliefs and a decrease in use of restraint and seclusion (Chang, Grant, Luther & Beck, 2014). However, without a thorough theoretical understanding of how staff attitudes are developed and the contributing factors, these interventions are limited. The results of this review backs up previous findings (Perkins et al., 2007) that there is a lack of use of attitudinal and behaviour change theories in relation to clinical staff and professionals. The implications of these findings for future research and clinical practice are discussed below.

1.6.1 Research Implications

The first issue that is apparent from reviewing the literature in this area is the lack of a reliable and valid measure of staff attitudes towards psychotic experiences. This has been a consistent criticism of research into attitudes (Link, Yang, Phelan, & Collins, 2004; Ucok, 2007; Wahl & Aroesty-Cohen, 2010). Future research needs to develop valid measures that reliably capture staff attitudes, and the factors that may influence them, that can be used consistently within this field, aiding in the synthesis of results from studies.

It is clear that further research is needed to understand how the different factors, such as age, professional background, link to how staff conceptualise psychotic experiences and their attitudes towards it. Although identified in discussion sections of many of the papers, further investigation is needed to evaluate what impact these different factors have on attitudes about which treatments are judged to be effective and the degree to which positive outcomes are anticipated. Research is also needed to test how these attitudes influence staff behaviours, and ultimately client outcomes.

Future research should also seek to make use of the wide body of literature relating to attitudinal change of service users and individuals, in order to apply it to staff attitudes. Theories, such as TPB and TRA as discussed in the introduction of this review (Ajzen, 1985, 1991; Madden et al., 1992) seek to change behaviour by understanding the key attitudes, norms and perceived control of behaviours. Therefore, to understand the behaviours and attitudes of clinicians, these theories will be imperative in being able to develop a model that accurately captures the development of more helpful attitudes to improve client care.

1.6.2. Clinical Implications

This review found evidence of negative and stigmatising attitudes towards individuals experiencing psychosis, although these appear to be influenced by a number of factors, such as culture or professional background. As discussed by many of the papers, the beliefs that clinical staff hold about potential outcomes and interventions are likely to influence the care they deliver to individuals experiencing psychosis. This means that individuals could be limited to accessing only those interventions deemed as effective by the individual clinician or team. Essentially, these individuals could be missing out on evidence-based interventions that are potentially beneficial to them. This appears to be especially true for psychological interventions for psychosis (Fowler, Garety & Kupiers, 1998; Prytys et al., 2011). In order to ensure that all service users have access to the high quality effective care, it is vital that staff attitudes are taken into account.

Several studies found that a biogenetic disease model is most strongly endorsed by mental health staff and that the majority view psychotic experiences as an “illness”, whereas relatives and the public give more weight to the role of psychosocial factors. This is not surprising, as the biological disease model has been the most prominent understanding of psychotic experiences (McGuire, 2000), as discussed in the introduction of this review. Additionally, in some cases with clear organic causes, this may the most appropriate method understanding and treatment. However, there is some initial evidence to suggest that attributing psychotic symptoms to mainly biological and genetic factors may lead to more stigmatising and unhelpful attitudes, whereas psychosocial models promote a more empathetic, contextual understanding of the difficulties. This has been backed up by findings that anti-stigma campaigns that adopt a biogenetic approach can serve to perpetuate negative attitudes (Lincoln, Arens, Berger, & Rief, 2008) and psychiatric campaigns have been criticised for de-stigmatising psychiatry itself rather than promoting understanding of these experiences (Schulze, 2007). Read and colleagues (2006) argued that viewing a mental health problem as essentially a result of biology can promote the perspective that it uncontrollable in nature and believing it is discrete “can promote the view that people are categorically different from normality, rather than sharing in our common humanity” (p. 312). Although the findings above have been established with general public studies, little consideration has been given to the implication of this for staff members working in mental health. Further research is needed to fully understand the mechanisms by which solely attributing psychotic experiences to biological causal factors underpins stigmatising attitudes. Nonetheless, it has serious implications for the way that services supporting those experiencing psychosis are structured and the models of understanding that staff working in those services are trained in.

From the findings of this review, any interventions implemented by service providers to target staff attitudes should consider the role of experiential and reflective learning, as simply increasing knowledge and contact has been shown not to eliminate negative attitudes.

1.6.3. Limitations

There are several limitations to findings presented in this review. This paper sought to investigate attitudes of staff teams working directly with psychosis and the attitudes they may hold. However, there appears to be a variety of perspectives held, which may be influenced by professional background and training received. This, therefore, may limit the validity of grouping “staff” or “clinicians” together for search purposes and a clearer picture may be given by reviewing the different professional groups separately.

As this review sought to evaluate attitudes solely relating to psychosis and a schizophrenia diagnosis, papers evaluating attitudes toward mental health more generally were excluded. Consequently, there may be studies investigating mental health attitudes that included relevant sections about psychotic experiences that were overlooked by this search.

1.6.4. Conclusion

In conclusion, the research investigating staff attitudes towards psychosis suggests the presence of a range of attitudes that are influenced by a number of factors. There is a lack of theoretical understanding of the factors that may influence behaviours. It is not clear why the theories used to understand clients’ attitudes and behaviours have not been applied to clinical staff. Any future research and clinical interventions to target staff attitudes should take this into account. There is some initial evidence to suggest that negative attitudes can affect clinical care and that future research is imperative to help develop staff develop attitudes that guide the best possible client care.

1.7. References

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2. Empirical Paper: Which Wolf To Feed? Exploring Clinicians' Experiences of Hope and Recovery Whilst Working with Individuals with First Episode Psychosis

2.1. Abstract

Introduction: Previous conceptualisations of psychosis as a chronic lifetime illness have impacted on the way services respond to individuals seeking help with these experiences. These responses have been criticised for being overly pessimistic and paternal. The recovery movement has called for a new, respectful and empowering response from services to psychotic experiences. Early Intervention (EI) services were developed in response to criticisms that fear of outcomes had led to reluctance to identify psychotic symptoms and aimed to engender a culture of optimism and expectations of recovery.

Aims: To explore clinicians' experiences of recovery from psychosis whilst working in EI services and how recovery-based values impact on the care they deliver. Furthermore, it aimed to investigate how hope for recovery might be developed within therapeutic relationships.

Method: A small-scale qualitative design was employed to allow in-depth explorations of the experiences of staff. Six clinicians from EI took part in-depth interviews, which were analysed using Interpretive Phenomenological Analysis (IPA).

Results: Seven main themes were developed from the data; Understanding the Psychosis in the Context of People's Lives, Taking Control of the Psychosis, Inspiring Hope, Is Recovery the Destination or the Journey? It's Out of My Control, Nothing Seems to Work for Some Clients, The Relationship is Where the Magic Happens and I Couldn't Do It Without My Team.

Discussion: The results indicate that the clinicians who participated in the study hold many of the recovery movement's values as central to their role in supporting people experiencing psychosis. Recovery is a complex, meaning-laden process that requires clinicians to be

reflective about their work and the underpinning approach. Furthermore, this process of reflection needs to be supported by organisational structures and policies.

2.2. Introduction

The medical model has dominated treatment options and services for those experiencing psychotic symptoms such as hallucinations and delusions, and therefore the definition of a good outcome has been analogous to a ‘cure’ and reliant on a decrease in symptoms and hospitalisation (McGuire, 2000). It has been viewed that experiencing such symptoms is indicative of the illness ‘schizophrenia’, a life-long chronic condition, within which recovery from such experiences was not expected (Kelly & Gamble, 2005). The work of Kraepelin and Bleuler describes individuals as having an incurable degenerative illness and that they would experience an inevitable decline in outcomes (Read, 2013). This viewpoint has influenced the way these symptoms are perceived in current psychiatry and is argued to have stifled therapeutic efforts to support individuals with these experiences (McGorry, Killackey, & Yung, 2008).

Despite psychotic experiences being conceptualised this way within mainstream psychiatry, a service user-led recovery movement has argued against these ideas. The recovery movement has called for recovery from psychosis to be viewed as a more complex, idiosyncratic, non-linear process involving moving towards a meaningful life and personal growth, regardless of the presence of symptoms. It has been described as ‘recovering a new sense of self’ and ‘taking back control’ (Deegan, 1993). Many of these recovery journeys were described in first-hand accounts written by individuals who have experienced psychosis such as Deegan (1988), Leete (1989), Lovejoy (1982) and Unzicker (1989). Pitt, Kilbride, Nothard, Welford and Morrison (2007) investigated service users’ subjective experience of recovery from psychosis, drawing out themes of hope for a better future, rebuilding life and rebuilding self. Hope has been consistently acknowledged to play a key role in recovery and is identified as a main component in the model of recovery developed by Andresen, Oades and Caputi (2003).

The growing recovery literature has implications for services aiming to provide support for individuals experiencing psychosis. Pitt et al. (2007) argue that in order to promote recovery, services need to focus on providing continuity in care, greater service user choice and access to more stories of recovery. A potential tension between the survivor movement and traditional service implementation has been identified by Allott, Loganathan and Fulford (2009). Although the recovery movement seeks to empower individuals to promote their own recovery, it is recognised that, for some, services play an important role in that. They suggest that the recovery movement is not against service use but that it seeks a new respectful and empowering response from services to psychotic experiences. Therefore, it is a movement away from services and professionals having ‘power over’ individuals to ‘cure’ them but power to play a role in and facilitate an individual’s recovery. Studies suggest hope for recovery needs to be ‘uncovered, supported and encouraged’ rather than imposed by clinicians (McCann, 2002) and fostering a meaningful therapeutic relationship with clinicians can be a catalyst for developing hope for recovery (Byrne et al., 1994). Therefore, clinicians working with individuals experiencing psychosis have a key role to play in the promotion of recovery.

Early Intervention (EI) services for psychosis were developed in response to concerns that an exaggerated fear of outcomes had led to traditional service models avoiding identification of psychotic symptoms until they had reached a certain severity to be sure of diagnosis (McGorry et al., 2008; Singh & Fisher, 2005). Following this, EI services were set up in number of countries, including the UK, with the key aim to ‘maximise optimism, engender hope and ensure service delivery in low-stigma settings’ (Singh & Fisher, 2005). In

2014, there were over 120 EI services identified in the UK to provide services for young people experiencing first episode psychosis (Birchwood, 2014) and national evaluations of UK EI services are showing promising clinical and economic results (Birchwood et al., 2014; Lester et al., 2011; Marshall et al., 2014; McCrone, Craig, Power, & Garety, 2010). The Schizophrenia Commission (2012) report highlights that EI teams are effective and valued by individuals and their families for the ethos and approach taken by these teams. The National Institute for Health and Care Excellence (NICE, 2014) recommends that EI services should be available to all individuals experiencing first episode psychosis. Service users under the care of EI value the positive relationships developed with individual key workers in non-stigmatising settings, such as the individual’s home or community venues (Lester et al., 2011). Recovery features heavily in the EI literature and the EI model embraces many of the recovery movement’s values. *Early intervention and recovery for young people with early psychosis: consensus statement* (Bertolote & McGorry, 2005) states generating optimism and expectations of recovery is a key vision for EI services, alongside valuing respect for young people’s right to recovery and social inclusion.

2.2.1. Study Aims

It is clear from the literature that services, in particular EI, are developing models to promote recovery and move away from traditional, pessimistic and biologically focused treatments for individuals experiencing psychosis. It has been highlighted clinicians have a role to play in recovery from psychosis for some individuals. However, it is yet to be explored how staff members experience working within EI and the values and ethos of a recovery-based service model. Furthermore, it is also unclear how key factors, such as hope, that contribute to recovery, are understood by clinicians working in EI services.

Therefore, the aim of this study was to explore how clinicians experience recovery from psychosis whilst working within EI services. It is hoped that by interviewing clinicians currently working within EIS, experiences of recovery can be explored, offering insight into whether recovery-based values impact on clinicians and the care they deliver. Furthermore, it aimed to investigate how hope for recovery might be developed within therapeutic relationships and how this is experienced by clinicians. The findings from this study will hopefully allow a deeper understanding of clinicians' experiences of working in EIS, in particular, how they experience recovery and hope in the work that they do.

2.3. Method

This study was conducted with an exploratory qualitative design in order to investigate staff experiences of working in EI as part of RC's DClinPsych thesis. RC previously worked as a research assistant and assistant psychologist in EI prior to starting her clinical training (Appendix 1). The University of Birmingham Ethical Review Committee approved the study protocol (Appendix 2).

2.3.1. Context and Recruitment

Birmingham EIS was the primary EI service to be set up in the UK and was established in 1990. It is a three-year community service designed to support young people aged between 14 -35 years old, experiencing a first episode of psychosis. EIS has a holistic approach to helping individuals explore and deal with their experiences and focuses on making a personally meaningful recovery. The service covers the whole of the Birmingham and Solihull region and is split into locality teams. The population covered includes a range of diverse cultural backgrounds and number of deprived areas. Two of these locality teams were approached to take part. A purposeful sampling approach was used to identify a homogenous group with experience of the phenomena under investigation. The smaller sample size was opted for due to the qualitative design of the study and to allow for the depth of experience to be explored sufficiently as per recommendations made by Smith, Flowers and Larkin (2009).

Team meetings (June 2015) were attended for the two localities participating in the study, where the aims of the study were described and participant information was given out (Appendix 3). The members of the teams present at the meetings were then contacted by email to formally invite them to take part in the study. For those who expressed interest in involvement, a time and place was arranged for the interview to take place at the participant's convenience.

2.3.2. Sample

A total of six participants took part and demographic details are presented in Table 1.

Pseudonym	Gender	Age	Ethnic background	Professional qualification	Years qualified	Areas worked in prior to EI	Years worked in EI
Betty	Female	41	White British	Post-graduate diploma in MH nursing	14	Acute in-patient, community mental health	11
Sarah	Female	38	White British	RMN (RN13)	15	Forensic, elderly, learning disability	13
Paul	Male	44	White British	RMN	13	Rehabilitation, in-patient	7
James	Male	52	White British	RMN	25	Assertive outreach team, rehab, Child and adolescent mental health, community mental health	10
Adam	Male	Not available	White British	RMN	Not available	Personality disorders	Not available
Charlie	Male	42	White British	Dip H.E Nursing	13	Assertive outreach team	8

Table 1: Participant demographics

2.3.3. Data Collection

Following written informed consent, the researcher (RC) conducted a single semi-structured face-to-face interview with each participant, lasting on average one hour. Recruitment and data collection took place between June to September 2015.

The in-depth interviews collected were audio recorded and transcribed verbatim by RC. Interviews were based around a topic guide (Appendix 4) designed to prompt exploration of the participants' experiences of working in EIS, their perceptions of recovery, and the concept of hope in the context of the clinicians' work. This was constructed based on previous research findings and was reviewed by EIS service users to ensure the issues most pertinent in their experiences of recovery, hope and the therapeutic relationship were captured.

2.3.4. Data Analysis

Interpretive Phenomenological Analysis (IPA) was conducted in order to investigate themes in experiences of working in a recovery-oriented service and hope in the therapeutic relationship. IPA aims to identify how individuals experience life-events, and how these events are interpreted and given meaning (Larkin, Watts, & Clifton, 2006) and the analysis process was guided by the description provided in Smith et al. (2009). The researcher (RC) undertook several readings of the transcripts and completed line-by-line coding, to identify any extracts of descriptive, linguistic or conceptual interest. This allowed RC to develop an in-depth understanding of the data collected and create initial interpretations of meaning. Following this, RC constructed initial emergent themes from the exploratory comments and the original transcript. An extract demonstrating the interpretative process of line-by-line coding and emergent themes is included in Appendix 5. The emergent themes were taken from the data and arranged visually by the researcher to pull out patterns and connections

In summary, this theme highlights how security and sense of safety within the team is key to being able to manage the challenges of the role. Organisational changes are perceived to be a threat to this, however participants feel powerless to change this.

2.5. Discussion

The analysis of this study has suggested several key themes around the unspoken aspects of working to promote recovery from psychosis. Throughout the interviews, there was clear sense of dedication and pride taken in the work conducted by these individuals. The interactions between the participants and their clients were meaning laden and thus, more than simple clinical transactions. Furthermore, the organisational systems that support clinicians play a key role in the degree to which recovery can be promoted. How these themes fit with existing literature are discussed below. Table 3 illustrates the clinical implications arising from the themes discussed.

2.5.1. Supporting Holistic Recovery

The descriptions collected show that for EI staff, clients are viewed as more than just their illness or symptoms; individuals are seen within the context of their own lives. Furthermore, they are seen in their familial, social and cultural context. Pitt et al. (2007) found that active participation in life and rebuilding social support were key aspects of recovery for service users. The findings of this study suggest that clinicians are actively engaged with, and truly value, the wider context of recovery.

Previous research has suggested that, although family can play a key role in supporting recovery, often they are not routinely included in care (Gamble, 2004). However, for the participants of this study, working with families was a readily accepted part of their role; they were very much viewed as ‘part of the package’. This is consistent with relatives’ experiences of staff in EI as supporting, care-giving and listening to worries about their relatives (Lavis et al., 2015). Failing to register familial and cultural understandings of experiences may result in clinicians not properly responding to individuals' distress (Bentall, 2003). Effectively engaging with the family required openness, acceptance and skilful negotiation of different viewpoints, as the families often held different cultural beliefs to those of the participants. This appeared to take time, and at points was challenging for the participant but ultimately beneficial. Thus, by incorporating families, culture and context, the participant appears able to support clients to rebuild social relationships and a meaningful life.

Experience Described	Associated Themes/ Subthemes	Clinical Implications
Complexity of working with different beliefs in the family system.	*Clients are part of families too.*	• Time to involve family to be factored into working day. • Skills training in working effectively with family systems. • Protected time for structured family work.
Value of supporting social activities.	*Psychosis is more than symptoms.*	• Resources to be available to effectively support social engagement. • Ensure time is available to promote social activities.
Helping clients to reach set goals.	*Is recovery the destination or the journey?*	• Space (e.g. informal contact time with colleagues, reflective groups) for staff members to consider the role of achieving goals in the context of developing a meaningful life.
Empowering clients to take control.	*Taking control of the psychosis* *Empowering clients as equals* *Seeing the bigger picture*	• Explicit consideration of power dynamics in relationships. • Organisations to consider how to best implement processes, such as hospitalisation, in the least disempowering way.
Psychosis being viewed as "just an illness".	*Taking control of the psychosis*	• Consideration of how different conceptualisations of psychosis might impact on staff attitudes. • Formulations of different understandings of psychosis to be shared within staff teams.
Hope being overshadowed or lost.	*Holding onto one's own hope.* *It's out of my control; nothing seems to work for some clients.* *I couldn't do it without my team.*	• Ensuring recovery is made visible to clinicians such as contact with clients in recovery. • Risk management procedures to consider how to ensure hope for positive outcomes are incorporated. • Protected space (e.g. informal contact time with colleagues, reflective groups) for clinicians to formulate hope for recovery with complex clients. • Access to interventions that incorporate the role of, and effectively target, the impact of possibly harmful life events.

Table 3: Clinical implications and relevant themes

Experience Described	Associated Themes/ Subthemes	Clinical Implications
Sharing stories of recovery.	*Giving hope to others.*	• Opportunities for clients to share recovery narratives, e.g. through groups or networks.
Being dependable and earning clients' trust.	*Developing a secure base.*	• Application of attachment theory and its role in clinical care.
Difficult emotions in response to clients' experiences and fears of becoming cut off.	*Dilemma of emotional connection.*	• Ensuring team organisation allows for informal contact with colleagues to support with emotional processing within a protected safe space. • Ensure risk procedures do not overwhelm clinicians and include consideration of emotional impact of risk events on clinicians and teams.
Standardised paperwork lacking meaning.	*Paperwork fails to capture value of relationship.*	• Organisational audit processes and paperwork to be more sensitively implemented to support the development of the relationship and the individuality of recovery.
Team support creating sense of shared responsibility.	*Dilemma of emotional connection.* *I couldn't do it without my team.* *Organisational changes threaten our team security.*	• Dedicated, consistent physical space for teams to sit in to create security and belonging. • Emotional needs and support to be considered during organisation change to ensure security is maintained. • Informal and formal contact with colleagues and team to be carved out to generate optimal working environment.

Table 3: Clinical implications and relevant themes

Recovery was recognised to be a highly individual process, including making sense of experiences and living a meaningful life, as consistent with service user accounts (Deegan, 1993). However, there were still a number of times that recovery was conceptualised as an outcome or achievement to be worked towards, despite these achievements being accepted to be different for different clients. This is in direct contradiction to the recovery literature, which focuses on the ongoing process of recovery rather than viewing it as a set outcome (Deegan, 1996). However, it is important to recognise that setting and achieving goals often forms a vital part of recovery (Andresen et al., 2003; Wilken, 2007). The lack of clarity in participants' data may indicate the complexity of recovery and confusion about how different components of recovery interact. Furthermore, there was some uncertainty about whether recovery meant moving forward from the psychosis or helping clients to get back to who they were before. Whilst much of the literature advocates that recovery is about integrating the experiences and developing a life which incorporates them, it is clear that for many clients, recovery can be understood to mean returning to the state prior to the illness (Andresen et al., 2003; Whitwell, 1999). This complexity of meanings presents challenges for clinicians working with clients to create a shared definition of recovery (Aston & Coffey, 2012). It is crucial that staff hold a clear understanding of the role of goals in a recovery conceptualisation that is about the process rather than the outcomes.

2.5.2. Issues of Control

An ability to understand clients' difficulties in their context was mainly highlighted as a positive but sometimes this raised interesting dilemmas for clinicians. When they were able to spot potential causal or perpetuating factors such as drug use, but clients were unwilling or unable to change these, clinicians experienced feelings of helplessness and frustration. This suggests staff feel that to a degree, the responsibility for change lies with the client. This fits with service users’ descriptions of empowerment and taking control of own recovery, which is viewed as a positive (Andresen et al., 2003; Deegan, 1993; Wilken, 2007) . This was also recognised as beneficial within the subthemes of *Empowering clients by viewing them as equals* and *Taking control of the psychosis*. Therefore, despite some frustration at times of not being able to *do* something active to help the client, the value of supporting them to take ownership of their recovery supersedes this and helps clinicians to manage these feelings.

The participants in the current study described a process of taking control from the psychosis and feeding it back to clients over time. This served to remove the fear from the psychosis and contain the client. A period of crisis and disorientation is described in many models of recovery. Wilken (2007) argues that this is a process of reconnecting to the world and coming to terms with the self. Andresen et al. (2003) describes a period of *moratorium* characterised by confusion and helplessness, as the initial stage of recovery. If clinicians are not fearful of the psychosis and are able to calmly implement steps to manage distress, it could be potentially reassuring during this time of confusion. However, some ‘controlling’ processes such as hospitalisation are experienced as coercive and distressing to service users (Gilburt, Rose, & Slade, 2008; Loft & Lavender, 2015). Participants recognised the implications of such processes for clients and spoke about these as a last resort, illustrating the complexities of power dynamics within the therapeutic relationship. Distribution of power has been a key area of interest in the literature discussing ways to move towards more recovery-based services (Allott et al., 2009; Masterson & Owen, 2006), and the findings of this study highlight that the interaction of empowerment and relationships with services is a complex and changeable process.

Several participants highlighted a need to view the psychosis as “just an illness” in order to reduce the fear and hopelessness associated with it. Studies have suggested that viewing psychotic experiences as solely attributed to biogenetic causes may increase negative attitudes toward outcomes (Schulze, 2007). Read and colleagues (2006) argue that believing mental illness to be a discrete biological product can elicit further beliefs about categorical difference, which reduces commonality between individuals. However, it appears that for the participants of the current study, “just an illness” was part of a wider contextual understanding that also valued viewing the person in context and equality within the therapeutic relationship, which may have served to prevent such attitudes. Thus, the way that psychosis is conceptualised is complex in nature, without a particular viewpoint being right or wrong; rather openness to exploration is important.

2.5.3. The Role of Hope

Hope was considered to be intrinsically linked with recovery and was experienced as a future-oriented belief that positive change was possible. Within Andresen and colleagues' (2003) conceptual model of recovery, the importance of hope is highlighted. The themes of future improvement and positivity are common within definitions of hope (Miller, 1992; Snyder, Michael, & Cheavens, 1999). Andresen and colleagues (2003) also concluded that hope can be developed from within the person experiencing psychosis or elicited from others around them. Participants described two aspects of hope in their role to support recovery, hope for themselves that recovery was possible and the process of instilling hope in clients. A major aspect of clinicians being able to hold onto hope was being able to *see* evidence of recovery and being able to share this evidence to inspire hope in others. Facilitating sharing stories of recovery was highly valued as a way of inspiring hope for clients, either through allowing opportunity for clients to meet or imparting stories or quotes. The importance of developing and sharing personal stories of recovery has been acknowledged to be a powerful tool for the individual (Gold, 2007; Thornhill, Clare, & May, 2004) but the impact of hearing these stories has yet to be explored.

Despite hope being cited as essential to recovery, there was a sense of fragility to hope experienced by clinicians. At times hope could be difficult to sustain. A focus on risk and complex clients was felt to overshadow hope. Whilst congruent with the previous recovery data about the importance of hope, the findings of the current study add a further dimension about the fragility of hope for staff members and the need to protect it within clinical care. It is important to understand any potential threats to staff members' hope, considering fundamental relationship to recovery and the role they play in supporting it.

Participants spoke about particular clients for whom recovery seemed impossible. At times, the clinicians felt overwhelmed by the severity and chaotic nature of their situations. Nothing seemed to work for these clients. Participants expressed a regretful acceptance that recovery is just not possible for everybody. One explanation for this could be a residual belief from the pessimistic chronic illness models discussed in the introduction; the belief that some people have “proper schizophrenia” (just not everybody who experiences psychotic symptoms). This could explain the view that traditional psychiatric treatments are the only option for such cases. However, it may be more complicated than that. To simply state that recovery is available to everybody (Shepherd, Boardman, & Slade, n.d.), neglects valid challenges faced by clinical staff working with these complex problems. This is particularly true when the meaning of ‘recovery’ that is activated relates to outcome rather than process. Participants accepted that despite their best efforts, some individuals' situations might not change. This reflected a belief that symptoms may persist alongside the chaos and distress in peoples' lives. Indeed, not one study of any intervention (biological, psychological or social) yields100% success rates in any field. The attributions made by staff about these difficult situations, is likely to impact on the degree to which they feel hopeful about overcoming them. Participants described a sense of determination suggesting that they did not attribute the hopelessness to the individual (i.e. it was not that some people are inherently ‘beyond help’). Rather there was a lack of resources to be able to effectively take into account and manage the complexity of harmful life events, especially when the severity of these is overwhelming. How we manage the impact of complex cases on clinicians’ conceptualisations of hope and recovery appears to have been neglected in the current recovery literature and is likely to be imperative in continuing to provide recovery-based services that meet all clients’ needs.

2.5.4. Complexity of Relationships

The relationships developed with clients were viewed to be meaningful opportunities to demonstrate the worth of the individual and create a space for exploration. The need to create safety from which independence rather than dependency could be created are consistent with the idea of a secure base within attachment theory (Bowlby, 2005). Berry and Drake (2010) argue that attachment theory within clinical practice can help staff to balance provision of reassurance and the encouragement of independence through recognising the importance of the relationship. Thus, an understanding of the role of a secure base within relationships may further benefit clinicians.

Within the relationships, participants valued being able to make emotional connections with clients that served to promote empathy and warmth. This, however, came with risk of being overwhelmed or burdened with the struggles that clients were experiencing. This is consistent with the idea of emotional labour within nursing, described by Guy, Newman, Mastracci and Maynard-Moody (2010) as the management of clinicians’ own emotions and behaviours in interpersonal reactions. It has been suggested that emotional labour features heavily for mental health nurses and contributes to levels of stress (Mann & Cowburn, 2005) and, thus, effective management of emotions elicited within the relationship is essential.

Literature suggests that the role of the therapeutic relationship in working with individuals experiencing psychosis has often been neglected (Hewitt & Coffey, 2005; Repper, 2002), and whilst the participants placed great emphasis on the importance of this, there was the sense that this was not reflected in the organisational processes, such as care plans. The intangible nature of the relationship suggests that organisational processes need to be better able to ensure the relationship has the required space and time to develop, and that paperwork can accurate capture the meaningfulness of this.

2.5.5. Risk Management

The management of risk posed a real threat to the degree to which participants felt they could be recovery-oriented and was raised in the sub themes, *Dilemma of emotional connection* and *Focusing on risk threatens hope for recovery*. The pressure arising from the system was deemed to change participants' focus so deeply that often the meaning of terrible incidences was lost. The conflict between risk management and community care is highlighted by Hewitt (2008), warning that a "better safe than sorry" approach is "pragmatically and ethically flawed" (p186). The focus on risk was experienced to serve mainly to protect the organisation from blame and place responsibility on the individual clinician if not completed. If recovery is essentially about empowerment and the relinquishing of services' control, and if risk management is about active preventative processes that enforce individuals to conform, then ultimately the two practices are at odds. Thus, the way that they are implemented within care needs careful consideration by organisations.

2.5.6. Team Working

Participants spoke highly of their colleagues and team dynamics were considered to be essential in helping individuals to fulfil their roles. The support, both emotional and practical, provided by the team created a sense of safety and shared responsibility. Relationships with colleagues have been found to be a significant source of support in other studies evaluating staff satisfaction, and appear to play a role in preventing burnout and managing the emotional demands of the job (Leiter, 1988; Molyneux, 2001; Reid et al., 1999). A fundamental part of managing the *Dilemma of emotional connection* was conversations with co-workers, which allowed difficult emotions to be processed. Qualitative investigations of staff stress have also found informal contact with colleagues to be a valued coping strategy (Reid et al.,1999).

However, concerns were raised by participants about the threat of organisational change to this valued way of working. It was perceived by staff that the organisation did not attribute enough worth to these valuable team processes. In order to effectively deliver care, thorough consideration of interpersonal environments is vital (Leiter, 1988).

2.5.7. Limitations

IPA utilises a smaller sample size to allow in-depth analysis of experience pertinent to a specific group (Smith et al., 2009). Thus, the findings of the current study cannot be readily generalised outside of the specific context and no claims of causality can be made. However the themes illustrated here are consistent with much current literature seeking to understand recovery and serve to deepen our understanding of the experiences of clinicians providing recovery-oriented care.

The themes developed from the data collected are interpretative in nature and thus are likely to have been shaped by pre-existing ideas about recovery held by the researcher, which is widely accepted as part of the interpretive process (Smith et al., 2009). In order to further improve the credibility of themes, triangulation with participants and the further team would be beneficial. However, it was not currently possible due to time limitations and the team undergoing a process of organisational change.

2.5.8. Conclusion

In summary, the above findings demonstrate an insight into the experiences of clinicians working in the EI model to support individuals with psychosis. It appears that clinicians working in EI have embedded many of the core tenets of the recovery movements values into their clinical work but that this has not been without challenges. Recovery is a complex process that requires clinicians to be reflective about their work and any underpinning approaches. It is not a set, prescribed procedure and as such necessitates time and reflective space, in particular in the form of regular contact with colleagues and team. In order for recovery to be facilitated, organisations must address risk policies and service structures to support the intangible elements of therapeutic care.

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3. Public Dissemination Document: Which Wolf to Feed? Staff's Experiences of Hope and Recovery

This document describes a research project investigating the way staff members think and feel about working with people experiencing psychosis. The project consisted of two parts; a review of the literature relating to staff attitudes about psychosis and qualitative investigation of staff experiences of working in Early Intervention. The research was done as part of the author's clinical psychology training.

3.1. Literature Review

3.1.1. Introduction

In the past when people have experienced psychotic symptoms, such as hearing voices or having fixed unusual beliefs, this has been thought to automatically mean that they have schizophrenia. This illness was seen as very disabling with little chance of improvement (Kelly & Gamble, 2005). However, more recently people who have had psychosis have spoken about living a meaningful life in spite of having psychotic experiences (Deegan, 1988). There are also theories that look at the role of interpretations and beliefs (Fowler, Garety, & Kupiers, 1998), the impact of trauma (Morrison, Frame, & Larkin, 2003) and changes in the structure of the brain (Lautenschlager & Förstl, 2001). These different theories of why people experience psychosis are likely to impact on how mental health staff members understand these experiences. Some studies of mental health staff's attitudes have found evidence of negative and stigmatising beliefs, in particular about psychosis (Wahl & Aroesty-Cohen, 2010). These findings raise concerns about the impact of negative attitudes on patient care.

3.1.2. Aim

The aim of this review was to look at studies that have investigated the attitudes of clinicians working directly with psychosis and any impact of these attitudes.

3.1.2. Method

Electronic databases were searched to find articles that looked at staff attitudes towards psychosis and schizophrenia. Articles were screened and excluded if they were not available in English, looking at general health care staff or students' attitudes, not about psychosis specifically or about attitudes towards medications. The reference lists of the articles included were screened to find any other relevant papers. A total of 22 papers were included.

3.1.3. Findings

The papers reviewed found a range of attitudes about; factors that may contribute to the development of psychosis, how effective different treatments are, potential outcomes for people with psychosis and stigmatising beliefs. This review found that culture, professional background, area of practice and age might influence different attitudes but *how* these factors do this has not been thoroughly researched. The findings support that contact with people experiencing psychosis has to be under the right conditions to reduce stigma and negative beliefs for staff attitudes. Staff attitudes were found to impact on whether psychiatrists would inform their patients of a diagnosis of schizophrenia and whether guidelines about psychological treatments would be followed.

3.1.4. Discussion

The development of staff members' attitudes is complicated and most studies have looked at what the attitudes are, not at how factors such as culture and professional background might have influenced them. The results of this review backs up previous findings (Perkins et al., 2007) that theories about attitudes and behaviour change have not been used to explain clinical staff's attitudes. There was some indication that staff who view psychosis to be mainly caused biological and genetic factors may have more stigmatising attitudes and be less hopeful about recovery. It is important to do further research to better understand how to help staff develop positive attitudes that promote high quality clinical care.

3.2. Research Paper

3.2.1. Introduction

The view that experiencing psychotic symptoms, such as hearing voices or having fixed unusual beliefs, indicates a long term, chronic illness has impacted on how services respond to people needing help with these. Services have been criticised by people with psychosis for being overly pessimistic and viewing controlling symptoms as the only important treatment option (McGorry, Killackey, & Yung, 2008; McGuire, 2000). A recovery movement led by individuals who have experienced psychosis has called for a new, respectful, empowering response from services (Allott, Loganathan, & Fulford, 2009; Pitt, Kilbride, Nothard, Welford, & Morrison, 2007). Early Interventions (EI) services were set up to support individuals experiencing psychosis in a way that promotes recovery and optimism (Singh & Fisher, 2005).

3.2.2. Aim

This study aimed to ask clinicians about their experiences of recovery from psychosis whilst working in EI services. In particular, it looked at whether recovery-based values in EI have any impact on the way they work. It also aimed to ask participants about what role they felt hope for recovery might have and how this is developed.

3.2.3. Method

A qualitative design was used. Interviews were done with six clinicians from EI, where they were asked about their experiences of working in EI, their thoughts about recovery from psychosis and the role of hope in recovery. These interviews were analysed using Interpretive Phenomenological Analysis (IPA, Smith, Flowers & Larkin, 2009), which aims to discover themes in the data that help us to understand the core aspects of working in EI.

3.2.4. Findings

Seven main themes were found to be important to participants' experiences of working in EI. Participants spoke about viewing individuals as more than just their symptoms and understanding their whole lives. The psychosis was seen as 'taking control' of people's lives and part of their role was to help take this control and then give it back to the person. Hope was described in two ways, having hope for themselves that the work that they do will be helpful, and being able to share and inspire hope in clients. Recovery was found to be complex and personal to the individual. Participants talked about recovery in terms of the process of recovering e.g. like a journey. However, participants also talked about recovery like it was set goal or aim at times, so the role of setting goals in recovery was not clear. Participants spoke about some clients, for whom it felt like no matter what they tried, recovery was not happening and how it was difficult to hold onto hope at these times. The relationships built with clients was seen to be a key part of helping people but that the time and effort this takes was not appreciated by higher management, because it is difficult to measure. Participants felt that the support of their team was very important to help them with the difficult aspects of their job so that they could be in the best position to support recovery for their clients. A summary of the themes is presented in Table 1.

3.2.5. Discussion

The results showed that the clinicians who participated embrace many of the recovery movement's values and are dedicated to helping individuals with psychosis create a meaningful life. Recovery is a complicated process that means different things to different people. The role of supporting individuals to recover, calls for clinicians to be flexible in their approach and value the client as a person. This needs to be supported by the way organisations (e.g. NHS trusts) structure teams and the support that they give staff. In particular, organisations need to recognise the importance of creating safety for their staff and supporting their emotional needs.

Theme	Subthemes	Experiences described	Example quotes
Understanding the Psychosis in the Context of People's Lives	• Psychosis is more than symptoms.	• Value of supporting social activities.	"But then they can talk to their brothers and sisters and 'Yeah, I went over to the shopping centre, I went to the park, played some crazy golf, like you know, I done something' and it, you know, there's a set of worth to it." Paul
	• Clients are part of families too.	• Complexity of working with different beliefs in the family system.	"It's that sort of understanding this, this cultural understanding, the jinns, and black magic and how that impacts the superstitions. And actually if you read a textbook on jinns and you read a textbook on psychosis it's one and the same thing. Word for word. My patient gave me a very good book some years ago, he was right, absolutely the same. And it's how we work with that, I think is really important and respecting that family." Sarah
	• Seeing the bigger picture.	• Holding an overview of the situation.	"There's a danger, in particular when sort of a lot of our service users use substances and it seems very clear that the more they're using the more fragile their mental health is. That, it can be frustrating (laughing) when somebody is sort of like busy sort of attributing all of their problems to everything else apart from their substance misuse." James
Taking Control of the Psychosis		• Psychosis being viewed as "just an illness".	"We try and liken it to a physical illness, like if you've got diabetes, then diabetes is manageable, if you've got heart problems, high blood pressure, all these are manageable and it's the same with psychosis." Charlie.
		• Empowering clients to take control.	"You have to sort of like, take a calculated risk about giving them their freedom." Paul

Table 1: Summary table of findings

Inspiring Hope	• Holding onto one’s own hope. o *Risk; Focusing on what goes wrong is the opposite of hope.* • Giving hope to others. o *Overcoming stigma.* o *Sharing hopeful stories*	• Hope being overshadowed or lost. • Sharing stories of recovery.	“I’m not sure my remit should always be or can be realistically to prevent bad things from happening. So long as I can have done what any other professional would do and I can justify my actions, that to me is what I was taught but it feels like that is less and less so. And it just makes me become less hopeful, I guess, about recovery because your focus then doesn’t become about recovery, it becomes about preventing bad things from happening. And I’m not sure you can always hold both.” Betty “Knowing that I think has been so important and some patients said, I said “what is it that was really helpful“ and one person goes “that you were able to tell me that there were people who got better” and when they said “well tell me what they do now” I was able to just go bang, bang, bang, bang, bang, bang.” Sarah.
Is Recovery the Destination or the Journey?		• Helping clients to reach set goals.	“I think it means different things to different people and in some ways, I think the recovery model, if you like, in air quotes, I think it has, it’s sort of, it has to be individual. It can’t be prescribed, you know, from “ooo this is how you recover from psychosis” because everyone’s experiences are different.” Adam. “And I like I say, their thing of recovery might be he need to be at university and it’s like well ok yeah, but we need to get to that, so we need work through the stages to get there.” Charlie.

Table 1: Summary table of findings

It’s Out of My Control; Nothing Seems to Work for Some Clients		- Hope being overshadowed or lost. - Some clients struggle to recover.	“Suppose we were always trying to, in particular his care coordinator, always trying, well, let see if, give him this chance, give that chance, give him that as a chance, and he just kept on coming back at us.” “I have to say but that, but that was a, you know, his is a situation which was, you know, one where it’s hard to see the hope in it. “ James.
The Relationship is Where the Magic Happens	- Developing a secure base.	- Being dependable and earning clients’ trust.	“I suppose if we’ve got to a stage where perhaps if you’ve got a proven track record in other areas, people might listen to us a bit more in terms of mental health.” James.
	- Empowering clients as equals.	- Valuing client’s beliefs and opinions	“So it was really important to sort of acknowledge that and not just go, ‘well I don’t agree with you, it’s a load of old nonsense’ go well, yeah, that’s, you know, that’s how you see things and yes let’s explore this.” Adam.
	- Dilemma of emotional connection.	- Difficult emotions in response clients’ experiences and fears of becoming cut off.	“You know, and I’m fairly used to managing it but then I can find if I become too hardened, I almost get a bit cut off. And a little bit defended, I guess about things. And a bit, you know, and I think as a clinician you’ve got to have that human empathy, that kind of empathising when someone’s telling you that but professionally it’s such a hard balance between trying to manage it.” Betty.
	- Intangibility means it gets lost in audit.	- Standardised paperwork lacking meaning.	“I think when you’re doing unnecessary paperwork, that’s a massive bugbear for lots of people. For example the trust will have standards and guidelines that care plans, for example, need to be done within 72 hours, but in that time you can’t, I don’t feel that you can engage with someone, get to know them and start doing that piece of work with them in a meaningful way” Adam.

Table 1: Summary table of findings

I Couldn’t Do It Without My Team	• Feeling supported by my colleagues. • Organisational changes threaten our team security.	• Team support creating sense of shared responsibility. • Concern that changes will not recognise importance of team working.	“So if they’ve heard something, they’ve been threatened or whatever’s happened, being able to offload it is what helps you cope in reality and I know that from other people who I supervise or who I work with, you know, in every team, it’s actually that’s what helps, being able to tell someone you’ve had a really crap day.” Betty. “But I think (sigh), especially with things like remote working, you know, they’re so busy focusing on the how will we know everyone’s safe and all the practicalities and what they forget is actually emotionally you need a team around you and I need to know that I can come back in and there’s someone in here.” Betty.

Table 1: Summary table of findings

3.3. References

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6.1. Appendix 1: Reflective summary of previous experiences

Before starting my clinical psychology training, I was a research assistant/assistant psychologist with the Norwich Early Intervention (EI) team. This was my first job following graduating and I feel it had a strong influence over shaping the clinician that I aimed to become. The values held within EI by my fellow colleagues were openly talked about and reflected in shared office spaces and MDT meetings. By working to a recovery-based model we were aware of how EI often worked differently from other community teams. I became passionate about advocating for alternative conceptualisations of psychotic experiences The EI I was based in also took part in many research projects, one of which I was potentially going to take on as PhD investigating positive psychology and negative symptoms. As EI values had a strong influence over me, I became interested in how other staff members how reflected on EI and what the recovery values movements meant to them. These experiences influenced the areas that I wanted to explore with participants and shaped the initial topic guide.

When presenting to the EI teams who participated in the study, I explained about my background in EI and how this had shaped my motivation for the project. I wonder whether this personal interest and experience influenced how the participants viewed me and thus, interacted with myself during the interview. There was very much the sense that they were talking to me as an equal and fellow colleague, however this may have just been because they were aware of my training in the NHS more generally. Additionally, my own experiences in EI are likely to have shaped which areas were pursued and explored in the interviews.

I am quite a positive person in my nature and alongside having interests in positive psychology. This is likely to have shaped the interpretations I drew from data, for example, being determined to hold onto hope rather viewing that hope is nearly all gone. I asked more about what helps to inspire hope for recovery rather than for particular examples where hope had been lost or gone completely. These are likely to have given rise to different data collected and interpretations from the alternatives.

Another important factor was the period of large organisational change that was imminent when I conducted the interviews. Whilst I was conducting the analysis, I was on placement with the organisation that the EI teams were moved to be part of. This was very unsettling for many of the staff in the organisation not just the EI teams, including job losses. Being on placement at this time may well have impacted on how I interpreted the data with regards to organisational change, and the data I felt was important and clinically relevant to present and capture within the themes.

All of these experiences and factors were discussed as part of my meetings with my supervisor ML.

6.2. Appendix 2: Ethical Review Confirmation

[redacted]

6.3. Appendix 3: Participant Information

Version 1

UNIVERSITY OF
BIRMINGHAM

PARTICIPANT INFORMATION SHEET

Exploring Clinician's Experiences of Delivering Recovery-Orientated Care to Individuals with First Episode Psychosis

Rose Christopher, Dr Michael Larkin and Dr Chris Jackson

You are invited to take part in a research project. Before you decide whether to take part or not, it is important to understand the reasons why this research is being done and what taking part might involve. Please take the time to read this information properly and feel free to discuss it with other colleagues, friends or family. Taking part is completely voluntary and will not impact on any other aspects of your employment in the Early Intervention Service. Please ask the researcher, Rose Christopher, if you have any questions about the project.

What is the purpose of this research?

Previous research has suggested that it is helpful for recovery from psychosis to be conceptualised as a more complex and individual process involving moving towards a meaningful life and personal growth, regardless of the presence of psychotic symptoms. This has sparked the government to champion 'recovery based services' such as Early Intervention Services (EIS) for psychosis. These services aim to 'maximise optimism, engender hope and ensure service delivery in low-stigma settings' (Singh & Fisher 2005). The purpose of this research is to investigate what it is like to work in EIS and deliver recovery-orientated care from the perspective of clinicians working directly with individuals experiencing first episode psychosis.

The research is being undertaken as part of the researcher's doctorate training in clinical psychology at the University of Birmingham.

Why have I been invited to take part?

You have been invited to take part as you are currently working in an Early Intervention team, regularly delivering direct care to service users.

What will happen to me if I agree to take part?

You will be asked to complete a consent form to say that you are happy to take part in the study and have understood the information in the participant information sheet. The researcher will conduct an interview with you to ask about your experiences of working in EIS, specifically about your views and opinions of working in recovery-orientated way. It is expected that the interview will last between 1-1.5 hours but that this will vary per interview.

What will happen to the interview I provide?

The interview will be audio-recorded and then transcribed to allow themes to drawn from the data as a whole. Once the interview has been taken place, it will only be identified by a case number and will be kept separate form any personal information about you. Direct quotations from individual interviews may be used during the analysis and in the final write up of the findings. Any identifiable information used during the interview will be changed and direct quotations will be presented with a pseudonym to prevent individual participants being recognised. Anything that is said during the interview will be used solely for the purpose of the research and will not be discussed outside of the research team. However if a disclosure of malpractice is made during the interview this will have to be passed on as per the policies and procedures in the employing Trust.

What the potential benefits of taking part?

It is hoped that the findings of this study will contribute to an improved understanding of clinician perspectives of working in Early Intervention Services and what is important for them to be able to provide recovery-orientated care. It may also provide individuals who choose to take part the opportunity to reflect on their experiences and the way in which they work.

What are the potential risks or disadvantages of taking part?

The research team appreciate that an NHS clinician's time and resources are very stretched in the current climate. In order to minimise the potential disadvantages of taking part, the interview will take place during work hours and at a time and place that is convenient for you. Furthermore, any disclosures of malpractice made during the interview may have implications beyond participation in the research as per the employing Trust's policies and procedures.

What will happen if I do not want to carry on with the study?

If at any time during in the interview you decide you would like to stop the interview, you can and you will be given the optionto withdraw any data you have contributed so far. If you decide after the interview has been completed that you do not wish to part of the study, you will have a two week reflection period where you can contact the researcher to withdraw your data. After this point, the data is likely to have been analysed and therefore it will not be possible to withdraw any specific contributions from the final themes that may have been found. However it would be possible not to include any direct quotations in any final write-ups of the study if requested after this point.

Expenses and payments

It is not anticipated any additional expenses will be incurred by taking part and therefore expense will not be reimbursed. Payment will not made to the individual for taking part.

What will happen to the results of the research study?

The results of the research will be written up as part of the researcher's DClinPsych thesis, which will be available from the University of Birmingham. Furthermore, it is hoped that the findings will be written up for further publication. It is anticipated that any results will be presented and any future publications will be circulated to the team who have taken part.

Has this study been approved?

This study has been approved by the Research Ethics Committee at the University of Birmingham and the Birmingham and Solihull Mental Health Foundation Trust Research and Development department.

What happens if I have any further concerns?
You are free to contact the researcher or any member of the research team if you have any concerns you wish to raise.

If you would like to discuss any aspect of this research please contact:

Rose Christopher

Email: [redacted]

Post: [redacted]

Version 1

Research site: ....

Participant Identification Number:...............

CONSENT FORM

Exploring Clinician's Experiences of Delivering Recovery-Orientated Care to Individuals with First Episode Psychosis

Study Number:

Researcher: Rose Christopher

Please initial box

1. I confirm that I have understood the information sheet dated 04/08/2014 (Version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason, without my own or my loved one's medical/social care or legal rights being affected.

3. I understand that the research interview will be audio-recorded

4. I understand that following the research interview I will have a two-week period for reflection. If I wish to withdraw my interview entirely or in part, I can contact the researcher to remove my data without giving any reason, without my legal rights being affected.

5. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data.

6. I understand that direct quotes from my interview may be published in any write-up of the data, and used for training purposes, but that my name will not be attributed to any such quotes and that I will not be identifiable by my comments.

7. I agree to take part in the above study.

.... Name of participant	.... Date	.... Signature
.... Name of researcher	.... Date	.... Signature

6.4. Appendix 4: Topic Guide

Areas for topic guide from literature

Experience of working in EI

Can you tell me about how you came to work in EI? Can you tell me a bit about your role, what does this involve? Can you describe your working week? Can you describe what the EI model means to you? How do you think working in EI has impacted on the way that you work? And what kind of impact does it have on you – what parts are enjoyable, interesting, challenging etc. Has this changed over time? (encourage reflection on personal experiences)

Experience of recovery/ recovery model

What are your thoughts about recovery from psychosis? Does this impact on the work you do? What factors do you think are important for you to be able deliver recovery-focused care? What do you find acts as barriers to you providing recovery-focused care?

What does recovery from psychosis mean to you? Do you think this differs from recovery means to your clients? How does this impact on the work you do with clients?

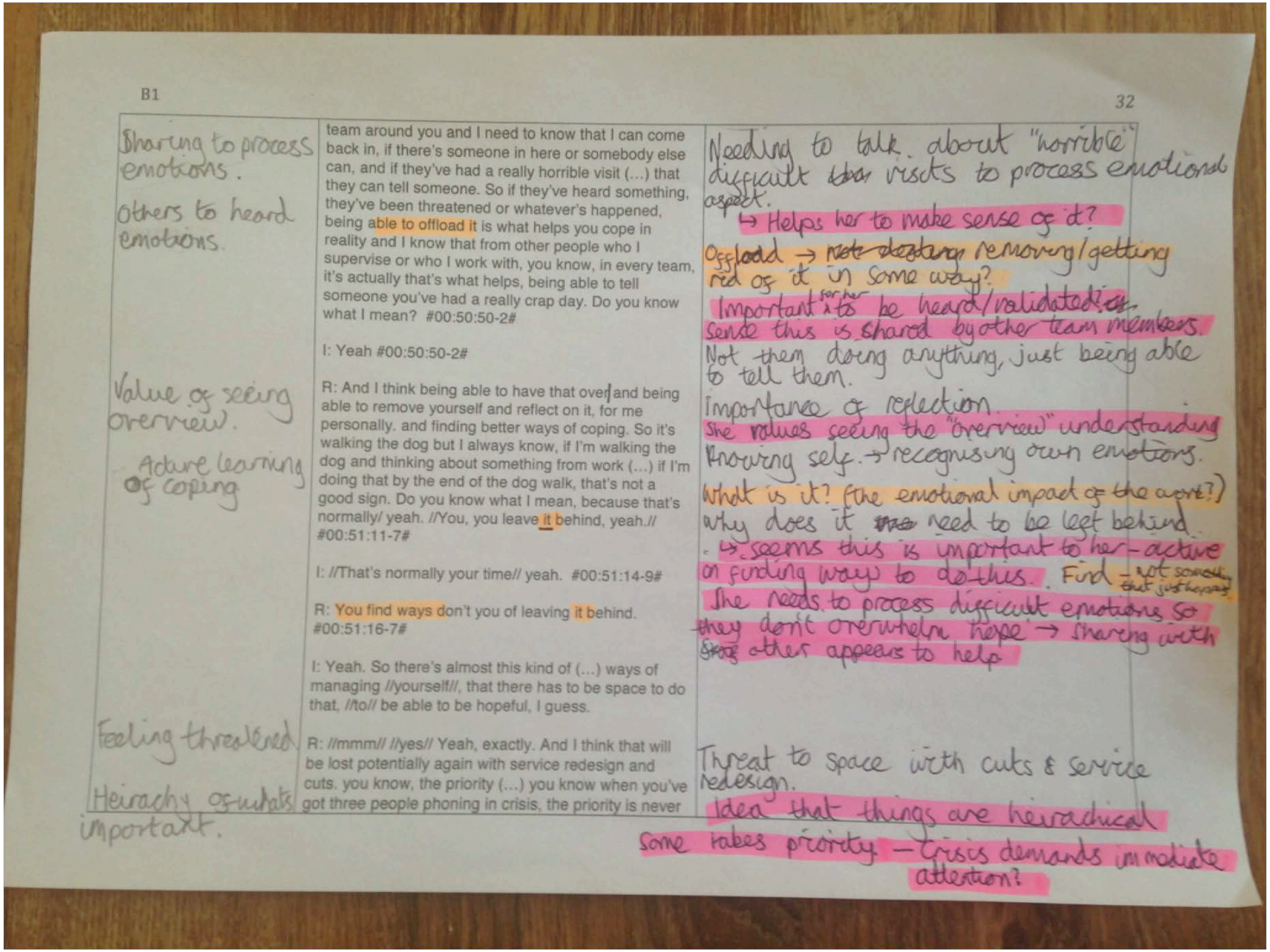
Do you expect the individuals you work with to recover? How do you support this? What is important to be able to do to this?

Experience of hope

What role does hope play in the work that you do? What does hope mean to you? Do you think it is important for you to have hope for your clients or for them to have hope for themselves?

What things impact on hope for you and your clients?

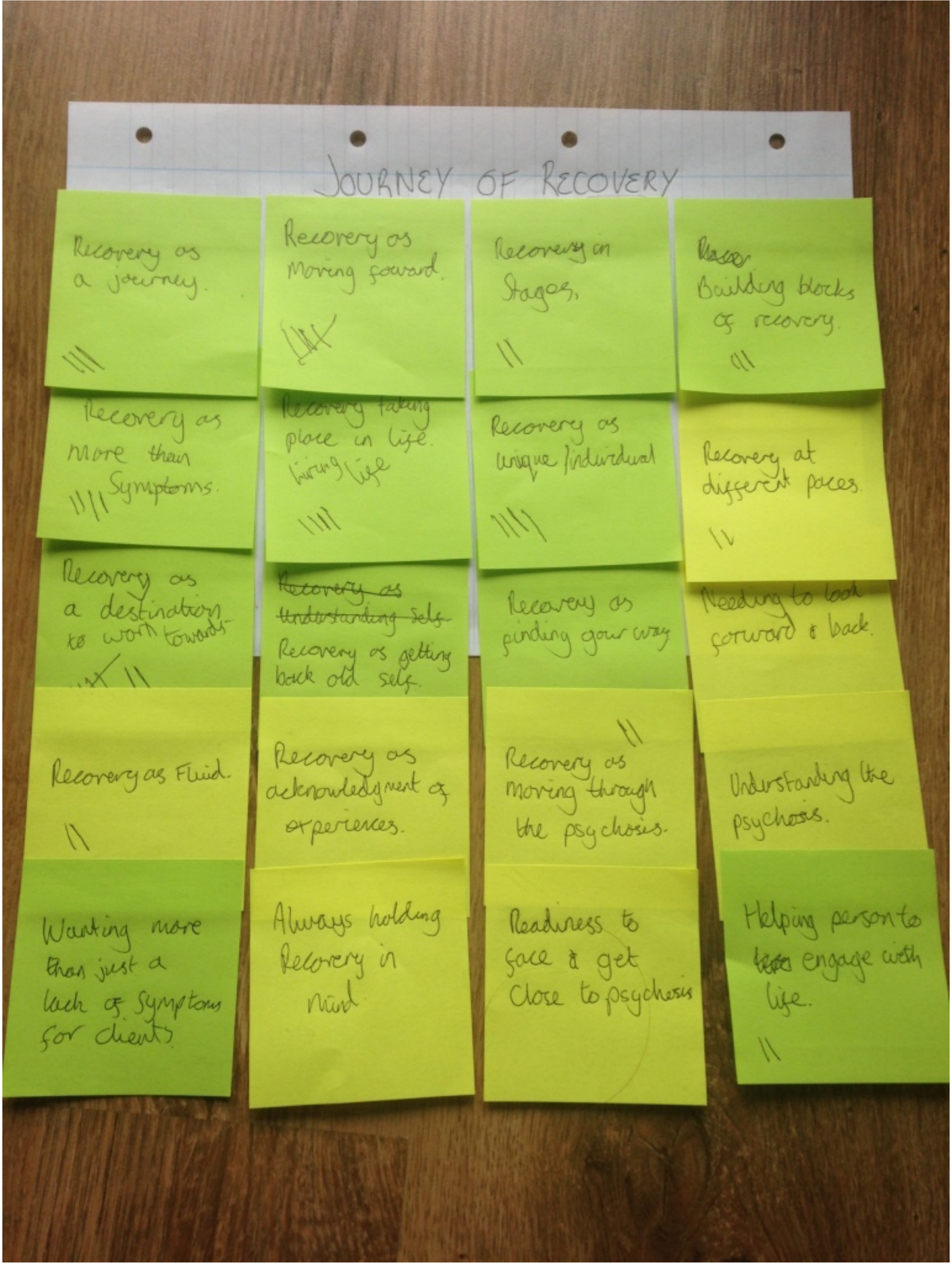
6.5. Appendix 5: Example of Line-by-Line Coding and Emergent Themes



B1 32

Sharing to process emotions. Others to heard emotions.	team around you and I need to know that I can come back in, if there's someone in here or somebody else can, and if they've had a really horrible visit (…) that they can tell someone. So if they've heard something, they've been threatened or whatever's happened, being able to offload it is what helps you cope in reality and I know that from other people who I supervise or who I work with, you know, in every team, it's actually that's what helps, being able to tell someone you've had a really crap day. Do you know what I mean? #00:50:50-2#	Needing to talk about "horrible" difficult ~~that~~ visits to process emotional aspect. ↳ Helps her to make sense of it? Offload → ~~not dealing~~ removing/getting rid of it in some way? Important for her to be heard/validated? ~~or~~ sense this is shared by other team members. Not them doing anything, just being able to tell them.
	I: Yeah #00:50:50-2#	
Value of seeing overview. Active learning of coping	R: And I think being able to have that over and being able to remove yourself and reflect on it, for me personally. and finding better ways of coping. So it's walking the dog but I always know, if I'm walking the dog and thinking about something from work (…) if I'm doing that by the end of the dog walk, that's not a good sign. Do you know what I mean, because that's normally/ yeah. //You, you leave it behind, yeah.// #00:51:11-7#	Importance of reflection. She values seeing the "overview" understanding Knowing self. → recognising own emotions. What is it? (the emotional impact of the work?) Why does it ~~the~~ need to be left behind ↳ seems this is important to her - active on finding ways to do this. Find - not something that just happens She needs to process difficult emotions so they don't overwhelm hope → sharing with [illegible] other appears to help
	I: //That's normally your time// yeah. #00:51:14-9#	
	R: You find ways don't you of leaving it behind. #00:51:16-7#	
	I: Yeah. So there's almost this kind of (…) ways of managing //yourself//, that there has to be space to do that, //to// be able to be hopeful, I guess.	
Feeling threatened Heirachy of what's important.	R: //mmm// //yes// Yeah, exactly. And I think that will be lost potentially again with service redesign and cuts. you know, the priority (…) you know when you've got three people phoning in crisis, the priority is never	Threat to space with cuts & service redesign. Idea that things are heirachical Some takes priority - Crisis demands immediate attention?

6.6. Appendix 6: Example of Visual Theme Organisation



6.7. Appendix 7: Example Data Summary for S1

Object	Associated Meanings
Person/ Client	In context, more than symptoms Complicated, human, equal Chaotic Individual, unique Valued, important, having ownership Disempowered, helpless (by system) Need consequences Validity of beliefs
Role	Varied, broad Passionate Rewarding More than medical Supportive, guiding, facilitative All-encompassing, inclusive Containing Simple and complex at the same time Action having meaning Intuitive caring Need to understand behaviour/person Dependable, committed Patience, perseverance Reassurance, comforting, normalising Boundaried, consistent, Creating safety Need to be effective, finding clients language Demanding, exhausting Messy, complicated Time as precious Acceptance of self-sacrifice Risk of burnout
Therapeutic relationship	Foundation, generates recovery, More than symptoms Needs emotional connection Being there, consistent, Intangible Valuable Providing information, empathy Equal, collaborative Takes time, process Openness, explorative Unconditional positive regard as impossible Acceptance not agreement Neglected, undervalued (organisational)

	Organic
Energy	As a finite resource, needing space and time
Recovery	As a journey, moving forwards Individual, unique, different, meaningful to individual Non-prescriptive Hard to conceptualise Opportunity for growth Complex Active process Not linear Need to make psychosis smaller, remove power Takes time More than achievements Needs to focus on the positives
Hope	Needs to be held, active process Future-oriented Possibility of positive change Faith Inspired by recovery
Sharing stories	Hopeful Normalising Powerful Communicate meaning
Team	Supportive, caring, Drive EI model Dedicated, striving Dependent, reliable As one, cohesive Valued More than just individuals Dynamics as complimentary, validity of difference, challenges encourage growth Openness, honesty, vulnerability, acceptance Unspoken way of working, Value of discussion Shared responsibility, helping sense making
Organisation	Anxious, defensive, punitive, short sighted System as careless Crude implementation Lack of resources blocking values, out of his control Underestimated value of relationship

Organisational tasks	Forced, coercive, imposed Standardised doesn’t capture individualised care Meaningless, lack value Frustration, irritation Wastes precious time Infantilised
EI model	Inclusive Consistent Attractive Ethos and set of values Attracts type of clinician Recovery at core
Psychosis	Illness Traumatic, damaging, disruptive, scary, chaotic, forceful, confusing, horrible, overwhelming, surrounding, isolating, lonely More than symptoms Random Meaningful, in context
Past beliefs about psychosis	Boring, simple, Medical Changing with experience
Medication	Limited effectiveness
Clients who don’t recover	Acceptance Sadness Hard work, effortful Immovable Helplessness Meaning in trying

What is distinctive about this person’s experience?

Previous view of psychosis as being simple, very medical. Being part of someone’s life for a period of time.

Role as essentially simple (being there), easy to say but difficult to do and involves many things. Relationship needs an emotional connection and this in it’s self is therapeutic. Can generate recovery and valuable information, need to be able to explore feelings about client including dislike, a need to be open and honest. True connection inevitably leading to empathy.

A real distain for buzzwords, but passionate about meaningful care and work with clients. Sense of strong irritation at organisational task that serve to benefit the organisation rather than clients, such as unnecessary paperwork. Standardised care lacks meaning and missed the individuality of recovery.

Description of boundaries and the importance this has for his care. He reflects on differences between team members’ approach and how this is beneficial for developing high quality care.

Recovery as a chance for transformation. Recognition that the relationship is neglected or overlooked at times. Recovery as more than achievements.

Individuals team members driving EI values and model.

What does this person's experience have in common with others?

EI as keeping him interested. EI as more than words, a set of values and ethos. Role as varied and interesting, engaging with more than just the psychosis, seeing the person as a whole. Role as rewarding. Role as supportive and guiding, not didactic, medical. Has learnt from experience and doing the job role.

Psychosis as traumatic, disruptive, a real sense of chaos with it. His job to be there and help the personto get through it. Job can include many actions but it is the meaning behind the action which is important.

Recovery as moving forward, more than symptoms, embedded in the person's life. Role as inclusive. Recovery as individual, different for each client and his role needs to accommodate this, his approach can not be prescriptive because people are too complicated for this. Client as more than symptoms, other needs that impact on mental health. A need to understand client's behaviour. A need to make psychosis smaller, less powerful.

Hope as needing to be held and is inspired by seeing people recover. Needs to be focused and given energy to promote recovery. Hope as the possibility of positive change and future-oriented. Faith.

Relationship as collaborative and equal. Intangible, and hard to define. Relationship as the foundation for recovery. Clients as complicated. Clients as valued, important. Important for clients to have ownership of their recovery and life. System carelessly repeating patterns of abandonment. EI being consistent and containing in their approach. Role can be demanding at times and it is important to have time away and the support of the team to be able to manage this.

Needing to be open with team, in order to be able do job and explore difficulties. Safety to do this created by non-judgmental, unwritten ways of working. Team as supportive, helping to make sense, using meaningful office discussions. Team working in the same way. Sense of real commitment to role and acceptance of self-sacrifice to do this.

Client's beliefs are viewed as valid explanations of their experience, accepted but not necessary to agree. Need for this to be the case to allow exploration of these beliefs. Therapeutic relation ship is a process and it takes time. Need to be patience and persevere. Paperwork lacking meaning at times and these tasks feel coercive.

Some clients won't recover, this is heart breaking for him. Acceptance that this is the way it is. This psychosis feels immovable. But there is meaning for him in trying, it says something to the client, even if it doesn't work.