The Exploration of Parenting Styles and Psychosis: Individuals with Lived Experience of Psychosis/Caregiver Retrospective Subjective Experiences of Parenting.

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A Thesis Submitted for the Doctor of Clinical Psychology.

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Date of submission for examination: October 2025

ACKNOWLEDGEMENTS

I am deeply grateful to my supervisors, Dr Antonella Trotta and Dr Lisa Wood, whose time, energy, and unwavering support have shaped this thesis at every turn. Thank you for your kindness, guidance, and patience.

Thank you to my friends in the cohort for standing beside me through the highs and lows. Your encouragement made the hard days lighter.

Finally, to my family and friends, thank you for helping me persevere, keeping me grounded, and reminding me of life beyond the doctorate. Your love and steady presence made this possible.

ABSTRACT

Background

Psychosis is lived not only individually but within families, cultural contexts, and communities. Parenting practices, such as warmth, boundaries, communication, and responses to stress, shape how distress is understood, expressed, and managed over time. This thesis comprises a systematic review and a qualitative study examining how parenting experiences are interpreted by adults with lived experience of psychosis and caregivers, and how these relational contexts intersect with adversity, culture, and recovery.

Aims

The research aimed to: (1) evaluate the quality and scope of evidence linking parenting features with psychosis-related outcomes; (2) explore how individuals with lived experience of psychosis and caregivers retrospectively describe parenting within family relationships; and (3) examine how broader emotional, cultural, and structural contexts shaped these experiences.

Methods

A PRISMA-aligned systematic review with narrative synthesis appraised empirical studies using the Mixed Methods Appraisal Tool (MMAT), with attention to design, measurement, and cultural context. The qualitative study used Reflexive Thematic Analysis (RTA) of semi-structured interviews with a UK-based purposive sample of adults with lived experience of psychosis and caregivers (not necessarily related), reflecting a small but information-rich dataset. A dual-perspective design enabled both groups’ interpretations to be analysed together while attending to points of convergence and divergence.

Results

The review mostly identified retrospective, single-informant studies using standardised self-report measures, with moderate methodological quality. Across studies, lower warmth and higher control were more frequently associated with greater symptom distress, while warmth with structure related to better functioning; adversity and contextual stressors amplified these effects.

The qualitative analysis generated four themes.

Theme 1: Emotional Climate and Relational Safety described climates marked by criticism, control, or inconsistency, alongside protective routines, repair after conflict, and steady, non-intrusive parental presence.

Theme 2: Parenting Style as a Pathway to Mental Health and Psychosis captured how permissiveness, role reversal, and blurred boundaries shaped participants' experiences of safety, autonomy, and early interpretations of distress.

Theme 3: Meaning-Making and Identity Reconstruction examined how participants reframed earlier experiences, moving from blame or confusion toward more nuanced understandings of parenting under strain and developing resilient identities.

Theme 4: Trauma, Belief, and the Emotional Ecology of Psychosis encompassed experiences of trauma, intergenerational loss, and cultural and spiritual framings of distress, alongside the stabilising effects of acceptance, love, and emotional presence.

Across themes, parenting was portrayed as dynamic, culturally embedded, and context-dependent: a relational environment in which psychotic experiences were interpreted and managed, rather than a singular causal factor.

Conclusion

Findings highlight non-blaming, feasible levers for practice, including supporting warmth

with structure, protecting sleep and daily routines, enabling repair after conflict and role clarity, and working with families’ cultural and spiritual frameworks while recognising the structural pressures that constrain caregiving. The thesis emphasises psychosis as relationally and contextually shaped, and it offers developmentally and culturally sensitive implications for family-inclusive and trauma-informed care.

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Chapter 1

Introduction

Chapter Overview

This chapter introduces psychosis, tracking its historical classification to today's contemporary Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and International Classification of Diseases (ICD-11) definitions. It summarises its psychosis prevalence, impacts and core psychological, biological, and social explanations. It reviews how language and recovery-oriented terminology can shape stigma, outlines evidence-based treatments, and situates UK legislative and service contexts. This chapter then delves into parenting, defining key dimensions and major models, and explores cross-cultural, ecological, and cognitive-behavioural influences on parenting practices and challenges. The end of the chapter brings together these strands, synthesising evidence linking childhood adversity, family climate, attachment, and parental bonding, linking them to psychosis risk and relapse. It highlights protective patterns of parenting and concludes by offering the study rationale to illuminate how parenting and early relationships intersect with psychosis. The chapter concludes by offering a rationale and research questions for this study.

Psychosis

Terminology

In the late 19th and early 20th centuries, Emil Kraepelin (1919) made significant contributions to the differentiation of psychotic disorders. He classified mental disorders based on their course and symptom patterns and identified "dementia praecox", which was later coined as schizophrenia, and "manic-depressive illness", now more commonly known as bipolar disorder. This laid the foundation for modern psychiatric classification. Eugen Bleuler (1911) expanded on this work by coining the diagnosis "schizophrenia" and highlighting its key features, such as fragmented thought process, delusions, hallucinations, and disorganised thinking.

Psychosis is classified as a complex and severe mental disorder, characterised by impaired reality testing (American Psychiatric Association, 2013). The history of psychosis reveals significant advancements in understanding its components, for example, its nature, causes and treatment. Evidence from psychiatry, psychology, and neuroscience disciplines has shaped modern-day views on psychosis (Bentall, 2003).

Literary evidence demonstrates that the language used to describe psychosis can strongly influence societal stigma and self-stigma (Angermeyer et al., 2003). For example, the term "severe mental illness" has been correlated with increased social distancing. Conversely, language that is considered to be recovery-oriented, such as referring to someone as a "person in recovery" or using the term "experiences" over diagnosis, is suggested to evoke hope and empathy, reduce stereotypes, and model more inclusive attitudes (Mulfinger et al., 2019).

A person-centred and recovery-oriented approach to psychosis terminology, in both research and clinical settings, has evolved. The British Psychological Society's (2014) "Understanding Psychosis and Schizophrenia" outlined terminology such as "experienced voices", "person experiencing psychosis", and "meaning-making" as some of the most inclusive phrases over medicalised and diagnostic terms alone. Creating more inclusive terminology endeavours to reduce stigma and oversimplification for people who are experiencing psychosis.

In addition to this, service-user movements, such as the Hearing Voices Network (2018), prioritise service-user subjective experiences over diagnostic labelling. They actively support the progressive shift toward psychosocial and cultural conceptualisations of distress, moving away from exclusive biomedical models (Longden et al., 2012). Taken together, these terms and shifts in language set the stage for how psychosis has been described and classified. The next section will explore how those definitions emerged and evolved. Throughout my thesis, I used Individuals with Lived Experience of Psychosis (ILEP) to refer to participants who have a psychosis diagnosis. Caregivers was the chosen term by the researcher and participants as the inclusive term for individuals who have parented an ILEP. I used psychosis or psychotic experiences when referring to experiences commonly labelled as hallucinations, delusions, or related phenomena to allow a distinction between biomedical models and psychosocial and cultural framings. The next chapter will explore how these definitions emerged and evolved over time.

Definition and Conceptualisation of Psychosis

History

The term "psychosis" was first coined in 1841 by German psychiatrist Karl Friedrich Canstatt. He used it to describe mental conditions that differed from neurosis, which, at the time, was a term used to describe milder psychological disturbances such as depression or anxiety (Burgy, 2008). Initially, psychosis was conflated with the broad and stigmatising term "insanity". This reflects the limited understanding of psychosis and its unique characteristics by medical professionals at that time.

Definitions have become increasingly refined over the 20th century and now distinguish psychosis from mood disorders and personality disorders. This has been achieved through clinical observations, family studies, and neuroimaging research (Jablensky, 2010). With diagnostic boundaries clarified, it becomes possible to consider how treatments have developed in response to this codified understanding.

Modern Psychiatric Definitions and Classifications

Detailed discussions of biological and psychological treatments appear in the sections “The Development and Biological Understandings of Psychosis” and “Psychological Understanding of Psychosis”.

The DSM-5 offers clear criteria for diagnosing psychotic disorders (American Psychiatric Association, 2013). The ICD-11 similarly defined schizophrenia spectrum disorders and other primary psychotic diagnoses with explicit attention to symptom duration, functional impairment, and cultural considerations (World Health Organisation [WHO], 2019). The DSM-5/ICD-11 operationalises criteria to give doctors clear checklists, improving inter-rater reliability. However, marked symptom heterogeneity, which is the variance in symptoms among people with the same diagnosis, can still manifest in very different ways, constraining construct validity. Therefore, these diagnoses are best treated as useful shortcuts for care and research rather than fixed terms or natural disease types (American Psychiatric Association, 2013; WHO, 2019; Jablensky, 2010).

Experiences, Prevalence and Impact of Psychosis

Psychosis often comprises profound disruptions to an individual’s perceptions, to one’s sense of self, and to their thoughts. Hearing voices, feeling as though one’s thoughts are being controlled or broadcasted, and experiences of delusion are commonly reported by those who experience psychosis. This can become deeply distressing and isolating. These experiences can be saturated with personal meaning, all of which likely stem from an individual's relationships, life context, and emotional experiences (Larsen, 2004). It is essential to take steps to try to understand a first-person perspective of psychosis to enable a compassionate, effective, and therapeutic approach that can transcend beyond symptom reduction alone and support individuals with their lived realities.

Psychosis is an umbrella term that encapsulates symptoms that can occur in schizophrenia spectrum disorders, affective disorders and can also appear secondary to experiences of trauma, substance use, and neurological conditions (American Psychiatric Association, 2013; van Os et al., 2009). Symptoms of psychosis can often cause impairments and disruptions across emotional, cognitive, and relational domains (Birchwood et al., 2000).

Psychosis affects approximately 3 in 100 people at some point in their lives, making it more common in the UK than diabetes (NHS England, 2019; McGrath et al., 2008). For many people included in this statistic, their first episode will occur in late adolescence or early adulthood. This makes psychosis the leading cause of disability for young people (Kirkbride et al., 2006). Considering the life stages of people experiencing the onset of psychosis, it can have a significant impact on education, relationships, vocation, and carry various other social and personal consequences. These ramifications elucidate the importance of early intervention for people experiencing psychosis and their families. It is known that caring for an individual experiencing psychosis, by integrating service-user perspective and family involvement, reduces risk of relapse and promotes recovery (National Institute of Health and Care Excellence [NICE], 2014; Garety et al., 2008).

The Development and Biological Understanding of Psychosis

By the mid-20th century, the understanding of psychosis had shifted towards a biopsychosocial model. This type of model integrates biological, psychological, and social factors related to each individual's personal context. Literary evidence has emphasised the role of societal stressors in the onset of psychosis (Brown and Harris 1978). This highlights the importance of environmental influences, such as the loss of a close relationship, a lack of social support or financial difficulties, etc., alongside genetic predisposition.

Supporting the notion that environmental and genetic factors can contribute to the risk of developing psychosis, twin studies indicate high heritability rates of schizophrenia and bipolar disorder, pointing to a strong genetic component (Cardno & Gottesman, 2000). Environmental factors such as prenatal infections, cannabis use, and psychosocial stress can also play crucial roles (van Os et al., 2010).

Neuroscience advancements have significantly enhanced our understanding of psychosis. Neuroimaging studies, including functional Magnetic Resonance Imaging (fMRI) and Positron Emission Tomography (PET) scans, have revealed abnormalities in brain structure and functioning amongst those with psychotic disorders (Weinberger & McClure, 2002). For example, reduced grey matter volume in the prefrontal cortex and temporal lobes is frequently observed in schizophrenia (Cannon et al., 2002). Whilst these biological findings are foundational, they do not operate in silo. Psychological models can help explain how experiences and appraisals translate biology into symptoms.

Antipsychotic treatments for psychosis have evolved from early and invasive methods to modern antipsychotic medication and psychosocial interventions. The efficacy of second-generation antipsychotics like risperidone and olanzapine has been supported by numerous clinical trials (Leucht et al., 2009). Group-level neurobiological differences, whilst robust, are insufficiently specific for individual diagnosis. This highlights the need for further studies and formulation alongside biological accounts (Weinberger & McClure, 2002).

Psychological Understanding of Psychosis

Understandings of psychosis have changed over the last century and have evolved from predominantly biological frameworks to models that are more integrative, incorporating psychological, social, and developmental factors. A key aspect of this is their recognition of early caregiving relationships, parenting styles, and childhood adversity, and how they influence an individual’s vulnerability to psychosis and can shape its trajectory (Varese et al., 2012). This segment will explore four complementary theoretical foundations: psychodynamic, cognitive, trauma-informed, and attachment-based perspectives, outlining their core concepts, empirical evidence, and therapeutic implications.

In addition to pharmacological treatments, psychosocial interventions such as Cognitive-Behavioural Therapy for psychosis (CBT-p), family interventions, and employment support have proven effective in improving functional outcomes (Wykes et al., 2008; NICE, 2014). Recovery-oriented models such as these emphasise and promote autonomy and social inclusion and consider personal meaning-making as opposed to symptom remission alone (Slade et al., 2014).

Psychodynamic Understanding of Psychosis

Amongst the first to explore psychosis beyond biological explanations were psychodynamic theories. Freud (1911) stated that psychotic symptoms, such as withdrawal from reality, serve as a protective function against overwhelming internal or external experiences, conceptualising psychosis as a defence against unbearable psychic conflict. Later down the line, theorists such as Klein (1946) brought to light mechanisms such as “splitting”. She suggested that this occurs when caregiving relationships fail to provide security, thus causing children to have separate experiences of good or bad as a defence mechanism to manage anxiety. These ideas were expanded by Bion (1962), who proposed that psychosis arises when caregivers are unable to support their children in processing distressing emotions, which leaves them unable to integrate thoughts and feelings coherently.

Psychodynamic concepts have been used to inform Mentalisation-Based Therapy for Psychosis (MBT-p). This is a therapeutic intervention that builds on Fonagy and Bateman’s (2006) work on mentalisation. MBT-p is a therapy that supports individuals to better understand their own and others’ mental states. It addresses areas around paranoia, mistrust, and relational difficulties. There is emerging evidence for its usefulness. A randomised control trial found that MBT-p, when added to treatment as usual, did not outperform controls immediately post-treatment. However, they did show superior social functioning at a six-month follow-up, demonstrating that the effects were stronger in more recent-onset cases as opposed to in chronic presentations (Weijers et al., 2021). De Salve et al. (2023) conducted a recent systematic review on mentalising across psychosis-risk spectrums, and their findings supported the theoretical and developmental rationale for targeting mentalisation processes in early psychosis pathways, though dedicated MBT-p reviews remain limited.

To balance this, it is reasonable to suggest that MBT-p has its merits and emerging empirical support, with the most robust effects observed during follow-ups and in more recent-onset trials. Further trials and a dedicated systematic review of MBT-p are needed and justified.

Alongside MBT-p, Cognitive Analytic Therapy (CAT) is an attachment and relationally informed therapy that helps people map repeating “reciprocal role” patterns, for example, criticised-ashamed, controlling-submissive, and try out new responses. In psychosis services, CAT has been adapted to address mistrust, self-criticism, and the interpersonal cycles linked to paranoia and voices. Early studies and guidance suggest that this adapted intervention is acceptable and potentially helpful, though larger trials are still needed (Ryle & Kerr, 2002; Taylor et al., 2019).

Cognitive Models of Psychosis

Empirically, cognitive perspectives are demonstrated to be able to highlight how maladaptive appraisals, reasoning biases, and negative self-schemas can contribute to psychotic experiences. Garety, Kuipers, Fowler, Freeman, and Bebbington (2001) collaboratively developed the widely cited cognitive model of positive symptoms. They proposed that psychosis emerges when external events or internal anomalies, for example, hallucinations, can be misinterpreted within threatening or self-critical belief systems. It has been suggested in integrated trauma research that psychotic experiences can often represent intrusive memories or thoughts appraised in catastrophic ways (Morrison, 2001).

These models are the underpinnings of CBT-p, which is recommended as a first-line psychological intervention by the NICE (2014). CBT-p is useful in targeting unhelpful appraisals, building coping strategies, and fostering alternative plausible explanations for an individual’s distressing experiences (Morrison et al., 2014). The results of meta-analyses demonstrate that CBT-p yields a small to moderate effect on positive symptoms of psychosis, which can enhance outcomes when combined with family interventions in high “Expressed Emotion” environments (Pharoah et al., 2010; Jauhar et al., 2014). CBT-p effects are small but diverse, with most consistent benefits lying within distress, coping, and functioning as opposed to large reductions in positive symptoms of psychosis (Jauhar et al., 2014).

Beyond CBT-p, there is a growing evidence base in third-wave approaches for psychosis. Third-wave refers to approaches that focus on how individuals relate to their thoughts and feelings without trying to dispute their content. They emphasise acceptance, present-moment awareness, personal values, and compassion. Acceptance and Commitment Therapy (ACT) and additional related mindfulness and acceptance-based interventions have demonstrated small effects that are considered beneficial on psychotic symptoms and symptoms of distress. Meta-analyses and overviews support their use as supplementary interventions within stepped-care pathways (Jansen et al., 2020). Promising findings for Compassion-Focused Therapy (CFT) for psychosis, which aims to target shame and self-criticism, have emerged through randomised control trials and case studies (Braehler et al., 2013; Heriot-Maitland et al., 2023). Whilst a recent meta-analysis demonstrates efficacy of CFT use across clinical populations more broadly, psychosis-specific trials continue to remain limited (Millard et al., 2023). In line with this, the NICE continues to recommend CBT-p as a first-line psychological intervention for psychosis, with third-wave approaches considered as supplements or alternatives where appropriate (NICE, 2014). Third-wave approaches show benefits when used as a supplementary intervention without clear superiority over CBT-p. However, the overall certainty of evidence remains moderate (Jansen et al., 2020; NICE, 2014).

Trauma-Informed Perspectives

There is extensive literary evidence linking childhood trauma to psychosis. This is inclusive of emotional neglect, physical abuse, and parental hostility (Varese et al., 2012). Trauma-informed perspectives build on this by suggesting that some experiences, like hearing voices or feeling paranoid, can be the mind's response to overwhelming threat rather than simply signs of discrete illness (BPS, 204, 2017). In keeping with this view, early studies found that many people who hear voices report traumatic events before their symptoms began (Romme & Escher, 1989).

There is emerging evidence supporting the safety and efficacy of trauma-focused therapeutic interventions in reducing post-traumatic intrusions and paranoia (O'Driscoll et al., 2016; Steel et al., 2017; van de Berg et al., 2015; de Bont et al., 2016). Interventions such as Trauma-Focused CBT (TF CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) are two approaches that have been adapted for psychosis. Recent UK-led work has evaluated TF CBT and EMDR for psychosis (EMDRp), including the Study of Trauma and Recovery (STAR) TF CBT-p multisite randomised control trial protocol and feasibility of EMDRp in early psychosis (Hardy, 2024; Peters et al., 2022; Varese et al., 2024). Due to the complexity of trauma-psychosis interactions, these approaches emphasise pacing, grounding, and collaboration, a good example of this is Hardy's (2024) review for guidance on stages and collaborative delivery. Trauma does not occur in a vacuum, its effects are filtered through early caregiving relationships, which attachment theory can help to conceptualise (Berry et al., 2007).

Family Intervention

The NICE recommends family interventions, in line with systemic accounts, for people with psychosis and their families. This usually includes the service-user and comprises approximately ten therapeutic sessions over a period of three to 12 months (NICE, 2014). Evidence from meta-analyses indicates that family interventions are able to reduce relapses and hospitalisations, and improve outcomes, including for individuals experiencing their first episode of psychosis (Pharoah et al., 2010; Camacho-Gomez & Castellvi, 2002; Rodolico et al., 2022). Whilst trial evidence is strong, real-world application and its impacts rely heavily on interventions being delivered as intended, family engagement, and service capacity (Pharoah et al., 2010; Rodolico et al., 2022). Historically, much of this evidence base was seeded by Ian Falloon's pioneering psychoeducational and behavioural family management programmes, which integrated structured problem-solving, communication training, and relapse-prevention planning with routine psychiatric care. Early controlled and longitudinal studies showed that these approaches could substantially reduce relapse and improve social and functional outcomes, helping to establish family work as a core component of schizophrenia care (Falloon et al., 1982; Falloon et al., 1985; Falloon et al., 1987).

Attachment Theory

Pioneers in attachment theory, such as Bowlby (1980) and Ainsworth and Bell (1970), have laid the groundwork for developmental frameworks to consider how experiences from early caregiving, including emotion regulation, self-concept, and interpersonal functioning, shape individuals and their experiences. Secure attachments, which are formed when caregivers are consistent, sensitive, and responsive, are known to foster resilience. Conversely, disorganised attachments, which often arise from neglectful, frightening, and inconsistent experiences of caregiving, are associated with psychosis vulnerability (Berry et al., 2008; Gumley et al., 2014).

A review demonstrated elevated rates of insecure attachment in psychosis populations, particularly those with avoidant and disorganised patterns (Korver-Nieberg et al., 2014; van Bussel et al., 2021). Whilst the causal direction between attachment insecurity and psychosis remains inconsistent, the association between the two is apparent and consistent. Having said this, evidence leans heavily on retrospective self-report and may not generalise across cultures (Carr et al., 2018; Rothbaum et al., 2000; Murphey et al., 2010).

Various bio-psychosocial factors have been studied pertaining to psychosis; most relevant to this study is the relationship between caregivers and individuals with lived experience of psychosis (ILEP) in childhood and the development of a psychiatric disorder in their ILEP in adulthood. A recent comparative study on parental bonding styles in schizophrenia, depressive and bipolar disorder patients in Iran hypothesised that “non-optimal parental bonding styles”, characterised by low care and high overprotection or affectionless control, would be more prevalent in patients with schizophrenia than in patients with depressive and bipolar disorders. Their results demonstrated that mothers of patients with schizophrenia, who accounted for 60.5% of the sample size, used non-optimal parental styles more than mothers of depressed and bipolar patients (Abbaspour et al., 2021, 1-8). UK evidence aligns with this pattern. Longitudinal cohort studies linked to maltreatment, bullying, and maternal perinatal depression with later psychotic experiences. UK-based first-episode psychosis studies associate more optimal parental bonding with better functioning. More recent mediation work suggests that parenting effects on adult psychosis are conveyed via insecure attachment and negative schemas (Arseneault et al., 2011; Srinivasan et al., 2020; Pollard et al., 2023; Akers et al., 2025).

Several attachment-informed treatments used in psychosis include individual approaches that draw on attachment mechanisms. CFT (Braehler et al., 2013; Heriot-Maitland et al., 2023), MBT-p (Weijers et al., 2021), and schema-based approaches have emerging support demonstrating social functioning improvements, particularly in individuals with recent-onset psychosis. Schema-based interventions have preliminary support, with studies linking early maladaptive schemas to symptoms and functioning (Taylor et al., 2017). Attachment-informed therapies such as Attachment-Based Family Therapy (Diamond et al., 2016) and Behavioural Family Therapy (Pharoah et al., 2010) have clear aims to improve communication within family systems, reduce criticism and hostility, and strengthen relational security, thus reducing the risk of relapse and improving psychosis outcomes.

The Dynamic Maturational Model

Contemporary models of attachment theory, such as the Dynamic Maturational Model (DMM) (Crittenden, 2008), can offer a more nuanced view than traditional attachment theory. The DMM acts as a continuation of Bowlby’s theory by considering how attachment behaviours can be adaptable based on a person’s responses to danger, trauma, or neglect. It suggests that children exposed to these elements may overcompensate by creating strategies that help to distort the way they process emotional information (Crittenden & Landini, 2011).

Various studies demonstrated that individuals who experienced such parenting in childhood subsequently created adaptive behaviours such as hypervigilance, distrust, and emotional suppression. These behaviours were noted to have continued into adulthood, leading to experiences of dissociation and paranoia (Varese et al., 2012; Schimmenti & Bifulco, 2015). The emphasis here is on how attachment theory informs assessment and formulation, for example, mapping threat anticipation, separation-related affect, and deactivation strategies (examples of attachment-informed treatments are in the preceding section). These studies elucidate the importance of considering attachment theory as a means to better inform clinical tools for understanding and supporting people affected by psychosis. Nonetheless, whilst the DMM offers an intriguing developmental model, it has received less empirical validation in comparison to more established diagnostic and pharmacological approaches in adult psychosis populations. These developmental accounts sit alongside wider social explanations that locate distress within contexts of inequality, threat, and support.

Psychosocial Understanding of Psychosis

A psychosocial account of psychosis considers and emphasises how stressful life experiences, cumulative adversity, and social context can contribute to shaping the onset and outcomes of psychotic disorders. It does not view psychotic symptoms as purely biological in origin, rather it recognises early-life trauma, enduring social stressors, and structural conditions such as deprivation, discrimination, migration, and urbanity, and how they interact with biological vulnerabilities to influence risk, course and recovery (Morgan & Gayer-Anderson, 2016; Varese et al., 2012).

Trauma, Adversity, and Psychosis

There is substantial literary evidence demonstrating that childhood adversities, including experiences of emotional neglect, sexual abuse, bullying, and exposure to domestic violence, are strongly associated with a heightened risk of developing psychosis later in life. A meta-analysis that combined patient-control, perspective, and population-based studies, reported that childhood adversity was linked to two to three times increased risk of likelihood of psychosis, with approximately one third of individuals attributing such experiences to their own circumstances (Varese et al., 2012).

Additional research has reinforced these findings, demonstrating that dose-response relationships, which are those where greater severity or frequency of adversity predicts higher risk, exist between childhood trauma and psychosis. They suggested that cumulative exposure is linked to progressively greater likelihood and severity of symptoms (Varese et al., 2012; Morgan & Gayer-Anderson, 2016).

Perspectives such as these reinforce the notion that experiences such as hearing voices or holding persecutory beliefs can be understood as meaningful responses to threat as opposed to symptoms arising at random (Varese et al., 2012). There are clear clinical implications from this, for example, working collaboratively with individuals to prioritise safety, stabilisation, meaning-making, and memory processing will likely support trauma recovery, as well as help to reduce psychosis-associated distress. Randomised control trials support the efficacy and safety of trauma-focused therapies such as EMDR for people with psychosis and comorbid PTSD, leading to improvements in PTSD related symptoms and reductions in paranoid thinking that are sustained in 12-month follow-up reviews (van den Berg et al., 2015; van den Berg et al., 2016; van den Berg et al., 2018). It is suggested that trauma-focused treatments are generally safe for individuals experiencing psychosis and co-morbid PTSD and tend to have effective outcomes for PTSD. However, the effects on core psychotic symptoms appear to be inconsistent. It is therefore important that phased and paced delivery is considered (van den Berg et al., 2015; de Bont et al., 2016; Hardy, 2024).

Wider Social and Environmental Influences

Psychosis risk and outcomes are strongly influenced and shaped by social environments and structural conditions. Migration and minority status have been linked to elevated rates of schizophrenia and other psychoses. This likely reflects the chronic social stress and discrimination (Cantor-Graae & Selten, 2005; Selten et al., 2019). In addition to this, living in areas where there are fewer people from one's own ethnic group has been associated with a greater risk of psychosis. This suggests that there are protective effects of social cohesion (Baker et al., 2021).

Urbanicity, or the degree to which an area is urban rather than rural, is another consistent factor in psychosis risk. Literary evidence demonstrates that being raised in an urban environment is associated with higher rates of psychosis. Research attributes this to social fragmentation, environmental stressors, and a lack of green space, which is said to heighten social distress as a possible mechanism (Pignon et al., 2023; Vassos et al., 2012).

Additional evidence has linked deprivation, inequality, and discrimination to psychotic symptoms, with stress, low trust, and limited social support mediating these factors (Wickham et al., 2014). Urbanicity, migration, and socioeconomic deprivation are all consistently linked with a higher risk of psychosis, though the exact reasoning remains unknown. Some of this association may be attributable to other unmeasured factors (Morgan & Gayer-Anderson, 2016; Vassos et al., 2012).

These findings point to a model where stress exposure, social position, and environmental safety interact with genetic and neurodevelopmental vulnerabilities to shape the onset and course of psychosis. Given these social determinants, it is important to consider how national policy and legislation structure the care systems designed to respond.

Legislative and Policy Context

The UK's approach to psychosis care is underpinned by a series of policies, acts, and guidelines designed to deliver comprehensive mental health support. These set out the legal basis for treatment, the organisation of services, and national strategies to reduce stigma and improve access to care.

Policies such as the Mental Health Act (1983, amended in 2007) and the Care Programme Approach (CPA) have been central in shaping how psychosis is understood and managed. Together, they emphasise the importance of coordinated, person-centred care whilst safeguarding service users' rights and recognising the vital role of families and caregivers, a particularly relevant consideration when exploring the influence of parenting and family relationships.

Early intervention and person-centred care have become part of the new progressive shift in UK mental health policy. Specifically, the inclusion of a familial perspective and support for caregivers and service users alike. The Mental Health Act 1983, as amended by the Mental Health Act 2007, mandates compulsory treatment under certain circumstances. This is to ensure the safety and protected rights of the service user. Alongside this, the CPA was introduced in 1991. It signified the beginning of more inclusive care for any individual enduring a severe mental illness. It promotes better healthcare coordination and the right to structured assessment, planning, and reviews (Department of Health, 1990).

National strategies, including No Health Without Mental Health (HM Government, 2011) and the Five Year Forward View for Mental Health (NHS England, 2016), were later introduced, reinforcing these policies and placing greater emphasis on early access to mental health care, the reduction of societal and systemic stigma, and recovery-oriented models of care. The NHS Long Term Plan (2019) introduced the most notable changes. It sought to incorporate the voices of loved ones and improve clinical outcomes for individuals with psychosis. It suggested the prioritisation of community-based intervention and early intervention in psychosis (NHS England, 2019).

Additional policies, such as the Care Act 2014, sought to further reinforce the legal rights of individuals with psychosis by emphasising the legal duties of local authorities. It recommended the assessment and implementation of carers' support and acknowledged the impact of caregiving for a loved one with psychosis (HM Government, 2014). Further guidelines also advocate for family intervention, indicating that this inclusion can reduce rates of relapse and improve social functioning (Pharoah et al., 2010; Kuipers et al., 2010).

In conjunction, these shifts in legislation and policy demand further exploration of how parenting styles and familial dynamics intersect with experiences of psychosis. They underpin the focus of this study and its aim to further explore features of parenting and psychotic illness. These policy commitments are realised through specific service models, most notably, Early Intervention in Psychosis (EIP) teams.

Service Provision of Early Psychosis

Early intervention and community support are widely acknowledged as essential in transforming outcomes for individuals experiencing their first episode of psychosis.

Established services that detect and treat psychosis early and offer continuity of care in the community have consistently demonstrated better clinical, social, and functional outcomes than delayed or fragmented models of care. Within and alongside EIP provisions, recommended psychological therapies translate theory into targeted interventions.

Early Intervention and Treatment Services

EIP services are specialist services that offer a multidisciplinary approach to care that is designed to engage individuals at the earliest point after psychosis onset and deliver a full-package or NICE-recommended care (NHS England, National Collaborating Centre for Mental Health, & NICE, 2016). These teams are typically made up of psychiatrists, psychologists, care coordinators, social workers, occupational therapists, and peer support workers. Their primary function as a team is to rapidly assess and prompt the initiation of pharmacological and psychosocial treatment, support with relapse prevention, and address subsequent vocational and educational needs.

Literary evidence strongly supports the effectiveness of EIP services. A systematic review and narrative synthesis highlighted that EIP services are both effective and cost-effective; however, implementation can often encounter barriers such as funding, staffing shortages, and coordination challenges (O’Connell et al., 2021). Clinical trials and service evaluations support this as the outcomes following a period of care with EIP services demonstrated reduced hospital admissions, better symptom control, improved quality of life and social functioning. They demonstrated a consistently superior standard in comparison to community mental health teams (Neale et al., 2017; Williams et al., 2023).

Timeliness is essential in psychosis intervention. Untreated psychosis for longer durations is associated with worse outcomes in symptom severity, function, and recovery trajectories. National guidance in England advises that individuals with psychosis should begin care under an EIP service within the first two weeks of referral (NHS England, 2023). This guidance aims to ensure that interventions occur as early as possible to maximise benefit. Whilst EIP services are known to improve outcomes and are typically cost-effective, the implementation of these services is often constrained by workforce and funding pressures (Aceituno et al., 2019; O'Connell et al., 2021).

Support Systems and Community Care Models

Beyond specialist EIP teams' support, community care models offer ongoing support and integration. This includes assertive outreach, care coordination post-discharge, family intervention, peer support, vocational support, and social recovery therapy. This type of care alongside small caseload models, allow for a more personalised therapeutic relationship, which appears to reduce rates of relapse and improves functioning (Neale et al., 2017; Fowler et al., 2018).

Literary evidence suggests that when Social Recovery Therapy is combined with EIP services, outcomes pertaining to social functioning and reduced negative symptoms are significantly improved. This demonstrates that enhancing community and relational capacities can make sizeable differences (Fowler et al., 2018). In addition to this, tools that predict risk of hospital admission post-EIP discharge have been developed with the aim of supporting teams in planning follow-up support, which can help to allocate resources and prevent relapse (Puntis et al., 2021).

Relational and Attachment-Informed Perspectives on Psychosis

Attachment theory has become increasingly relevant when trying to understand the course and development of psychosis. Literary evidence already tells us that disorganised and insecure attachment styles, commonly found in parent-child relationships, are linked with a heightened vulnerability to experiences of psychosis. These experiences can include dissociation, paranoia, unusual beliefs, and emotion regulation difficulties (Gumley et al., 2014; Korver-Nieberg et al., 2013). Insecure attachment styles can make it difficult for individuals to form trusting relationships, including in the form of help-seeking and engagement with mental health services (Berry et al., 2008; Korver-Nieberg et al., 2014).

Relational frameworks in modern-day psychology are already considered essential and support clinicians in attending to attachment dynamics. Family interventions specifically are a crucial component that aims to reduce expressed emotion, improve communication within family systems, and model a collaborative approach to understanding psychosis (Pharoah et al., 2010). Family interventions for psychosis treatment are recommended in national guidelines as a key component of care (NICE, 2014).

MBT-p (Weijers et al., 2021; Bateman & Fonagy, 2010) and CAT for psychosis (Taylor et al., 2019; Ryle & Kerr, 2002) are two attachment-informed psychological therapies that have been adapted to support individuals with complex relational difficulties and psychosis. These approaches seek to support individuals in exploring interpersonal patterns and internal states. It is believed that a better understanding of these difficulties may mitigate the intensity and frequency of experiences caused by psychosis (Berry et al., 2008). Combining these theories with family-focused interventions could provide a nuanced therapeutic experience for individuals who have had psychotic experiences and their loved ones.

Considering this literary evidence, it is clear that when early caregiving relationships are secure and supportive, they can act as a barrier against the development of psychotic experiences. In contrast to this, insecure or disorganised attachments can increase the vulnerability to psychological distress and thus psychotic experiences in some cases (Berry et al., 2008; Gumley et al., 2014; Korver-Nieberg et al., 2014). The connection between early caregiving, insecure attachment, and mental health difficulties elucidates the relevance of attachment theory in clinical practice and as a conceptual tool (Korver-Nieberg et al., 2013). In sum, converging evidence across biology, psychology, and social context underpins a biopsychosocial approach to psychosis.

Summary of Understanding of Psychosis

Psychosis understanding has evolved from biological models to more inclusive models that emphasise genetic vulnerabilities and cognitive mechanisms, to integrated biopsychosocial perspectives. Literary evidence demonstrates that early adversity, trauma, insecure attachment, and social stressors such as deprivation, discrimination, migration, and urbanicity can interact with neurodevelopmental and cognitive vulnerabilities. These predispositions can increase and shape levels of risk, symptom expression, and subsequent recovery (Varese et al., 2012; Morgan & Gayer-Anderson, 2016).

Modern interventions and care should thus combine pharmacological, psychological, and social interventions. For example, CBT-p, family therapy, and trauma-focused treatments with a person-centred and recovery-oriented approach, as recommended by national guidelines (NICE, 2014). A natural bridge from this synthesis is parenting, which encompasses early caregiving, family climate, and social context, themes central to the present study.

Parenting

Definitions and Dimensions of Parenting

Parenting is broadly categorised as a set of behaviours and attitudes, alongside interactions through which caregivers nurture, protect, and socialise their children across developmental stages (Bornstein, 2012). This includes the provision of practical care as well as emotional and social environments that affect children's well-being and adjustment. More contemporary research defines parenting as multidimensional and inclusively captures components such as emotional warmth, behavioural control, psychological control, responsiveness, and involvement (Pinquart, 2017). Elements of care, such as emotional warmth, marked by expressions of affection, support, and acceptance, are consistently associated with positive developmental outcomes, including secure attachment, better emotion regulation, and higher self-esteem (smaller studies demonstrate this, e.g., Pinquart, 2017; Pinquart & Kauser, 2018). Conversely, high levels of psychological control, marked by intrusiveness, criticism, or guilt-inducing tactics, have been associated with increased difficulty with emotion regulation and internalising difficulties within children and adolescents (Soenens & Vansteenkiste, 2010; Pinquart & Kauser, 2018). Behavioural control, marked by boundary setting and behavioural monitoring, appears to have merit when delivered alongside warmth and open communication. This reduces the risk of externalising problems and supporting adaptive social functioning (Pinquart, 2017). These core dimensions are elaborated upon in several influential theoretical models.

Psychological Models of Parenting

There are several psychological models that have been developed to understand parenting and its influence on child development. Most notable to explore for the present study are Baumrind's Parenting Style Model (1966, 1971), Social Learning Model (Bandura, 1977), Attachment Theory and parenting (Bowlby, 1982/1969, 1980), Family Systems Theory of parenting (Minuchin, 1974), and Ecological Systems Theory of parenting (Bronfenbrenner, 1979).

Baumrind's Parenting Styles Model

Baumrind's (1966, 1971) model of parenting is one of the most influential models. It identifies three main parenting styles: authoritarian, authoritative, and permissive. These are based on two key dimensions: responsiveness, which is categorised by warmth and acceptance, and demandingness, which is marked by behavioural control and expectations. Authoritarian parenting is high in demandingness and low in responsiveness, emphasising strict rules, obedience, and punitive discipline with limited dialogue. Authoritative parenting is high in demandingness and responsiveness, combining clear expectations and consistent boundaries with reasoning and support. Permissive parenting is low demandingness and high responsiveness, marked by high acceptance but few limits and inconsistent enforcement. This model was later expanded by adding a fourth style, neglectful or uninvolved parenting, which is marked by low levels of both warmth and control (Maccoby & Martin, 1983). Baumrind's *responsiveness* maps closely to attachment notions of caregiver sensitivity; similarly, *demandingness* overlaps with structured and non-intrusive control. The Parental Bonding Instrument's (PBI) *affectionless control,* characterised by low care and high overprotection, is similar to the insensitive caregiving described in attachment research (Parker et al., 1979). Literary evidence demonstrated that authoritative parenting, marked by high warmth and high control, is consistently associated with optimal outcomes such as academic achievement, social competence, and psychological well-being. Conversely, authoritarian parenting, marked by low warmth and high control, and neglectful parenting styles are frequently associated with poorer emotional and behavioural functioning (Baumrind, 1966; Maccoby & Martin, 1983).

Despite its influence, Baumrind's model has historically been critiqued for its oversimplification of complex caregiver-child dynamics by categorising them into fixed typologies, thus potentially neglecting essential influences such as cultural context, socioeconomic factors, and child temperament on parenting behaviours and outcomes (Darling & Steinberg, 1993; Cheah & Rubin, 2003). Additionally, much of the early evidence relied on correlational designs, thus making it difficult to determine causal relationships between parenting style and child outcomes.

Social Learning Models

The Social Learning Model is rooted in Bandura's (1977) Social Learning Theory. It comprises another important framework that emphasises that children learn behaviours, attitudes, and emotional regulation through observation, imitation, and reinforcement. Within families, parental modelling of emotional regulation and social problem-solving, together with patterns of reinforcement and punishment, shape coping and interpersonal styles. Conversely, coercive caregiver-child cycles can escalate oppositional behaviour and dysregulation (Patterson et al., 1992). Although developed later and independently of attachment theory, social-learning processes are compatible with attachment accounts. For example, observed caregiving practices and contingencies help to stabilise children's internal working models across development (Bandura, 1977; Bretherton, 1992; Patterson et al., 1992). These principles underpin parent-training approaches that can alter contingencies and promote constructive modelling, though detailed intervention coverage is not the primary focus here (Dretzke et al., 2009; Michelson et al., 2013; Dimova et al., 2021).

There are, of course, critiques of Social Learning Models, such as their primary focus on short-term behavioural change as opposed to long-term developmental outcomes (Gardner et al., 2019). Similarly, the programs often make assumptions such as consistent parental engagement and resource availability, which may not be representative of the realities of families that are facing socioeconomic hardship or systemic access barriers (Scott et al., 2001). Cultural adaptations of these programs have been limited, thus raising concerns around the generalisability across diverse cultural and community settings beyond Western norms (Leijten et al., 2016).

Attachment Theory and Parenting

Bowlby's (1982/1969) attachment theory outlines four primary attachment styles describing the relationships between children and their caregivers. These attachment styles can influence emotional and social development throughout life. The four main styles are:

1. Secure Attachment: This style develops when caregivers are consistently responsive and emotionally available. Children feel safe and confident that their needs will be met, leading to secure and trusting relationships in adulthood.
2. Anxious-Preoccupied (Insecure) Attachment occurs when caregivers are inconsistent, sometimes responsive, and sometimes neglectful. As a result, children may become overly dependent and seek constant reassurance, leading to anxiety in relationships.

3. Avoidant (Insecure) Attachment: When caregivers are emotionally unavailable or unresponsive, children may learn to suppress their emotions and become emotionally distant, avoiding intimacy and closeness in relationships.
4. Disorganised Attachment: This style results from erratic, frightening, or abusive caregiving. Children with disorganised attachment may exhibit confusion and fear towards their caregiver, leading to difficulty forming coherent or stable relationships later in life.

These attachment styles influence how individuals perceive and respond to relationships and stress, shaping emotional and behavioural patterns into adulthood. Whilst Bowlby's framework is highly influential, it has been critiqued for not being culturally sensitive enough in relation to attachment patterns, and for hyper-focusing on material care (Rothbaum et al., 2000). Modern-day progressions of attachment theory, such as the DMM (Crittenden, 2006) and mentalisation theory (Fonagy & Target, 1997), have further shaped our understanding of its psychopathology.

Historically, Bowlby's attachment theory (1958; 1969/1982) predates Baumrind's typology and Bandura's social learning theory. His synthesis drew primarily on the science of animal behaviour and psychoanalysis. Nonetheless, these models converge in practice around caregiving warmth and learned patterns of relating (Bretherton, 1992; Ainsworth et al., 1978; Bandura, 1977).

Bowlby's widely and globally recognised attachment theory (1969) is applied in psychopathology to understand psychiatric disorders. Bowlby associated certain patterns of parenting, such as high levels of control and limited responsiveness, with disruptions in caregiving. Researchers have studied parental bonding worldwide (Rothbaum et al., 2000). However, attachment theorists now recognise that attachment security is also contributed to by peer relationships, trauma and neurodevelopmental factors, alongside early caregiving experiences.

Using Bowlby's theory of attachment as a guide, we know that children need love, warmth and a close relationship with their parents to create a stable environment, which facilitates independent growth. It is suggested that without these critical structures and emotions, children will be raised in a highly anxious climate, which could subsequently lead to the development of psychiatric disorders (Bowlby & Ainsworth, 1992, 75-759). Parental bonding extends throughout life and is closely linked with quality of life. It is theorised that optimal parenting, warm parenting with sufficient boundaries and a caring nature, is crucial to the development of a child's mental health. To juxtapose this, unaffectionate, inattentive and neglectful parenting, with a cold affect, is suggested to predispose a child later to have trouble with interpersonal relationships and psychiatric disorders (Marshall et al., 2018).

Leading on from Bowlby's parental bonding styles, Parker created a more fluid concept of parental bonding styles (Parker, 1983). These styles also come with a prediction of consequence or outcome; for example, "caring parental bonding reflects a warm, close and empathetic relationship as opposed to a cold, rejecting and neglecting relationship. The second style is the over-protection or control of parental bonding, which involves parents' severe control and protection over their children, leading to the non-completion of independence in the children" (Abbaspour et al., 2021, 2).

Family Systems Theory

Family Systems Theory posits that families operate as an interconnected system with defined roles, boundaries, and hierarchies (Minuchin, 1974). It suggests that dysfunction arises when families implement boundaries that are too rigid, which leads to disengagement, or too relaxed, leading to enmeshment, both of which can disrupt the consistency of parenting and thus child adjustment. Minuchin (1974) developed Structural Family Therapy, which allows these principles to be applied clinically with the aim of restoring balance and healthier family dynamics (Cox & Paley, 1997).

Whilst Family Systems Theory has been influential in conceptualising familial dynamics, it is sometimes criticised for overemphasising the family unit to the detriment of considering broader social, cultural, and economic factors that can also have an influence on parenting and child outcomes (Henggeler & Sheidow, 2012). Much of the early work supporting Family Systems Theory was based on small, clinically referred samples that limit its generalisability to diverse family contexts (Carr, 2019). Structural Family Therapy has variable evidence base despite its wide application. Some studies have reported mixed or modest effects compared to other evidence-based interventions for child and adolescent difficulties (Barlow et al., 2012).

Ecological Systems Theory

Bronfenbrenner (1979) proposed Ecological Systems Theory, which highlights the paramount importance of multilayered environmental factors such as schooling, community, and broader social contexts in shaping parenting practices. It considers how socioeconomic status, cultural norms and public policy have the ability to influence parenting behaviours and child outcomes. This demonstrates that it cannot be exhaustively understood without the consideration of the wider ecological systems that families are embedded in.

Though this theory has received praise for its inclusivity and its comprehensive and multilevel perspective, critics have argued that its broad scope can make it difficult to operationalise in empirical research, thus creating difficulty in testing its propositions in a systematic way (Tudge et al., 2016). In contrast to other models, Ecological Systems Theory has been criticised for its lack of attention to individual agency and the bidirectional process between children and their environments. It is believed that this may cause oversimplification of complex developmental interactions (Neal & Neal, 2013). Despite this, its focus on policy and structural factors, interventions and evidence-based practices informed by this theory remains limited (Ceci, 2006). Alongside multilayer context, cognitive-behavioural perspectives describe how parenting beliefs and attributions shape day-to-day practices.

Cognitive Behavioural Perspectives on Parenting Practices

Cognitive-behavioural perspective on parenting elucidates how parents' beliefs, attributions, and expectations can shape their own parenting behaviour as well as their children's outcomes. For example, parents who interpret their child's misbehaviour as deliberate defiance rather than understanding it as opposed to developmental immaturity are more likely to use punitive and harsher discipline techniques. In contrast, parents who are supported to reframe these beliefs tend to respond in a more calm and effective manner (Morrisey-Kane & Prinz, 1999). Empirical research demonstrates that cognitive-behavioural interventions target parenting behaviours such as reinforcement and consistent discipline, as well as addressing any underlying thought patterns that may drive them. This produces meaningful reductions in externalising problems across a range of child populations (Riise et al., 2021). More recent literary evidence shows that incorporating training for caregivers on parental attributions, expectations, and beliefs about aggressive child behaviours can strengthen parental engagement and treatment effects for children with conduct issues (Fleming et al., 2022; Matthys et al., 2024). Though there are benefits to cognitive-behavioural approaches, they can also be demanding for caregivers who are managing high stress with limited resources. This raises questions about accessibility and long-term sustainability in diverse family contexts. As beliefs and practices are culturally embedded, it is important to situate parenting within social and cultural norms.

Parenting norms and practices vary considerably across cultural, socioeconomic, and spiritual contexts, shaping how warmth, authority, emotional expression, and caregiving roles are understood. These variations mean that behaviours labelled "supportive" or "controlling" in Western frameworks may carry different meanings in other cultural settings. Recognising this diversity provides a foundation for interpreting parenting experiences without assuming universality in psychological constructs.

Social and Cultural Influences on Parenting

Parenting practices emerge from a complex web of cultural values, social structures, and economic realities. These factors shape how children are raised, and which outcomes are prioritised. There are universal parental aspirations across cultures, for example, wanting children to feel secure, loved, and capable (Lansford, 2022). However, there are profound differences in how these goals are expressed. In Western culture, there are many individualistic societies that promote independence, self-expression, and autonomy and parents in these cultures will often encourage their child to voice opinions and make choices from a very early age (Yaman et al., 2010; Park, 2016). Conversely, in collectivist cultures, interdependence, obedience, and respect for authority often take priority as they are viewed as qualities that will create and maintain familial harmony and social cohesion (Bornstein et al., 2011; Park, 2016). This contrast is not always a simple dichotomy as many communities socialise their children towards autonomous relatedness, promoting independence within a connected familial context (Kâğıtçıbaşı, 2005).

There are culturally embedded meanings within parental norms about what constitutes care, control, and warmth. For example, some cultures may prioritise words of affirmation as a display of love and warmth, whereas others may prioritise communicating warmth through acts of service, shared mealtimes, or expectations of academic diligence and family loyalty (Bornstein, 2012; Lansford, 2022). These differences serve as a reminder that the same parenting behaviours, such as strict discipline or high academic expectations, can carry different implications across cultures depending on the lens through which they are understood.

Socioeconomic status is a powerful intersection that runs through these cultural frameworks. Families facing economic hardship are often more likely to encounter chronic stress, limited access to good-quality childcare and healthcare, and inequitable education opportunities. These factors can all contribute to shaping the emotional climate of one's home, and they can restrict parenting choices (Conger & Donnellan, 2007; Roubinov & Boyce, 2017). As an anomaly, material disadvantage does not necessarily dictate or predict poorer outcomes. The presence of strong familial and community connections can buffer against these effects. In many cultures, extended family members such as aunts, uncles, grandparents, and older siblings contribute significantly to child-rearing by offering practical caregiving, emotional support, and cultural continuity across generations (Sadruddin et al., 2019; Sear & Mace, 2008). These relational dynamics are able to sustain children's health and well-being even when primary caregivers face financial or social pressures. This demonstrates how parenting is embedded within broader ecological and cultural systems. There are cultural and structural factors that intersect with everyday stressors, which can either stretch or constrain parenting capacity.

Parenting Challenges

Parenting capacities can ebb and flow depending on the pressures and resources surrounding each individual family. Everyday stressors such as financial worries, time pressures, and housing or vocational instability can impact a parent's emotional bandwidth. This can make it more difficult to sustain patient and attuned responses to their child, potentially decreasing the capacity to stick to consistent routines. When enduring, these stressors can be linked with less sensitive interactions, more inconsistent discipline, and increased emotional and behavioural difficulties in children (Crnic & Low, 2002; Deater-Deckard, 1998). When caregivers are contending with their own mental health difficulties, such as anxiety or depression, the parental load can feel increasingly heavy. Literary evidence demonstrates that depressive symptoms are associated with lower parental warmth and more withdrawn and irritable responses from children. These are patterns that can erode caregiver-child reciprocity and can negatively impact child adjustment (Lovejoy et al., 2000). In contrast to this, anxiety often presents as increased control, overprotection, and threat-focused monitoring. The effects of this are usually small to moderate but remain consistent across studies and can maintain child anxiety over time (Wood et al., 2003; McLeod et al., 2007). A lack of sleep can amplify these effects; short or disrupted sleeping patterns can deplete self-regulation and increase irritability and harshness the following day. Longitudinal evidence has linked poorer parental sleep, particularly in fathers, to higher harsh parenting one year later (Kelly et al., 2021).

It is rare that barriers to effective parenting only sit within the caregiver-child dyad. Practical obstacles such as shift work and a lack of childcare can undercut parental efforts to attend appointments or follow programs (Axford et al., 2012; Koerting et al., 2013). Parents have also described uncertainty around where to access support or how to seek help, and fears around stigma and blame. There are frequently described mismatches between service expectations and the realities of families. Clear signposting, flexible delivery, and collaborative working would likely improve uptake and retention (Koerting et al., 2013; Reardon et al., 2017, 2018). Within a family home, alignment within the caregiving team is paramount. It is documented that when co-parents undermine each other or disagree on boundaries, consistency reduces. Conversely, coordinated co-parenting with mutual support is commonly associated with better child outcomes (Feinberg, 2003; Teubert & Pinquart, 2010). With this groundwork, it is possible to consider how childhood experiences and parenting relate to later psychosis.

Childhood Experiences, Parenting, and Psychosis

A broad evidence base links early caregiving and parenting climates with later psychotic experiences. Specific study examples are summarised below.

Attachment Theory and Parental Bonding in the Context of Psychosis

As psychosis becomes more widely understood, it is said to be shaped by biological factors as well as relational, emotional, and environmental influences. Attachment theory is able to serve as a useful framework to further explore how early caregiving relationships are experienced and how they may affect psychotic symptoms across the lifespan (Berry et al., 2008; Gumley et al., 2014). However, whilst attachment theory is widely applied when trying to understand the interpersonal difficulties of psychosis, this remains a contested practice in some disciplines. This is particularly the case where neurobiological or genetic models are prioritised (Bentall, 2003; Read et al., 2009). Early attachment is one pathway, another widely studied pathway involves exposure to adverse experiences in childhood. In UK inpatient samples, higher attachment anxiety and avoidance are associated with greater interpersonal difficulties, including within therapeutic relationships (Berry et al., 2008).

Parental Bonding Styles

The PBI, created by Parker, Tupling, and Brown (1979) was developed to measure the retrospective perceptions of parenting. These were measured across two categories: care and control. These categories comprise four primary bonding styles:

- Optimal Parenting (high care, low control)
- Affectionless Control (low care, high control)
- Affectionate Constraint (high care, high control)
- Neglectful Parenting (low care, low control)

The PBI relies on retrospective self-reported accounts thus, critics often call into question the element of recall bias. They suggest that it may not be inclusive when considering variability in parenting experiences (Murphy et al., 2010; Wilhelm & Parker, 1990). This concern is heightened in psychosis research, where current symptoms and mood can shape how early caregiving is remembered and reported, potentially biasing associations between perceived parenting and psychosis outcomes (Fisher et al., 2011; Gayer-Anderson et al., 2020; Hardt & Rutter, 2004).

Attachment and Bonding in Early Childhood

Whilst there is evidence of global research contributing to our understanding of parental bonding styles in association with the development of psychiatric disorders in ILEP, a literature search has highlighted a deficit in the knowledge. This deficit specifically pertains to experiences of parenting ILEP, highlighting caregiver voices alongside ILEP narratives in the psychosis literature. It is fundamental to consider the evolution of attachment theory. Increasingly, researchers are edging towards systemic, trauma-informed, and relational approaches that offer a better fit for the complexities surrounding psychosis than caregiver behaviour alone (Liotti & Gumley, 2008; Schore, 2012). In psychosis research, insecure attachment and perceived low care/high control are more common (Korver-Nieberg et al., 2014), and family climate, particularly high expressed emotion, predicts relapse (Ma et al., 2021). Consistent links between childhood adversity and psychosis further underline the need to consider context (Varese et al., 2012), and clinical guidance supports family-inclusive care (NICE, 2014). This research aims to gain insight demonstrating the need for a thorough and robust assessment of family dynamics and functioning, and early intervention for service users and families alike by integrating caregiver and ILEP perspectives to inform assessment and early intervention in psychosis.

Adverse Childhood Experiences and Psychosis

Adverse childhood experiences including abuse, neglect, violence within the family home, loss, and chronic family adversity are all associated with increased risk levels for the development of psychotic symptoms and diagnoses (Flinn et al., 2025; Varese et al., 2012). Flinn et al. (2025) suggested that the greater the cumulative exposure to adverse experiences, the higher the risk, including earlier onset and more persistent symptoms. Varese et al. (2012)

suggested that timing and chronicity matter, stating that repeated and prolonged exposure to adversity in early and middle childhood can make an individual's stress-response system more sensitive. This can heighten their anticipation of threat and contribute to the shaping of maladaptive cognitive and interpersonal patterns that can later amplify an individual's vulnerability to psychosis when under stress. Although many adversities reviewed are family-based, the meta-analysis did not test caregiving context or parental support as moderators. Evidence for potential buffering by family climate comes from other studies, for example, lower relapse risk with higher familial warmth/low criticism and prospective links between greater warmth/appropriate structure and fewer psychotic-like experiences (Ma et al., 2021; Shahimi et al., 2013; Raudino et al., 2013).

Specific Parental Factors

Daily parenting practices can work to mitigate or magnify the impact of adversity. Emotion regulation, reality testing, and help-seeking appear to be supported by parental warmth and sensitive responsiveness. This reduces the likelihood of unusual experiences becoming entrenched symptoms (Butler et al., 2019; O'Brien et al., 2006; Schlosser et al., 2010). Utilising a parental framework that provides structure, clear expectations, predictability, routine, and a fair background setting can help to lower background stress and improve sleep and daily functioning (Freeman et al., 2017).

In practice, the most protective patterns of parenting include a combination of warmth with appropriate boundary setting, encouraged but graded autonomy, and collaborative problem-solving, whilst actively reducing familial conflicts, working to improve communication, and encouraging healthy sleep routines (Butler et al., 2019).

Parenting Styles, Psychosis Risk, and Mechanisms

The pathways here are likely very complex. Biological responses, such as sleep disruption or feeling constantly on edge, can intersect with social factors, including isolation or discrimination, as well as psychological processes, including negative self-beliefs or dissociation (Kapur, 2003; Reeve et al., 2015). Not every type of adversity will carry equal weight. Experiences marked by interpersonal threat or ongoing unpredictability appear to have a stronger impact in comparison to consistency and supportive relationships, which can buffer against these risks and support recovery (Varese et al., 2012). Beyond cumulative adversity, specific day-to-day parenting practices may buffer or amplify these risks. In particular, parenting styles can influence more than just their child’s well-being; they also appear to play a role in vulnerability to severe mental health outcomes, including shaping the risk of psychosis. For example, maternal authoritarian parenting prospectively predicted symptom emergence in ultra-high-risk youth (Peh et al., 2020), authoritarian/neglectful styles predicted paranoia/delusions in a cohort study (Raudino et al., 2013), and low care/high control related to greater symptom severity in first-episode psychosis (Pollard et al., 2023).

Authoritative parenting, marked by warmth, behavioural control, and promotion of autonomy, is reliably linked to the reduction of internalised symptoms over time, whereas harsher or more psychologically controlling parenting styles, hallmarked by inconsistency and neglect, are associated with higher rates of emotional distress, anxiety, and depression (Kassis et al., 2025; Gorostiaga et al., 2019). Literary evidence pertaining to psychosis populations and family environments demonstrates that exposure to harsh criticism or low warmth correlates with increased risk of relapse and persistent symptoms. For example, Ma et al. (2021) conducted a meta-analysis that found high expressed emotion could predict relapse in schizophrenia, whereas high warmth was found to be a protective factor. These findings suggest that parenting can influence psychosis risk via several interconnected mechanisms. This can increase stress sensitivity and impair cognitive appraisals of ambiguous experiences, thus shaping vulnerability over time (Ma et al., 2021; Mazza et al., 2022).

Family Dynamics, Expressed Emotion, and Psychosis

Family functioning, particularly the quality of communication, levels of conflict, and expressed emotion, has been strongly associated with mental health outcomes and psychosis relapse. Ma et al. (2021) reported that individuals who come from a family home with high expressed emotion are significantly more likely to relapse within a twelve-month period. Experiences of critical comments were a high predictor of this in comparison to parental warmth, which was demonstrated to have reduced the likelihood of relapse. A meta-analysis completed by Mazza et al. (2022) confirmed that expressed emotion is a valid and reliable predictor of relapse in schizophrenia and major depression. Familial dynamics such as these likely operate using mechanisms of emotional arousal, threat appraisal, and reduced sleep, which reduces help-seeking (Butzlaff & Hooley, 1998; Ma et al., 2021; Fahrer et al., 2022). Family climate is also shaped by culture and by patterns transmitted across generations.

Intergenerational and Cultural Perspectives

Cultural and intergenerational legacies shape parenting norms and outcomes. Cross-cultural literary evidence demonstrates that what constitutes warmth or control can be interpreted and impact families differently depending on cultural expectations. This can influence how children appraise care and develop coping strategies (Bornstein, 2012; Lansford et al., 2022). Whilst direct psychosis risk by cultural and parenting style is a lesser studied area, existing research in adolescent mental health demonstrates that warmth, control, and autonomy granted map differently onto internalised symptoms depending on an individual's cultural backgrounds (Gorostiaga et al., 2019). Intergenerationally speaking, parenting psychopathology and familial climate are transmitted through family systems. This means that parents who experienced harsh or inconsistent parenting themselves are more likely to exhibit those styles in their parenting of their own children, which contributes to an increased risk in ILEP (Fahrer et al., 2022). Taken together, these strands point to converging risks and protections.

Implications

Prevention and early intervention are most effective when the approach combines considerations around exposure and context. This is likely to reduce ongoing adversity and strengthen caregiver well-being, which helps to build consistency, warmth, and autonomy-supportive parenting, and target risk factors such as sleep and social isolation (Reeve et al., 2015). A trauma-informed and family-centred approach combined with culturally sensitive support and practical problem-solving offers increased chances of altering trajectories prior to distress solidifying into disorder (Flinn et al., 2025; Varese et al., 2012). One-way researchers have operationalised these ideas is through standardised measures of perceived parenting.

Critical Summary of Childhood Experiences and Psychosis

Synthesising childhood adversity, parenting styles, and family climate reveals a set of risk factors and a set of protective factors. These risk factors include high expressed emotion, including criticism and hostility, chronic or repeated adversity, harsh or inconsistent parenting, low warmth, and sleep disruptions. Protective factors include authoritative parenting, marked by warmth, structure, and autonomy support, a secure attachment, stable and consistent communication within the family, and early intervention when disruptions to functioning or stress occur. This demonstrates that psychosis risk cannot solely be attributed to exposure to adversity, rather it is deeply influenced by how children are parented and how families respond to stress over time. This synthesis motivates the focus and design of the present study.

There is substantial evidence associating adverse childhood experiences, familial climate, and psychosis risk. However, these literatures are often examined in isolation. There are a few empirical studies that have integrated multiple rationale processes, such as warmth, conflict, emotional responsiveness, and familial communication, into a singular framework. Additionally, a combination of the perspectives of ILEP and caregivers is scarcely included in psychosis research, leaving uncertainty in qualitative psychosis research. The present study attempted to address these gaps by drawing on retrospective accounts from caregivers and ILEP alike, exploring how parenting practices, family dynamics, and early relational experiences can interact with preestablished risk and protective factors in psychosis, offering a more nuanced and integrated family-centred understanding. I will now situate the work by outlining my positionality and the clinical encounters that shaped these research questions.

Chapter 2

Literature Review

Chapter Overview

Offering contextualised and existing literary evidence is essential. Having explored more conceptual links between caregiving, parenting features, and psychosis in the previous chapter, this chapter will offer more concise insights into the existing associations between parenting and the development of psychosis. Parenting and parental influence play a crucial role in the formation of a child's emotional and psychological development. It is increasingly recognised as an essential factor in the onset and progression of psychiatric disorders. In order to situate this research study within the existing literature base, a systematic literature review was completed. This review explored how parenting experiences related to experiences of psychosis.

This chapter will outline relevant and key definitions and frameworks in relation to psychosis and parenting. It will then present a PRISMA-aligned systematic review organised by review aims: (1) the quality of the evidence base, (2) how parenting experiences relate to psychosis-related outcomes, and (3) the role of adversity. It will also explore key family processes and cultural/contextual factors are considered insofar as they address these aims. Detailed findings are reported in the Results under these headings. The aim of this review was to synthesise and critically appraise existing literary evidence on how parenting relates to psychosis, e.g., onset, emergence, social functioning, and symptom severity, to identify any consistent patterns, limitations, and implications for research and practice. Given the established role of childhood adversity in psychosis risk, this review also examined how parenting co-occurs with trauma/stress where reported. This chapter concludes with a discussion and conclusion.

Introduction

Parenting features have long been recognised as a pivotal influence on a child's emotional, psychological, and social development (Baumrind, 1991; Parker, 1983). Beyond general development outcomes, they also play a significant role in the aetiology and progression of severe mental health conditions, including psychosis, especially when trauma and adversity are present (Varese et al., 2012; Luyten et al., 2020). Psychosis is a spectrum of disorders that includes schizophrenia, schizoaffective disorder, and certain forms of bipolar disorder. It is characterised by a sense of disconnection from reality, which often manifests through hallucinations, delusions, and disorganised thinking (British Psychological Society [BPS], 2014). Understanding its multifactorial origins requires considering a range of biological, environmental, and psychological factors (van Os et al., 2010). Increasingly, research is turning to early life experiences, particularly the quality of parenting, as a significant environmental contributor (Gumley et al., 2010; Berry et al., 2008).

In addition to typologies, parenting is defined as a multidimensional construct that includes caregiving practices such as warmth/responsivity and monitoring/discipline, the quality of the caregiver-ILEP relationship (attachment/bonding), and wider family processes such as communication patterns and expressed emotion, shaped by contextual factors such as parental mental health and stress, and socioeconomic culture and context (Bowlby, 1988; Berry et al., 2008; Varese et al., 2012). Classic typology work, such as Baumrind (1966) and Parker (1983), is referenced where studies operationalised parenting via care/warmth and control/discipline, but specific styles are treated as one strand within the broader parenting landscape examined in this review.

Gap and Rationale for the Qualitative Study

There were two striking gaps identified in the review. Firstly, the scarcity of qualitative studies and caregiver perspectives, and secondly, the dominance of retrospective self-report methods that capture patterns but not relational processes or meaning-making. A dual-perspective qualitative design is therefore warranted to illuminate how ILEP and caregivers understand parenting practices, relationship quality, and family processes in context. By exploring the convergence and divergence in accounts, the differences are able to be treated as meaningful evidence rather than errors (Mays & Pope, 2000; Kuipers et al., 2010).

Review Aims and Objectives

1. What is the quality of the literature examining parenting and psychosis?
2. How do parenting experiences relate to experiences of psychosis?
3. What is the role of adversity in parenting and psychosis?

Method

Systematic Literature Review: Parenting and Psychosis

The review selection and search strategy followed the principles and guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page et al., 2021). No formal protocol was registered prior to conducting this review. The review's objectives were to (a) map associations between parenting practices, relationship quality, and family processes, and psychosis outcomes, including onset, emergence, symptoms severity, and functioning, (b) evaluate strengths and limitations of included evidence, and (c) identify gaps and implications for research and practice (see Review Aims and Objectives).

Review Rationale

Prior studies on parenting and psychosis, dispersed across the dimensions outlined above, are dominated by retrospective self-report measures, and scarcely include caregiver perspectives or qualitative evidence (Berry et al., 2008). Given this fragmentation and indications that contextual factors such as stress and trauma may moderate associations, a systematic review using narrative synthesis was warranted to map the evidence, appraise methodological quality, and identify consistent patterns and gaps to inform research and practice.

Eligibility Criteria

Eligibility criteria were pre-specified:

Inclusion Criteria

Studies were included if they:

- Examined clinical populations with DSM-5/ICD-11 psychotic diagnoses, or who were high risk of psychosis or experiencing first episode psychosis OR caregiver populations to ILEP with a psychosis diagnosis. Caregiver refers to adults who provided day-to-day care in childhood/adolescence, including biological, adoptive, step-parents, legal guardians, or kinship carers.
- Explored the relationship between parenting and psychosis
- Examined exposures to parenting practices, relationship quality, and family processes
- Included outcomes relating to psychosis onset, emergence, symptom severity, and functioning

- Were peer-reviewed empirical studies, including qualitative, quantitative, and mixed-method designs
- May have included measures of adversity/trauma, e.g., maltreatment, abuse, neglect, adverse childhood experiences, and chronic stress. They were not required for inclusion but were extracted when available. Trauma/adversity was defined as exposure to maltreatment (emotional/physical/sexual abuse, domestic violence, bullying/peer victimisation, or cumulative adverse childhood experiences as assessed by a validated tool (Childhood Trauma Questionnaire [CTQ], Adverse Childhood Experiences [ACEs] checklist) or documented clinical report. Stress refers to validated measures of contextual stress (e.g., life events, family stress)

Exclusion Criteria

Studies were excluded if they:

- Focused exclusively on drug-induced psychosis
- Were non-empirical papers, such as editorials, opinion pieces, commentaries and essays
- Were not available in English
- Focus on foster parents as parenting spans only a minority of an ILEP's childhood
- No exclusions were applied on the basis of adversity/trauma reporting (or non-reporting).

Search Strategy and Extraction

A structured and transparent approach was used to identify, review, and select the relevant studies about parenting features and psychosis. This process encompasses defining clear inclusion and exclusion criteria, systematically searching databases, using predefined search terms, and screening titles and abstracts of papers before a full-text review of the appropriate papers. The final decisions to include studies were based on their relevance to the research aims of this study. In order to ensure transparency and replicability, this process was documented using a PRISMA flow diagram (see Figure 1) and followed the PRISMA checklist (see Appendix K). All data pertaining to parenting features and trauma/adversity were extracted.

To maximise coverage, I ran a systematic search across six databases via EBSCOhost (APA PsychArticles, APA PsychInfo, APA PsychTests, CINAHL Ultimate, MEDLINE Ultimate, and Open Dissertations). Guided by the SPIDER framework (Cooke et al., 2012), terms were drawn from prior reviews and key studies, then iteratively refined with a research librarian for sensitivity and specificity. The final search strategy combines the following domains with Boolean operators:

- Sample: psychosis OR schizophrenia OR psychotic disorder OR psychotic OR schizoaffective OR first-episode OR early psychosis OR first episode psychosis OR FEP OR clinical high risk OR ultra-high risk OR psychotic-like experience
- Phenomenon of Interest: parenting OR parenting style OR parenting feature* OR caregiving OR family environment OR parent* OR carer* OR guardian* OR family AND parent-child relationship OR bonding OR attachment OR expressed emotion OR emotional overinvolvement OR hostility OR criticism OR warmth OR responsiv* OR sensitivity OR nurtur* OR monitoring OR discipline OR control OR overprotection OR affectionless control OR family communication
- Design: qualitative OR interview OR focus group OR narrative OR thematic analysis OR phenomenology OR retrospective OR longitudinal OR cross-sectional OR cohort OR case-control OR mixed-methods

- Evaluation: experience OR perception OR belief OR relationship OR bonding OR attachment OR symptom* sever* OR hallucinations OR delusions OR paranoia OR relapse OR functioning OR emotion* regulat*
- Research Type: qualitative OR quantitative OR mixed methods

Selection and Data Collection Process

Study selection numbers, including identification, screening, eligibility, and inclusion, are reported at the start of the Results section and summarised in the PRISMA flow diagram (see Figure 1).

Searches covered the database inception to 30th September 2025. All papers identified from these database searches were then imported into Zotero 5.0 (Roy Rozenzweig Centre for History and New Media, 2017), a reference management software. Data were extracted by one reviewer. Extracted items were cross-checked against the original articles, no author contact was undertaken for missing data.

Extracted variables included the author, year, design and sample, population, diagnosis, parenting exposure constructs and measures (e.g., PBI care, overprotection/control, other relevant scales), psychosis-related outcomes/measures, statistical results and variance where reported, and notes on context, for example, stress indices/trauma. Trauma/adversity variables were extracted where available. Parenting features and trauma/adversity were coded separately to avoid conflation.

Quality Appraisal

The studies included in this review underwent critical appraisal. Despite ongoing debates about the appropriateness of applying quality criteria to qualitative studies (Lachal et al., 2017), the decision was made to use the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018), following the Cochrane Collaboration recommendations (Higgins et al., 2022). The MMAT (see Appendix L) is designed to assess the quality of quantitative, qualitative, and mixed methods studies, and consists of a checklist and criteria tailored to different study designs. Section 4 was applied to the nine quantitative studies, and section 5 to the single mixed-methods study (Weintraub et al., 2021) No studies were excluded based on quality.

Synthesis Methods

A narrative synthesis approach was taken to analyse and collate the findings from the included studies. The rationale for this choice is outlined in the review rationale. Narrative synthesis guidance was followed (Popay et al., 2006), which included developing a preliminary synthesis across the studies, exploring the relationships within and between studies, and evaluating the strength of the synthesis. Adversity/trauma variables were treated as contextual moderators and narratively synthesised when reported. No meta-analysis of moderation was attempted.

Although quantitative pooling was considered, a meta-analysis was not undertaken because too few studies reported comparable effect-size statistics with variance estimates, and those that did examined differently defined outcome and follow-up periods. There was substantial clinical and methodological heterogeneity across samples, alongside wide variations in how parenting and psychosis outcomes were operationalised. Analytic approaches were similarly inconsistent, with mixed adjustment strategies, non-overlapping covariate sets, and infrequent reporting of interaction terms needed for extraction. These factors meant that any pooled estimate would have limited interpretability and risk being misleading. Consistent with guidance discouraging statistical synthesis under high heterogeneity (Higgins et al., 2022), a narrative approach was therefore deemed the most appropriate and transparent option for this evidence base.

Each study's results section was used as data. Each study was reviewed individually, extracting the core information, which included the study characteristics (design, sample characteristics, diagnoses, and the parenting features that were examined), as well as the key outcomes. All relevant data were extracted and narratively synthesised together to answer each aim in turn:

- Aim 1: What is the quality of the literature examining parenting and psychosis?
- Aim 2: How do parenting experiences relate to experiences of psychosis?
- Aim 3: What is the role of adversity in parenting and psychosis?

To structure the synthesis, parenting was examined across three key domains: (a) caregiving practices, for example warmth/care; monitoring/control/discipline, (b) caregiver-ILEP relationship quality, for example attachment/bonding, and (c) family processes, for example communication patterns and expressed emotion, within contextual factors for example, parental mental health or stress, and socioeconomic and cultural contexts. Style labels were applied only when authors reported PBI typologies (Parker et al., 1979; Parker, 1983), such as "optimal boning", affectionate constraint", "affectionless control" and "neglectful". This follows the PBI conventions (Parker et al., 1979; Parker, 1983). No labels were imposed otherwise. Construct groupings followed the extracted measures and authors' operationalisations, such as the PBI care/overprotection. Classic frameworks were used as organising lenses rather than imposed taxonomies (Baumrind, 1966; Parker et al., 1979; Bowlby, 1988; Ma et al., 2021). Categories were applied only where warranted by the data.

To reduce subjectivity, coding proceeded in two phases, first at the construct level, using verbatim extraction of measures or subscales and their direction, then at the interpretive level, using feature-based shorthand with the original authors' wording kept where relevant. Ambiguous cases were flagged and not assigned to style-linked categories. Synthesis followed narrative methods, examining convergence/divergence across designs and populations whilst weighing interpretation by study quality (MMAT) and clarity of construct operationalisation.

Both retrospective and prospective studies were included in the review. Given their stronger longitudinal value, prospective findings were summarised in their own dedicated subsections.

Results

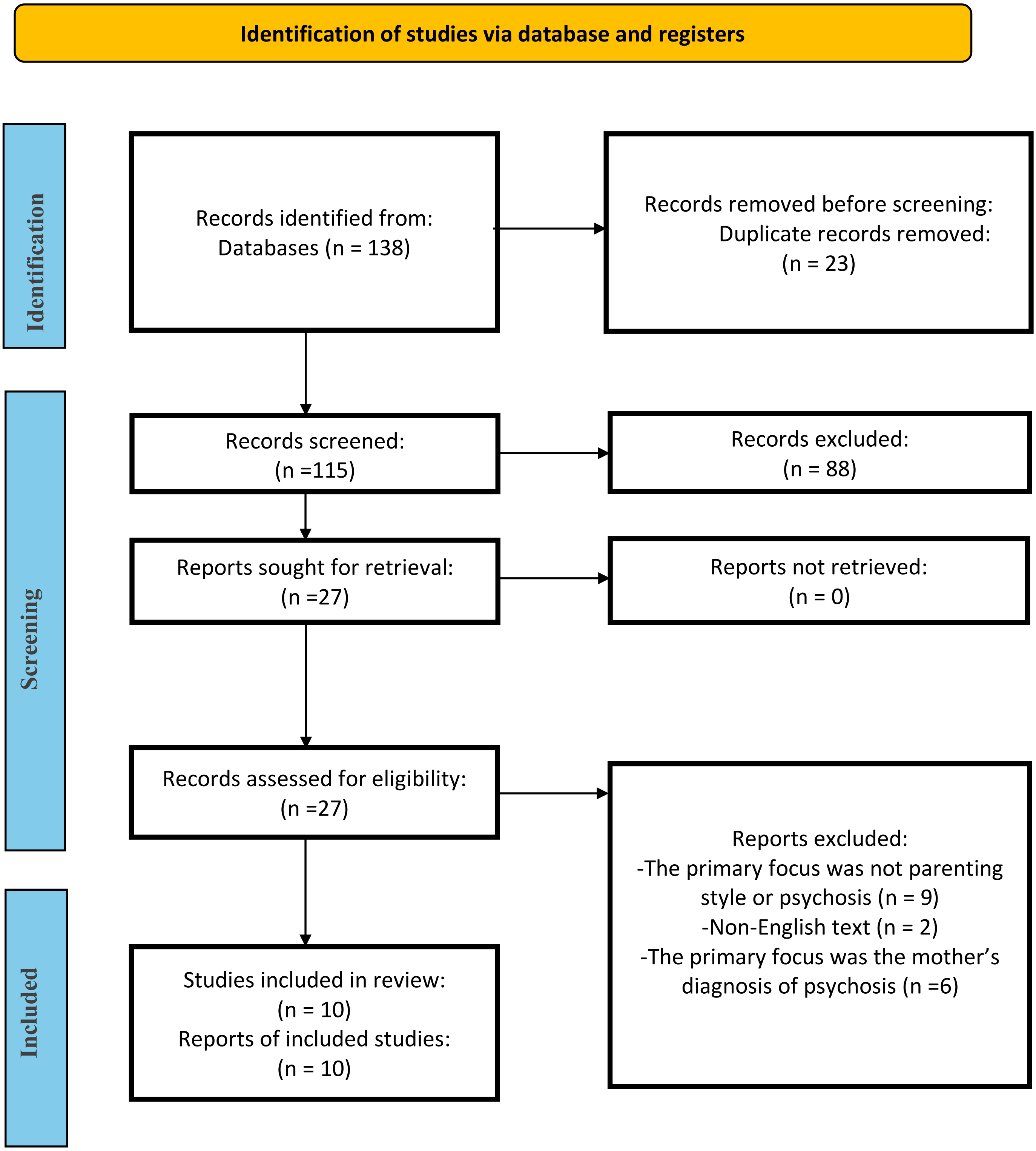
The results of this review are presented in order of the review aims: (1) quality of the literature, (2) associations between parenting and psychosis, and (3) the role of adversity.

Study Selection

Data Extraction and Findings

The initial search returned 138 results. Duplicates were automatically removed using Zotero, and an additional duplicate was manually excluded. Title and abstract screening led to the exclusion of 88 studies that did not meet the inclusion criteria, leaving 27 studies for full-text review. Based on the defined eligibility criteria, ten studies were included in the final synthesis. Full texts were obtained and reviewed for any papers lacking sufficient abstract information (see Figure 1 for the identification process). Searches were restricted to English-written peer-reviewed journal articles that involved only human participants.

Figure 1: *PRISMA 2020 flow diagram for new systematic reviews (Page et al., 2021)*



Study Characteristics

The review included 10 studies ranging from 1979 to 2023 (see Table 1). Of the ten studies included, nine were quantitative and one used a mixed-methods design; no purely qualitative studies were identified. (Weintraub et al., 2021). Sample sizes varied considerably, from 72 (Sevilla-Llewellyn-Jones et al., 2019) to 924 participants (Raudino et al., 2013). The populations studied included individuals diagnosed with schizophrenia (Pollard et al., 2023), bipolar disorder (Gomes et al., 2023), those at ultra-high risk for psychosis (Peh et al., 2020), and general or clinical adolescent populations (Shahimi et al., 2013; Raffagnato et al., 2021; Raudino et al., 2013). In the context of this systematic review, studies referred to as having retrospective designs include cross-sectional studies where participants used self-reported accounts of past experiences. Prospective designs refer to participants who were followed over a longer period of time, also known as longitudinal cohort studies. No randomised control trials were included in this review.

This literature review highlighted a clear gap in the evidence on parenting and the development of psychosis. The quantitative papers predominantly relied on standardised self-report tools such as the PBI (Parker et al., 1983). These tools are useful for identifying patterns but limit access to contextualised, subjective accounts (Mathews et al., 2014). ILEP views were captured via self-report (Pollard et al., 2023; Sevilla-Llewellyn-Jones et al., 2019; Shahimi et al., 2013; Raudino et al., 2013; Abbasapour et al., 2021), whereas caregiver perspectives appeared only in a single mixed-methods paper (Weintraub et al., 2021), which included mood disorders alongside psychosis and provided limited qualitative material.

The details of the studies reviewed in this literature review can be found in Table 1.

Table 1. *Review of Studies (listed in alphabetical order)*

Study	**Methodology**	**Study Type**	**Design**	**Sample Size**	**Population Type**	**Diagnosis**	**Measure Used**	**Parenting Features & Psychosis Relationship**	**Statistical Results**
Abbasapour et al., (2021)	Quantitative	Retrospective	Cross-sectional	130	Adults with psychosis	Schizophrenia, Bipolar Disorder	PBI (Parental Bonding Instrument)	Higher care with appropriate control linked to better social and occupational functioning.	P < .05, OR not reported
Gomes et al., (2023)	Quantitative	Retrospective	Cross-sectional	200 (100 clinical group- 100 control group)	Clinical vs. control	Schizophrenia, Bipolar Disorder	CTQ (Childhood Trauma Questionnaire), PBI	Low care/high control more prevalent in clinical groups; increased childhood trauma.	p < .01, Cohen's d = .45
Peh et al., (2020)	Quantitative	Prospective	Longitudinal cohort	164 clinical, 510 controls	Youths at ultra-high risk	Prodromal psychosis	Parental bonding questionnaire	Maternal authoritarian parenting predicted psychotic symptom onset.	HR = 1.76, CI [1.30-2.38]
Parker et al., (1979)	Quantitative	Retrospective	Cross-sectional	867	Psychiatric outpatients	Various psychiatric disorders	PBI	Higher parental care with moderate control linked to greater resilience against psychosis.	Associations with psychotic disorders specifically were weak

Study	Methodology	Study Type	Design	Sample Size	Population Type	Diagnosis	Measure Used	Parenting Features & Psychosis Relationship	Statistical Results
Pollard et al. (2023)	Quantitative	Retrospective	Cross-sectional	84	Adults with psychosis	First episode	PBI	Maternal low care and high control was associated with greater symptoms severity.	p < .01
Raudino et al., (2013)	Quantitative	Prospective	Longitudinal cohort	924	Adolescents	Variation of clinical disorders	Parental style interview	Authoritarian/ neglectful parenting predicted paranoia and delusions.	p < .05, there was a significant association between all measures of attachment and bonding and later outcomes
Sevilla-Llewellyn-Jones et al., (2019)	Quantitative	Retrospective	Cross-sectional	72	Clinical adults	Schizophrenia spectrum disorder	PBI	Maternal affectionless control linked to severe personality pathology.	Not reported. Significant predictive relationship between PBI bonding styles and relapse risk

Study	Methodology	Study Type	Design	Sample Size	Population Type	Diagnosis	Measure Used	Parenting Features & Psychosis Relationship	Statistical Results
Shahimi et al., (2013)	Quantitative	Prospective	Longitudinal	884	Adolescents	Psychoticism	Self-report scales	Lower warmth and/or inconsistent/strict control linked to higher psychoticism (trait)	p < .05, significant group differences
Weintraub et al., (2021)	Mixed methods	Mixed methods	Cross-sectional	123	Parents and adolescents with mood disorders	Psychosis and mood disorders	Parenting questionnaire	Authoritarian parenting predicted psychosis under high stress.	Interaction p < .01
Raffagnato et al., (2021)	Quantitative	Retrospective	Cross-sectional	125	Adolescents	Varied clinical diagnoses	PBI, child behaviour checklist, self-report	Parenting style and psychopathology	p < .01

Aim 1: What is the quality of the literature examining parenting and psychosis?

Methodological Quality

Across the ten studies, designs ranged from retrospective self-report surveys to longitudinal cohort studies, with one mixed-methods paper. Using the MMAT to structure appraisal (see Appendices L & M), ratings indicated generally moderate methodological quality overall.

Sampling and Representativeness

Sample sizes varied considerably, with several modest, often convenience-based clinical samples. This raises concerns about selection and non-response/participation bias noted in the MMAT assessments. Cultural context also moderates how families understand, respond to, and communicate about unusual experiences. Help-seeking patterns, stigma, expressions of distress, and interpretations of psychotic symptoms differ across cultural and religious communities, with some families drawing on spiritual or collective frameworks before accessing clinical services (Morgan & Gayer-Anderson, 2016; Selten et al., 2019; Baker et al., 2021). In addition, expressed emotion, threat appraisal, and communication styles show culturally patterned variations, meaning that “high criticism” or “emotional over-involvement” may not map neatly across groups (Lopez et al., 2004). These factors underscore the need to situate parenting within broader cultural, migratory, and structural contexts.

Measurement Quality and Bias

Most quantitative papers set out clear questions and used validated tools, most often the PBI, which helped keep measures consistent. However, many relied on a single person’s retrospective account of childhood. These reports are vulnerable to recall bias as people may interpret earlier experiences in light of current symptoms, which weakens confidence in cause-effect conclusions (Fisher et al., 2011; Susser & Widom, 2012; Gayer-Anderson et al., 2020). Where relevant, assessors' blinding was rarely reported. Much of the data was self-reported, but the lack of blinding still limits the confidence.

Control of Confounding and Design Limitations

Cross-sectional designs predominated, offering a snapshot rather than a sequence. Because of this, they are unable to establish causality, leaving unmeasured variables potentially accountable for observed links between parenting features and psychosis (Shadish et al., 2002; Hernan & Robins, 2020). Where prospective cohorts were used, attrition was reported or likely, and adjustment for baseline differences and confounders was typically partial. Outcome measures are covariate sets varied widely across papers, reducing comparability and limiting the feasibility of meta-analysis.

Mixed-Methods Integration

The single mixed-methods study offered a clear rationale for combining two approaches but reported limited integration of qualitative strands at the interpretation stage. This is an MMAT concern for method quality.

Evidence Gaps

Across the set, caregiver perspectives were under-represented and purely qualitative studies were absent, underscoring the need for in-depth inquiry into relational processes and meaning-making. No studies were excluded on quality grounds, rather, MMAT appraisals were used to weigh interpretation of synthesis.

Contextual Note on Design Types

Retrospective studies (Sevilla-Llewellyn-Jones et al., 2019; Pollard et al., 2023) provide valuable insight into how individuals with psychosis perceive earlier parenting and commonly employ standardised tools such as the PBI. At the same time, their susceptibility to recall bias (Fisher et al., 2009; Susser & Widom, 2012; Gayer-Anderson et al., 2020) and their inability to determine chronological ordering sit behind the narrative (rather than pooled) synthesis choices, with causal claims avoided in line with guidance (Shadish et al., 2002; Hernan & Robins, 2020).

Aim 2: How do parenting experiences relate to experiences of psychosis?

Across ILEP reported studies, lower care/warmth and higher control/overprotection were generally associated with more adverse psychosis-related outcomes, for example, greater symptom severity or earlier or elevated risk of psychosis (Pollard et al., 2023; Raudino et al., 2013; Peh et al., 2020; Gomes et al., 2023). Contrary to this, warmer and more responsive caregiving with clear structure and boundaries corresponded with better social and occupational functioning as well as reduced symptom expression (Parker et al., 1979; Shahimi et al., 2013; Abbasapour et al., 2021). Mechanistic accounts suggest that high-arousal family climates can heighten threat appraisal and that sleep disruption can exacerbate suspiciousness and distress, linking parenting context to symptom expression (Kapur, 2003; Reeve et al., 2015; Ma et al., 2021). Where instruments such as the PBI were used, these patterns often reflected differences in measured dimensions, such as lowered scores on warmth/care and higher scores on control/overprotection.

Though few and far between, prospective studies were influential in offering longitudinal insights. Peh et al. (2020) suggested that experiences of low care/high control parenting could predict the emergence of psychosis in youths who were considered to be ultra-high risk of psychosis. They suggested that experiences of authoritarian parenting can shape early emotional development and increase long-term vulnerability. Shahimi et al. (2013) demonstrated that higher warmth/responsivity with appropriate control could have protective properties. They concluded that adolescents raised with higher warmth and appropriate structure demonstrated reduced risk for psychotic symptoms even when other factors were present. Raudino et al. (2013) suggested that authoritarian or neglectful parenting styles could predict later psychotic features such as paranoia and delusions. This pattern is consistent with the protective role of warmer parenting features with clear structure. These studies suggested temporal ordering but did not imply or establish causality.

Low Warmth/High Control Caregiving

Parenting characterised by high control and low emotional warmth was frequently associated with negative psychosis-related outcomes. Studies repeatedly correlated this with an increase in the severity of symptoms (Pollard et al., 2023; Sevilla-Llewellyn-Jones et al., 2019), emotional dysregulation (Raffagnato et al., 2021), and earlier onset of psychosis (Peh et al., 2020).

"Affectionless control" is a PBI quadrant (see Appendix N for all quadrants) characterised by low care, high overprotection, which was originally described in the PBI literature (Parker et al., 1979, 1983) and operationalised in recent psychosis samples (Sevilla-Llewellyn-Jones et al., 2019). Their results demonstrated a strong association between this parenting features and the presence of severe personality pathology, particularly those with borderline or schizotypal traits. These are both widely recognised as risk signs for psychotic disorders.

Similarly, Pollard et al. (2023) found that participants in their study frequently recalled parenting marked by low emotional and parental care, and high control, particularly from mothers. Their results demonstrate that these dynamics were associated with substantial emotional neglect, social dysfunction, and more severe psychotic symptoms.

These associations were reinforced by Gomes et al. (2023), who found that individuals who suffer from schizophrenia and bipolar disorder experienced significantly higher rates of low care/high control caregiving in comparison to their control group counterparts.

This was again reinforced by Raudino et al. (2013). Their study reported that lower warmth/care combined with higher control/overprotection was associated with unusual thought experiences and paranoia in adulthood. They suggested that the components of authoritarian parenting, emotional unavailability and high control during childhood could impair elements of psychological development, specifically, emotional regulation and psychological resilience.

High Warmth/Responsivity with Appropriate Structure

In contrast, warm and responsive caregiving with appropriate and consistent boundaries and monitoring, often captured by higher care and appropriate monitoring structures or control, was frequently associated with psychological resilience, better social and occupational functioning, and reduced symptom expression. Multiple studies suggested that this can act as a buffer against vulnerability to psychosis, and the emergence and progression of psychosis (Abbasapour et al., 2021; Parker et al., 1979; Shahimi et al., 2013).

Abbasapour et al. (2021) suggested that a caring but firm fatherly parental input bolstered emotional resilience, thus creating more stable social functioning and better occupational functioning. It was suggested that this parental framework can work to mitigate against psychopathology.

It was similarly suggested by Parker et al. in 1979 that children raised in households where parental care was prioritised, and only a moderate level of control was implemented, were less vulnerable to psychiatric disorders. Their results attributed this to nurturing environments modelling autonomy, nurture, emotional intelligence, and adaptive coping techniques. Each of these factors has been demonstrated to reduce vulnerability to psychotic disorders.

Aim 3: What is the role of adversity in parenting and psychosis?

Parenting, Adversity, and Psychosis

Building on Aim 2, Aim 3 examines whether measured adversity/stress modifies links between parenting features and psychosis outcomes, for example, onset/transition risk, symptom severity, dissociation, and emotion dysregulation.

Consistent with the analysis plan (as described in the Methods section), trauma/adversity was defined as measured exposure to ACEs or validated stress indices. In this review, trauma/adversity was treated as an influential contextual factor of parenting-psychosis associations. Its interaction with parenting has been a critical area of inquiry for quite some time. Gomes et al. (2023) examined parenting alongside childhood maltreatment

(CTQ; Bernstein and Fink, 1998; Bernstein et al., 2003), and Weintraub et al. (2021) tested interactions with stress, allowing consideration of contextual moderation.

The studies suggested that these dimension-level associations were amplified for adverse psychosis outcomes when adversity was present. For example, risk of psychosis onset/transition was only predicted when low care/warmth were present alongside high stress (Weintraub et al., 2021), and links between high control and psychosis were stronger amongst individuals reporting greater trauma exposure (Gomes et al., 2023). Together, these findings point to adversity intensifying parenting-outcome associations.

Research demonstrated that maternal low care/high control caregiving could have a negative impact on the way childhood maltreatment is experienced and its enduring effects (Gomes et al., 2023). Outcomes included higher dissociative symptoms and elevated psychosis risk, suggesting that a child is more susceptible to trauma and difficulties with emotional regulation if they have already been subjected to emotional coldness and high control in their parental dynamics.

Raffagnato et al. (2021) suggested that there are broader links between lower warmth and high or inconsistent control and emotional dysregulation (an adverse outcome). They reported that low warmth with rigid control and low warmth with low control (withdrawn/neglectful features) were linked to psychopathological outcomes in adolescents.

Gomes et al. (2023) confirmed these findings with a much larger clinical sample. They reported an association between emotional and physical abuse and low care/high control caregiving. When these co-occurred, adverse psychosis outcomes increased, consistent with a compounding effect of adversity on parenting-psychosis links.

In summation, these results address Aim 3 and refine Aim 2: when trauma or ongoing stress is present, the negative impact of lower warmth and higher control on psychosis-related outcomes appears stronger (Weintraub et al., 2021; Gomes et al., 2023). One study found no direct symptom links, but it did note poorer functioning (Abbasapour et al., 2021).

Discussion

To reorient the reader, I will now restate the review aims and summarise the main findings before interpreting them in context.

Aim 1: What is the quality of the literature examining parenting and psychosis?

Across 10 studies, nine were quantitative and one was mixed-methods. No purely qualitative studies were identified. Most papers relied on retrospective self-report measures, commonly the PBI, with limited caregiver perspectives. MMAT appraisals indicated generally moderate methodological quality. Clear questions and validated measures were common strengths, whilst cross-sectional designs, limited control for confounding variables, and potential non-response/selection bias were frequent limitations. Prospective studies were few but offered useful chronological information. No studies were excluded on quality grounds. MMAT ratings were used to weigh interpretations (Appendix L).

Aim 2: How do parenting experiences relate to experiences of psychosis?

Findings consistently associated lower warmth/higher control with more adverse psychosis outcomes, for example, greater symptom severity, earlier/heightened risk, whereas warmth/responsivity with appropriate structure related to better functioning and reduced symptom expression. Mixed results, such as functional benefits without direct symptom effects, suggest parenting operates alongside other mechanisms and should not be read as a simple causal pathway.

Aim 3: What is the role of adversity in parenting and psychosis?

Consistent with the prespecified plan, adversity/stress was treated as a contextual moderator rather than a parenting feature. Where measured, adversity amplified parenting-outcome links. For example, onset risk was elevated when low care/warmth co-occurred with high stress and associations between high control and psychosis were stronger with greater trauma exposure, such as dissociation or emotional dysregulation. Together, these data indicate that adversity intensifies the relationship between less optimal parenting profiles and poorer psychosis outcomes.

How Do These Findings Sit with the Wider Literature?

This pattern fits with psychosocial models that highlight how adversity and relationships shape psychosis (Varese et al., 2012; British Psychological Society, 2014, 2017), and it is consistent with parenting and attachment theories (Baumrind, 1966; Bowlby, 1988), suggesting that warm, responsive care combined with consistent boundaries is linked to greater resilience. Family-process evidence on expressed emotion similarly points to the protective role of warmth and the risks of criticism/hostility for relapse (Ma et al., 2021;

Mazza et al., 2022). At the same time, heterogeneity in operationalisations and cultural context cautions against over-generalisation.

Limitations

Many studies relied on retrospective self-reports of parenting, which are vulnerable to recall bias as memory can be coloured by current mental health, so accuracy is uncertain (Susser & Widom, 2012). The majority of the studies were also correlational. This means that we can see links but not claim cause and effect (Shadish et al., 2002; Hernan & Robins, 2020). Important factors such as genetics, trauma history, and socioeconomic context were not always measured or controlled. Samples were often small, single-informant, and largely from Western settings, which limits how far the findings can be generalised.

From a methodological standpoint, this systematic review process had its limitations. The review was not prospectively registered, which will have reduced transparency and could have increased the risk of selective reporting (Moher et al., 2015). The PRISMA reporting guidance was followed. Study quality was appraised using the MMAT, however no formal calibration or pre-testing of the tool, and no second reviewer was undertaken, which may have reduced scoring consistency. These factors limit replicability and introduce some risk of bias despite efforts to apply systematic methods.

A key limitation of the literature reviews was the low number of studies initially yielded through database searches (n = 138). The initial search strategy was created using the SPIDER framework and refined through consultation with a librarian. Searches were limited to EBSCOhost databases and English-language publications, and I did not undertake backward/forward citations chasing or searching the grey literature, which may have further reduced the yield. The narrow focus and specific search terms may have restricted the results.

Given the variable indexing of parenting constructs, relevant papers may not have been retrieved with my chosen keywords. This highlights that the Boolean combinations and search terms created likely were not broad enough to capture sufficient literary evidence within this topic area. Future reviews could improve the returns by trialling alternative and more inclusive search terms. Expanding databases could also contribute to enhanced data returns and replicability. A future update could broaden database coverage, expand controlled vocabulary, and add backward/forward citation chasing to improve recall and replicability.

A second limitation of the literature review is that interrater reliability procedures were not utilised, meaning that all study selections, appraisals and data extractions were completed by the researcher alone. Guideline procedures were employed to reduce bias and ensure consistency; however, a second researcher was not used to offer independent verification of the decisions made. This increases the likelihood of researcher bias. Future reviews could include a second researcher to conduct interrater checks to enhance the transparency and reliability of the review.

A pairwise meta-analysis could, in principle, have been conducted, as it requires as few as two comparable studies and can sometimes be appropriate (Deeks et al., 2019, Chapter 10). In the present review, only a small subset reported comparable outcomes with complete variance statistics, alongside substantial clinical and measurement heterogeneity in how parenting and psychosis were operationalised. As measures and outcomes were not sufficiently comparable across studies, a formal meta-analysis was not appropriate at this stage. A targeted meta-analysis may be feasible as more homogenous data accumulate (see Review Rationale; Popay et al., 2006).

The small number of studies contributing to each outcome and the mix of designs precluded a formal assessment of small-study bias. Potential selective reporting and publication bias can therefore not be ruled out. No formal certainty of evidence appraisal was undertaken because of the heterogeneity of designs, measures, and outcomes across predominantly observational studies. The overall confidence in the synthesised findings should be interpreted tentatively.

Whilst there were limitations, this study also had strengths. It had a prespecified, PRISMA-aligned process along with comprehensive database searches and transparent flow reporting. It also completed a formal methodological appraisal using the MMAT to guide interpretations, and it included an appropriate narrative synthesis that supported the organisation of findings across caregiving practices, relationship quality, family processes, and contextual moderators (Page et al., 2021; Hong et al., 2018; Popay et al., 2006).

Clinical Relevance and Implications

Understanding the parenting experiences of individuals with lived experience of psychosis and the caregivers of individuals with a psychosis diagnosis has important clinical implications. Family-based interventions, including psychoeducation, support with intrafamilial communication, and problem-solving strategies alongside coping techniques, are considered best practice in supporting families affected by psychosis (NICE, 2014). Using these psychological approaches aims to improve overall family communication and reduce carer burnout, leading to reduced relapse rates (Pharoah et al., 2010; Garety et al., 2001). Given the limited evidence base in this review, a tentative clinical implication is that routine psychosocial formulation may benefit from attending to caregiving dimensions such as warmth/responsivity, monitoring/control, and communication/expressed emotion, particularly in at-risk and early psychosis services (Carr, 2015).

As poor treatment engagement is often associated with relational trauma and attachment difficulties (Korver-Nieberg et al., 2013; Berry et al., 2008), the inclusion of relationally focused psychological intervention could improve outcomes. Parent training and attachment-focused programs (Triple-P, attachment-focused work) reduce coercive practices and enhance warmth and responsiveness (Sanders et al., 2014). Preventative work that cultivates emotion coaching, problem-solving communication, and consistent yet flexible discipline is potentially indicated (Hosman et al., 2005; Parker et al., 1979). By exploring the subjective narratives of those impacted by psychosis, an opportunity presents itself to better understand the intricate dynamics that arise, potentially later informing more tailored therapeutic offers.

This research tentatively supports the shift toward relationally informed, family-based models of care. Where low warmth/high control co-occur with adversity, trauma-informed care should be prioritised. TF CBT and family systems approaches may mitigate risk and interrupt intergenerational patterns (Li et al., 2022; Varese et al., 2012). This is particularly relevant in early intervention services, which show better recovery trajectories when familial involvement is integrated from the outset (NHS England, 2019; McFarlane, 2016).

This study's dual-perspective design seeks to better understand individual narratives of parenting experiences as well as how they are made sense of by caregivers and ILEP alike.

Critical Questions for Future Research

Longitudinal, multi-informant studies to test when and for whom parenting features such as warmth, clear boundaries, and repair after conflict matter most, and through which pathways they operate. More diverse samples are required to examine cultural relevance. An intervention trial should also clarify which parts of family-focused interventions reduce distress and support recovery, and for whom these approaches are most effective. Identifying which specific elements of authoritative parenting, such as emotional warmth or appropriate boundary-setting, are most protective could help refine these interventions, ultimately aiding in psychosis prevention and early intervention strategies.

Future work should centre caregivers' own contexts, such as mental health, trauma, financial strain, and competing demands, and how these shape day-to-day capacity for warmth, structure and repair. Attending to these pressures helps explain gaps between good intentions and actual impact, and points to supports that are realistic and sustainable in family life. Research should investigate how these parental challenges affect their capacity to offer emotional warmth and appropriate guidance, especially within authoritarian or neglectful parenting contexts. There is also a need to explore the barriers parents face in accessing mental health services and support systems, particularly in hard-to-reach communities. For parents dealing with high levels of stress or limited resources, it may be challenging to seek help or implement recommended parenting interventions. Future studies should examine how accessible and effective current family support services are and what kinds of resources, such as parent education programmes, psychological therapies, or community support networks, could better equip parents to provide the care their children need to reduce the risk of psychosis. Understanding and addressing these challenges from a parental standpoint will be crucial for developing holistic intervention strategies that support children and empower parents to overcome their own barriers.

Chapter Summary

This chapter encapsulates a systematic review with a narrative synthesis to explore how parenting features may relate to experiences of psychosis. A total of 10 studies were reviewed, spanning multiple designs. Across the evidence base, lower warmth and higher control parenting features were more often associated with poorer outcomes, for example, increased symptom severity and emotional dysregulation. To juxtapose this, warm and responsive caregiving with appropriate structure and boundaries was commonly linked to better outcomes, such as reduced risk of psychosis and increased emotional resilience.

Early intervention, family-focused interventions, and the importance of trauma-informed care were discussed in the clinical implications. Several limitations were noted from reviewing existing literature, including reliance on self-report measures and the limited representation of caregiver narratives. These findings have shaped the direction of the current research, which seeks to explore ILEP and caregiver narratives through a qualitative lens.

Conclusion

This review shows three consistent patterns. First, the evidence base is moderate in quality but narrow in scope as most studies are retrospective, single-informant, and rely on standardised self-report (commonly the PBI), with caregiver voices largely absent. Second, across designs, lower warmth and higher control are more often linked with better functioning. Third, stress and adversity appear to have an amplifying effect on these associations, highlighting the importance of family context rather than simple, linear causality.

These findings direct the present study. The concentration of single-informant, checklist-based designs means we know that associations exist, but far less about how they are understood and negotiated within families. A dual-perspective qualitative approach, hearing from both ILEP and caregivers, is therefore warranted to elucidate convergence and divergence in narratives around parenting practices, relationship quality, and family processes, and to capture the context and meaning-making that quantitative tools miss. In short, the gaps identified here, limited caregiver perspectives, reliance on retrospective self-report, and insufficient attention to relational processes, shape the study's design and research question.

Looking ahead, the study aims to build a clearer, more contextual picture of how ILEP and caregivers understand parenting features such as warmth and responsiveness, monitoring and discipline, and everyday communication, and how these practices are negotiated in the context of psychosis, including when stress or trauma is present. By comparing where accounts overlap and where they differ, the study seeks to generate practice-relevant insights and hypotheses to inform family-focused prevention and early-intervention work. The next chapter outlines the methodology for this exploratory and dual-perspective design.

Rationale for the Present Study

Although the study was originally designed to recruit caregiver-ILEP dyads, recruitment challenges meant that only one dyad participated. The remaining participants were independent and unpaired caregivers and ILEP. The aims and research questions therefore relate to perspectives across these two groups rather than systematic dyadic comparison.

Study Aims and Research Questions

Overall aim:

This current research aims to explore how individuals with lived experience of psychosis and caregivers of individuals with a psychosis diagnosis retrospectively make sense of their experiences of parenting in the context of relational dynamics. Although the study was originally designed to include caregiver-ILEP dyads, participation did not require that caregivers and ILEP be related to one another, the final sample therefore reflects perspectives from both groups independently. ILEP participants were adults with a psychosis diagnosis, a childhood diagnosis was not required for inclusion. It seeks to use a qualitative approach to interviewing both caregivers and ILEP to better understand how parenting, including features indexed by warmth/care and monitoring/control where relevant, is shaped and to identify themes relating to the emotional, relational, and contextual dynamics that have shaped these experiences.

Specific aims:

- To explore how adults with lived experience of psychosis retrospectively describe their experiences of being parented.
- To explore how caregivers retrospectively describe their experiences of parenting a child who later received a psychosis diagnosis.
- To identify shared and contrasting themes across caregiver and adult with lived experience of psychosis accounts, regardless of whether participants were related, in order to better understand parenting experiences in the context of psychosis.

Research Questions

This research builds on existing literature pertaining to psychosis, attachment theory, and parental bonding. Previous literary evidence highlights research examining the association between early caregiving and psychiatric outcomes (Bowlby, 1982/1969; Varese et al., 2012). However, gaps remain in UK-based psychosis literature, leaving the subjective experiences of caregivers and ILEP uncaptured. In particular, there is limited qualitative work that brings together the perspectives of adults with lived experience of psychosis and caregivers, even when they are not recruited as matched dyads or currently in an active caregiver role.
The following research questions were designed to help guide this study:

1. How do individuals with lived experience of psychosis and caregivers (not necessarily related to one another or currently providing care) retrospectively describe parenting experiences within their family relationships?
2. How do participants understand the role of parenting in relation to experiences of psychosis?
3. What broader social, emotional, or cultural factors are seen as influencing these parenting experiences or mental health outcomes?

These research questions were designed to remain open-ended to encourage exploration, in line with this study's epistemological stance. This study does not aim to determine causality; rather, it aims to bring forward participant narratives that speak to relational patterns, emotional semantics, and contextual factors. In practice these questions were addressed using a sample comprising one matched caregiver-ILEP dyad and otherwise independent ILEP and caregiver participants, with many caregivers reflecting on past rather than ongoing caregiving roles.

Chapter 3

Methodology

Chapter Overview

This chapter provides an overview of the qualitative approach, methodology, and analysis for this thesis. It explores the philosophical underpinnings, including the ontological and epistemological stances, as well as other facets such as this research's processes, procedures, and ethical considerations.

Rationale for Qualitative Approach

The present study aimed to explore retrospective experiences of parenting in the context of psychosis, thus, it focused primarily on meaning-making and lived experiences. This made a qualitative approach the most suitable and appropriate as it prioritises depth, complexity and subjective interpretations (Creswell & Poth, 2018; Denzin & Lincoln, 2018).

Psychosis and parenting are both deeply personal and relational experiences that are not able to be fully understood through quantitative measures alone. A qualitative methodology allowed participants' voices to remain the focal point and offered space for nuanced and diverse experiences to come to light (Greenhalgh & Taylor, 1997). This is essential for frequently marginalised and misrepresented groups in research. Qualitative approaches have been shown to empower participants by prioritising lived experience and co-constructed meaning (Beresford & Croft, 2012). Recovery-oriented research pertaining to psychosis has highlighted that participants' narratives capture resilience as well as challenges (Davidson, 2003).

A qualitative approach felt both the correct practical and ethical choices, as it acknowledges the limitations of fully accessing another person's reality whilst continuing to attempt to represent these experiences in the most respectful and reflexive manner. This aligns with the present study's aims to explore any common themes between parenting and psychosis within personal and relational contexts.

Research Paradigm

As noted by Creswell (1998), the aims and the nature of a piece of research will likely shape its methodology. Thus, choosing an approach that reflects the research's questions and focus is essential. Methodology is described as a tool enabling researchers to explore and subsequently define what they believe to be known (Guba & Lincoln, 1994). In its broadest terms, quantitative research is utilised for its ability to test specific hypotheses and manipulate variables. Qualitative research offers a more nuanced focus, drawing on understanding personal experiences and the meanings attached to these (Greenhalgh & Taylor, 1997). Typically, quantitative approaches are deemed the more robust and rigorous option, however, qualitative methodology provides the ability to capture subjective experiences in ways that quantitative approaches simply cannot facilitate (Denzin & Lincoln, 2000).

Epistemological and Ontological Positioning

Ontology

Ontology refers to the definition of existence, and it asks the fundamental questions about the nature of what can be known (Creswell & Poth, 2018). When speaking about ontological positioning in relation to research, it refers to the assumptions a researcher holds in relation to their reality and the phenomena being studied (Ponterotto, 2005). Ontological positioning sits on a continuum that ranges from positivism, which assumes one single objective reality, to relativism, which views reality as multifaceted, subjective, and socially constructed (Crotty, 1998; Guba & Lincoln, 1994).

On one end of the continuum sit positivist and post-positivist perspectives, and these assume that a singular reality can only be accessed through objective and rigorous methods (Giddens, 1974). Contrasting this, interpretivist and constructivist perspectives argue that there are multiple realities, each of which are uniquely shaped via individual meaning-making and varying contexts and social interactions (Hudson & Ozanne, 1988; Gergen, 1985). Between these two extremes lie the realist and critical realist perspectives. These accept that a particular reality can exist independently of us. However, it is always accessed and understood via our own subjective lenses, such as culture and language (Bhaskar, 1978; Danermark et al., 2002).

A critical realist ontological positioning was chosen to explore the intersection of parenting and psychosis for the present study. This is due to its ability to recognise that whilst participants' narratives are inevitably shaped by their own perceptions of the world, personal memories, and their experiences of culture and language, they also reflect much deeper structures that shape their life experiences (Pilgrim & Bentall, 1999). With particular reference to the present study, participants' narratives simultaneously captured personal interpretations of familial dynamics, as well as highlighting broader social structures such as intergenerational parenting practices.

A critical realist positioning is particularly relevant to the study of parenting and psychosis as it offers a balanced stance that considers both the subjective and interpretive natures of retrospective accounts and the realities that underpin them. Participants' experiences simply could not be reduced to one extreme positioning or another; thus, the aim was to consider how these elements coexisted and interacted and how these subjective realities were shaped by parenting experiences.

Epistemology

Whilst Ontology seeks to explore *what* reality is, Epistemology focuses more on *how* knowledge about reality can be gained and understood, what constitutes valid knowledge, and the dynamic between the researcher and the investigated phenomenon (Ponterotto, 2005; Willig, 2013). In qualitative research, this translates to having a lesser focus on discovering absolute truths and more on obtaining a better understanding of how an individual might make sense of their experiences and how these understandings are co-constructed through the world around us, such as language and interaction (Crotty, 1988).

In the context of the present study, an epistemological stance shapes how retrospective narratives are treated. A solely positivist approach might dismiss memories as biased or unreliable (Schacter, 1999), whilst a critical realist epistemological positioning would view these as meaningful within their own right (Riessman, 2008; Flick, 2023). It matters less about the recall accuracy of participants' narratives and more about what patterns and emotional truths they uncover (Josselson, 2013). This is essential for understanding the lived experiences of parenting in the context of psychosis.

A critical realist epistemology was adopted for the present study. This acknowledges that whilst participants' narratives might be created by interactions, they are still able to provide deeper insights into the processes and mechanisms that might have shaped these experiences (Danermark et al., 2002). An example of this might be the narratives that suggested controlling parenting being underpinned by both personal perceptions and wider social factors, such as socio-economic inequalities or stigma.

The present study's approach ensured an emphasis on reflexivity and transparency. This was to ensure that the nuances created by researcher-participant interactions, such as the researcher's interpretive lens, were captured and considered. Reflexive Thematic Analysis (RTA; Braun & Clarke, 2019, 2021) was consistent with this stance and was thus adopted for this study, as it allowed for the generation of knowledge grounded in lived experience, as well as consideration of the social and relational contexts in which these experiences arose.

Justification for a Critical Realist Position

When thinking about psychosis, particularly unusual beliefs and hallucinations, in the context of epistemology, there are several difficulties that need to be considered. Psychosis is unique to each person who experiences it and no two people will ever have the same experience, thus, it would not be possible to apply a lens that subscribed to an assumption of a single, objective reality that could be objectively directly accessed. Mary Boyle (2002) has been a significant voice in critiquing the dominating medical model for psychosis. She argued that positivist approaches are reductionist as they view experiences of psychosis as merely symptoms, stripping them of all meaning and context. Critiques such as this highlight the importance of understanding that psychosis cannot be understood through frameworks that seek to prioritise objectivity and generalisability alone. This is because they reject the subjective and relational nature of lived experience. One individual's experience of psychosis should not be dismissed or deemed less representative of reality than another's. Using an intersubjective approach, which allows researchers to adopt a dual perspective to consider how people make sense of their experiences within broader social contexts, acts as a more suitable framework for this study (Laing, 1967).

Critical realism acts as a perspective that can balance these challenges, making it well-suited for research into parenting and psychosis. Unlike strict relativism, which could risk reducing participants' narratives down to equally valid but disconnected perspectives, critical realism views subjective experiences as being grounded in underlying realities, even if they are not fully accessible (Bhaskar, 1978; Danermark et al., 2002; Pilgrim & Bentall, 1999). This is an approach that is increasingly encouraged in mental health research in instances where individual experiences and broader social and structural factors intersect (Sayer, 2000; Fletcher, 2017).

There are alternative epistemological positions that may have been suitable, such as social constructionism, as this can offer valuable insights into how experiences are shaped through cultural and discursive practices (Burr, 2015; Willig, 2013). However, does not fully account for enduring psychological and social mechanisms that might underpin these experiences (Archer, 1998). An example of this is how discursive analysis, a qualitative method underpinned by social constructionism, may be able to explore how psychosis is talked about within a family system, but it may not necessarily be able to account for any relational processes that may have contributed to distress or resilience over time (Harper, 2011). In contrast to this, critical realism is able to explore both the meanings ascribed by participants, as well as any causal dynamics that may influence them, thus providing and more appropriate and layer explanatory account (Danermark et al., 2002; Bhaskar, 2016).

This is not to say that a critical realist stance does not have its limitations. Given the tensions between subjective meaning-making and positing underlying mechanisms, there is a risk of over-extending interpretations beyond the descriptions participants gave (Willig, 2013). Additionally, critical realism has been critiqued for occasionally leaning too heavily into realist explanations as a means to attend to the fluidity of lived experiences (Archer, 1998). These challenges were mitigated in the present study via the use of RTA (Braun & Clarke, 2019, 2021), which encourages the researcher to put participants' voices at the centre whilst ensuring researcher reflexivity and transparency around the interpretive process.

Theoretical Framework and Current Research Position

The present study sits within a body of research that elucidates the relational and developmental impact of parenting on mental health outcomes, including vulnerability to psychosis. Parenting styles, particularly those with inconsistent patterns, have been associated with emotion dysregulation and later psychological distress (Baumrind, 1991; Varese et al., 2012). Opposing this, relational dynamics that are said to hold emotional warmth and secure attachment are understood to buffer against these risks and increase resilience (Gumley et al., 2010; Luyten et al., 2020).

This study builds on this existing evidence by focusing on retrospective accounts from caregivers and ILEP alike. Whilst much of the literary evidence has examined parenting styles and psychosis through quantitative designs, there is still limited evidence that speaks to the lived experiences and relational meaning-making within family systems (Dolman et al., 2013; Radley et al., 2023). A qualitative framework was subsequently chosen to capture these perspectives in depth, recognising that parenting practices are embedded in generational, cultural and societal contexts.

By positioning itself within this landscape, this research contributes to a more nuanced comprehension of how parenting and psychosis intersect. This research seeks to depict the challenges and the resilience that lie within family narratives. It aims to inform clinical practice that is sensitive to relational complexity and that address the needs of caregivers and ILEP alike.

Method of Approach

This research sought to capture the retrospective experiences, opinions, thoughts and feelings of the participants in relation to their experiences of parenting prior to psychosis diagnosis. As it would have been difficult to capture and encapsulate these experiences using a quantitative approach, a qualitative approach was used to inform this research. A qualitative approach allowed the interviewer to facilitate open discussions and formulate follow-up questions that generated relevant and valuable conversations, thus allowing a more in-depth understanding of the topic. A qualitative approach was adopted to gain a better understanding of the research that has already been completed and to inform new concepts (Berkwits & Inui, 1998, pp. 195-199).

Whilst retrospective accounts provide rich and unique qualitative data, they also come with notable limitations. One key challenge is the absence of a comparison or control group, making it difficult to validate the accuracy of recall experiences. Memory recall does not occur in isolation, and it can be informed by external influences such as experiences that occur later in life and social interactions. This can alter how past experiences are reconstructed (Tofthagen, 2012; Conway & Pleydell-Pearce, 2000). Social interaction threats where interactions with other people shape the way an experience is recalled and interpreted, in particular, can act as an additional complexity to the use of retrospective accounts (Gabbert et al., 2003; Roediger et al., 2001).

Whilst there is limited literary evidence focusing on specific challenges associated with retrospective reporting within psychosis populations, Newbury et al. (2018) highlight numerous relevant issues in the field of childhood trauma. These issues include biases that might contribute to the under-reporting of early life experiences, reduced recall accuracy among older populations, and questions around the generalisability of findings that are drawn from retrospective methods (Brewin et al., 1993; Henry et al., 1994).

Baldwin et al. (2019) built on this by comparing retrospective and prospective designs in trauma research, emphasising that each approach can offer unique insights. Retrospective accounts capture individuals' interpretations and meaning-making processes about past recollections, whereas prospective methods are able to provide a more detached and objective record that may lack the same personal resonance (Baldwin et al., 2019). The distinction between these reinforces the value of retrospective narratives when exploring lived experiences, even when their limitations are acknowledged.

Reflexive Thematic Analysis (RTA) and Analytic Approach

RTA was selected as the analytic framework for this study as it is able to offer a flexible but rigorous method for exploring complex, subjective experiences (Braun & Clarke, 2006, 2019, 2021). Originally developed by Braun and Clarke in 2006 and refined years later, RTA is explicitly interpretive, positioning the researcher as an active part of the meaning-making process as opposed to a neutral observer. Themes are therefore considered co-constructed through interaction between the data, the researcher's theoretical stance, and the analytic process (Braun & Clarke, 2019).

One of the major strengths of RTA is its adaptability to different epistemological positions (Braun & Clarke, 2013). For the present study, it was situated within a critical realist stance that recognises participants' accounts as shaped by perception, language, and culture, as well as influenced by deeper social structures and relational mechanisms (Bhaskar, 1978; Danermark et al., 2002). This was particularly appropriate for the exploration of parenting experiences and psychosis, where individual meaning-making intersects with family dynamics, cultural contexts, and systemic influences.

RTA facilitated the analysis being moved beyond surface descriptions and allowed it to veer towards interpretive depth, exploring *what* participants experienced, *how* they experienced it, and *why* these experiences were shaped in particular ways. This aligns with the aims of the study, which sought to integrate retrospective accounts of caregivers and ILEP to better understand parenting, psychosis, and any mechanisms linking them.

Researcher reflexivity was employed as a central component throughout this study, which is consistent with Braun and Clarke's (2019) emphasis that transparency and reflexivity strengthen, rather than weaken, qualitative research credibility. Reflexive practice helped manage potential biases and made it explicitly clear how analytic decisions were shaped by theoretical positioning and personal engagement with the data (Fletcher, 2017; Finlay, 2002).

By combining meaning-making with attention to broader social, cultural, and relational contexts, RTA was able to provide a coherent and flexible analytic framework to address the present study's research questions.

Justification for Reflexive Thematic Analysis (RTA)

Careful consideration was given to the selection of the epistemological and ontological positioning underpinning this research. Ultimately, RTA was chosen due to its alignment with the contextualist-critical realist stance. This stance highlights the value of participants' accounts and how their perceptions of these are shaped by language, culture, experience, and interaction with the researcher (Bhaskar, 1998; Braun & Clarke, 2013; Madill et al., 2000). This encouraged the researchers' sensitivity to lived experiences and consideration of the interpretive role of the researcher. Additionally, RTA is frequently recommended for clinical research that aims to understand the experiences of either services or a particular phenomenon that might have direct implications for clinical practice. Thus, making this a strong methodological choice for the present study (Braun & Clarke, 2014; Clarke & Braun, 2014). Braun & Clarke (2014) particularly have highlighted the value of RTA for health and well-being researchers.

Thematic analysis is one of the most widely used approaches to analysing qualitative data (Guest, MacQueen, & Namey, 2012). This is due to its accessibility and flexibility. Within this, RTA offers an adaptable yet systematic framework for identifying, analysing, and interpreting patterns across datasets (Braun & Clarke, 2006, 2019, 2021). An essential part of this is its ability to allow for inductive or deductive, and latent or semantic properties of meaning when developing codes and themes. This creates the ability to explore nuanced and under-researched areas (Braun & Clarke, 2018; Terry et al., 2017; Byrne, 2022). Given the qualitative and exploratory nature of the present study, these attributes were considered a strength.

In addition to this, a further rationale for the selection of RTA lies within its demand for reflexivity. Highlighting the researcher as active participant in the meaning-making process is essential for this study's credibility due to the high interaction rate with the data (Braun & Clarke, 2019, 2021). This aligns with the critiques of "mechanical" approaches to analysis that introduce the risk of data being perceived as solely self-evident as opposed to co-created (Finlay, 2002; Holloway & Todres, 2003). The inclusion of reflexivity allows the researcher to critically consider how their own experiences and assumptions interact with the data and subsequently shape the analysis, thus increasing transparency and credibility (Berger, 2015). This was a particularly important consideration for the present study as the researchers positioning was likely to influence the interpretations of data and the presentation of findings.

RTA has been successfully applied to qualitative research exploring parenting styles and psychosis (Strand et al., 2020; Radley et al., 2023). This highlights its suitability for capturing the commonalities and patterns within the subjective experiences of parenting from both people with lived experiences of psychosis and caregivers of people with a psychosis diagnosis. However, unlike these earlier studies, the present research combines the perspectives of both caregivers and ILEP within the same study and focuses specifically on parenting in a UK context, address gaps around cultural diversity, intergenerational experiences, and mechanisms such as emotion regulation and family dynamics. RTA provides the focus required to address the present study's aims (Braun & Clarke, 2006).

Alternative analytic approaches such as Interpretive Phenomenological Analysis (IPA; Simth, Flowers, & Larkin, 2009) and Grounded Theory (Charmaz, 2014) were considered for this study, however, were not deemed the measure of best-fit for this thesis. IPA was ruled out as its primary concern is idiographic (Smith, Flowers, & Larkin, 2009), which would limit this study's focus on shared patterns across participant accounts. Likewise, Grounded Theory was considered a less suitable option as its primary aim is to generate new theoretical models (Charmaz, 2014), whereas this thesis aims to explore and interpret data using existing frameworks. RTA superseded these approaches as it is able to simultaneously give attention to individual experiences and facilitate the identification of broader themes, whilst ensuring flexibility and reflexivity in its epistemological application.

Researchers' Positionality and Motivation

As a mental health professional and student, I am interested in client groups that could be considered high-risk and challenging. I felt drawn to adults who had experienced psychosis; I found their narratives compelling and noticed commonalities, such as recollections of being parented across the landscape. I often saw my curiosity in their childhood stories and their relationships with their parents. I remained excited about working with this client group for eleven years and still feel captured. I noticed that whilst in inpatient services, entering floridly psychotic and becoming rapidly better with medications and therapy, there was a time that appeared significant. Just before the point of discharge, when clients were still experiencing psychotic symptoms such as auditory and tactile hallucinations, still marginally believing delusions but feeling able to rationalise the reality of this, I noticed that frequent conversations with various service users touched on the pressures that they experienced as a child. This also captured narratives that explored the expectations experienced within the parent-child relationship, such as educational, religious, and societal expectations and varying levels of emotional connectivity. Aligning with family values and not bringing shame to the family. The pressure of experiencing mental health for some felt shameful, embarrassing, and, at times, fearful that they would be sent to another country to receive religious reprimands to remove the “demon” or “devil” within them.

As a female Arab, I felt connected to these pressures and experiences and the cultural stigma that surrounds mental health, more so in some regions of the world. As a part of my role, I was frequently involved in multidisciplinary meetings involving service users and families. The purpose of these meetings was to discuss how best to support the users of the service; these meetings included users of the service, their professional support network, and, with consent, the users of the service’s personal support network, such as caregivers. Parents had varying responses and reflections on their parenting styles and the influences this may have had on their children. Some carried shame and blame, whilst others appeared numb if harsh words had been exchanged from child to parent. Others appeared defensive, I wondered if this might have been a way to protect themselves from feeling of guilt or perceived judgement. I felt that these varied responses often revealed a deeper emotional complexity around parenting and mental health within families affected by psychosis. Having witnessed with breadth of reactions, my curiosity sparked about how early relational experiences, parenting styles, and cultural expectations may intersect with the development and course of psychosis. I wanted to conduct research that honoured both voices and perspective of caregivers and ILEP alike, exploring risk factors as well as potential avenues for resilience and recovery. This professional and personal exposure ultimately shaped the focus of my study, aiming to contribute to a more nuanced and culturally sensitive understanding of parenting, childhood experiences, and their relationship to psychosis.

Design

Study Design and Ethical Approval

This study is qualitative and follows a cross-sectional design. It uses semi-structured interviews to retrospectively explore accounts of early life experiences of parenting of family members who have been affected by psychosis. An RTA approach (Braun & Clarke, 2021) was employed to identify common themes across participant narratives. This study focused on both the experiences of individuals with lived experience of psychosis and primary caregivers who have parented a child who later received a psychosis diagnosis.

This research received full approval from the NHS Research Ethics Committee (reference number: 24/WA/0093) and Health Research Authority (project ID: 331244). This study is in compliance with the British Psychological Society's Code of Human Research Ethics (BPS, 2021). It adhered to NHS and institutional guidelines for confidentiality and risk management.

Participants

Sample Size

The target sample size of this study was 12-15 participants. A total of 15 participants were recruited who either had a lived experience of psychosis (n = 11) or were the primary caregivers of a person with psychosis (n = 4). Recruitment concluded at 15 participants because these were the first individuals identified as eligible within the study period, and continuing recruitment was not feasible within the doctoral timeframe. This resulted in fewer caregiver than anticipated. Achieving a more balanced sample would have required extending recruitment beyond the time available. Nonetheless, the dataset was sufficiently rich to address the study aims, and increasing the sample further would have exceeded the analytic capacity of the study.

Fifteen interviews, lasting on average 55 minutes (range: 30 minutes to 1 hour 35 minutes), were completed. The decision to conduct 15 interviews was informed by RTA guidance, whereby depth or engagement and richness of data are prioritised over breadth (Braun & Clarke, 2013; Clarke & Braun, 2018). This was considered sufficient to capture diversity in experiences whilst ensuring the dataset remained manageable for in-depth, idiographic analysis.

Sample sizes in qualitative data are often influenced by the nature of the topic being explored, the richness of data collected, and the research aims (Braun & Clarke, 2019). A sample size of 15 for the present study helped to strike a balance between analytic depth and manageability. This generated meaningful patterns across the dataset whilst also allowing for context-sensitive interpretation (Braun & Clarke, 2013).

Non-Participation

This study did not have any participants who withdrew from participation. However, two participants were declined due to recruitment capacity being reached, and one could not participate as they did not meet study eligibility criteria (i.e. they did not have a psychosis diagnosis).

Inclusion and Exclusion Criteria

Inclusion Criteria - ILEP

Participants must:

- Have a formal diagnosis of affective or non-affective psychosis in accordance with ICD-10 (F20–F29, excluding F1x.5 for substance-induced psychotic disorder) or DSM-5 criteria
- Have the capacity to consent at the point of engagement
- Be adults aged 18+
- Be able to undertake a qualitative interview in English
- Not be required to be related to, or paired with, a participating caregiver (dyads were optional rather than required)

Inclusion Criteria – Caregivers

Caregiver participants must:

- Have been the primary caregiver during the participant's childhood, regardless of whether they were providing active care at the time of the interview
- Be adults aged 18+
- Be reflecting on past or current caregiving; ongoing caregiving at time of interview was *not* required
- Be able to undertake a qualitative interview in English
- Not be required to be related to an ILEP participant (dyads were optional)

Exclusion Criteria - ILEP

Participants must not:

- Be in an acute phase of psychosis at the time of interview, as this would impair their ability to engage and consent (confirmed through observation and discussions with the clinical team)
- Have an intellectual disability that would impair their ability to understand the research aims and/or consent
- Present as an immediate risk to self or others for ethical and safety reasons

Exclusion Criteria – Caregivers

Caregiver participants must not:

- Have cognitive or mental-health related difficulties that would impair capacity to consent or meaningfully engage in interview
- Present as an immediate risk to self or others
- Be unable to complete an interview in English

Sampling Method

A purposive sampling approach was used to recruit participants to ensure the inclusion of individuals with a confirmed diagnosis of psychosis, primary caregivers, or individuals with such a diagnosis. Psychosis was defined in alignment with DSM-5 or ICD-10/11 criteria and included diagnoses such as schizophrenia, schizoaffective disorder, and other related psychotic disorders, with the exception of substance-induced psychosis. Diagnoses were verified through participant self-report or via the referring clinician. This study recruited adult participants to explore parenting experiences through a child development lens, focusing on themes that may reveal the lasting impact of early caregiving on adult functioning and mental health. ILEP and caregivers were both included to explore both similarities and differences in recollections of sharing experiences, enhancing depth and validity through triangulated accounts.

Materials

The materials used in this study included semi-structured interview guides (see Appendices A and B), participant information sheets (see Appendices C and D), informed consent forms (see Appendix E), demographics questionnaires (see Appendices F and G), and a recruitment poster (see Appendix H). The demographics questionnaires captured information on age, gender identity, sexual orientation, ethnicity, religion, employment, living arrangements in childhood, parental occupation, parenting style, and, where relevant, psychosis diagnosis and age at onset for either the participant or ILEP. All materials were rigorously and ethically reviewed and subsequently approved by the Health Research Authority (see Appendix I) and NHS Research Ethics Committee (see Appendix J). A full submission of documentation, including the Sponsor Confirmation Letter, Research Poster, Professional Indemnity Certificate, and CVs of the research team, was submitted.

Development of Interview Schedules

Separate semi-structured interview guides were created for caregivers and ILEP. These schedules were designed to encourage in-depth conversations, enquiring about retrospective experiences of parenting, and exploring emotional and relational dynamics in early years.

These interview guides were created in consultation with supervisors and drew on empirical literature about parenting styles (Baumrind, 1991; Parker et al., 1979), attachment theory (Bowlby, 1988; Ainsworth et al., 1978), and existing literary evidence stemming from qualitative studies on family dynamics in psychosis (Kuipers et al., 2010; Onwumere et al., 2011). The two interview schedules differed in that the caregivers’ guide focused on parenting approaches, their perceived challenges in parenting, and reflections on their child’s mental health journey, whereas the ILEP guide focused on their experiences of being parented, experiences of emotional closeness or distance, and how they made sense of their familial relationships.

Initial drafts of caregiver and ILEP interview guides (see appendices A and B) were reviewed and revised based on supervisory and ethical feedback. Questions were designed to be open-ended and flexible to encourage participants to take a lead in the discussion and to support the emergence of meaningful narratives. The interview guide provided useful prompts that supported the maintenance of conversation whilst ensuring consistency across all interviews.

Research Procedure

Recruitment Strategy

A number of recruitment avenues were utilised for this study. Services were contacted via a secure university email account. These services were the local Early Intervention in Psychosis team, the Acute & Rehab Directorate service, and the Patient Involvement team (comprising individuals with lived experience and carers), which were in the South-East of England. Brief presentations were delivered to these organisations, and recruitment posters were shared (see Appendix H). Posters were shared with staff in inpatient wards and placed in locations visible to the users of service.

The procedure dictated that should a participant express interest, any member of the multidisciplinary team supporting them would have to contact the researcher via secure NHS email to share the participant's verbal consent to be contacted to receive more information about the research and to participate in an initial edibility screening process, the interested party's name, and contact details. Participants from the Involvement team were able to self-refer directly via email.

Data Collection

Interviews were offered either face-to-face or virtually via MS Teams. The researcher considered computer literacy and digital poverty, as well as confidentiality; using a space that is considered their safe space as a place to discuss difficult topics could have been conflicting. Thus, the researcher booked rooms within the local NHS buildings as an option for all participants. All participants who chose to have interviews digitally opted to complete these in their own homes. The researcher used a private booked space to complete these.

This study used semi-structured interviews and participants were interviewed individually to gather rich qualitative data. The benefit of using this approach was that it produced in-depth insight into the subjective experiences and perceptions of participants. The aim of qualitative RTA (Braun & Clarke, 2019, 2021) is to identify themes that are unique to the participants. The results generated from this study were compared to other similar studies, allowing researchers to gain a more holistic view of the topics explored. The contribution of a qualitative research method was to deepen the understanding of the personal challenges and strengths experienced in early life. It could also be used to complement findings from quantitative studies that may focus primarily on pathology and negative risk factors.

Initial Contact

Once verbal consent had been obtained, the researcher made telephone contact to check for eligibility and to arrange a subsequent face-to-face or MS Teams meeting to share the Participant Information Sheet (see Appendices C and D), gain signed consent (see Appendix E), and complete the Demographics Questionnaire (see Appendices F and G). Participants were also given an opportunity to see the interview topic guide at this point. Once eligibility was ascertained and consent obtained, a date for the research interview was arranged. Participants were given at least 24 hours post information sharing and consent to withdraw from the agreed-upon interview, and a further opportunity to ask any additional questions at the start of the interview. At this point, participants were reminded of their rights to withdraw from the research at any time should they wish to.

Consent

Participants were required to meet with the researcher in person or via video call, where the information sheet was read through together. Once the information had been disseminated, participants were asked to demonstrate their consent by initialling in the box next to each statement on the consent form and then signing and dating at the bottom. The interviewer also signed this, and one copy was given to the participant, and one copy was kept by the researcher. This was completed via secure email for digital interviews and paper copies were scanned to a secure computer once completed for face-to-face participants. Participants were given the option to pick their own pseudonym as part of the consent process. If they declined, they consented to being randomly assigned one by the researcher.

Interview Process

Interviews were completed in person or via MS teams. Participants who were recruited from inpatient wards were interviewed in a private room off the ward once their risk was deemed low enough to facilitate this by their professional network. All virtual participants were asked to confirm that they were in a confidential and comfortable space before beginning the interview. Once confidentiality had been secured, MS Teams recording and transcription functions were commenced. In-person interviews were also recorded and transcribed via MS Teams functions.

At the end of each interview, participants were offered time to debrief, and after 48 hours, the interviewer emailed to offer a well-being check.

Reimbursement

Following the completion of their interview, participants were reimbursed with a £20 Amazon voucher. This was sent to the participant directly from the research finance officer via email.

Ethical Considerations

This research was conducted in line with the Code of Human Research Ethics outlined by the British Psychological Society (BPS, 2021). These are a set of general principles that should be applied to all research that aims to use human participants. Following this guidance ensures that respect for the rights and dignity of the participants is prioritised, scientific integrity and quality of research are present, social responsibility for the collective welfare of participants has been considered and is evident, and with a focus of maximising benefit and minimising harm.

Valid Consent

This research ensured that every participant was given adequate information to freely and voluntarily give written informed consent to participate. Additional consent was requested to audio record all interviews for the purposes of transcription. The participant was fully informed of how these recordings would be securely stored and destroyed once transcribed. Transcriptions were anonymised. All information pertaining to the research and consent procedures was given orally and in textual information sheets. Participants were given the right to withdraw from the study at any point and were able to ask for the destruction of all the data they had contributed to. All communications with participants were delivered in a polite, respectful, and compassionate manner. Information and the sharing of information were thought out, created, and delivered using a lens that has considered literacy and understanding levels.

The information given to participants encompassed a clear statement of aspects of the research that were relevant and essential for their decision to participate in or decline engagement with the project. Such aspects included: the aims of the research, the types of data that were being collected and the method of collection, their rights to confidentiality and anonymity specifically associated with the data collected inclusive of any exceptions to this, for example a disclosure of immediate risk to self or others that needed to be reported and escalated for safety purposes, and how the project adhered to the Data Protection Act (2018). The information presented to participants discussed the time commitment expectations, their right to decline to provide any information that may be requested by the researcher and the opportunity to withdraw from the project without any adverse consequences. A full disclosure of any risks associated with participation was discussed with every participant as well as the offer of a gift card as reimbursement for their time and participation in the study. Participants were given the name and details of the principal investigator and the primary supervisor for this research. Participants were informed of any planned outcomes, such as opportunities to present and share the research outcomes, how the research was made available to all those who chose to participate, and the benefits of the research.

This research aimed to recruit participants who had a lived experience of psychosis, including those who had experienced a psychiatric inpatient admission. It sought to explore their potentially challenging life experiences, and therefore, it was essential to consider risk. An assessment of risk was performed and considered when preparing information that was given to participants, and the researcher carefully considered capacity and the ability to consent at the point of contact and participation. All concerns surrounding risk and risk management were carefully considered for each individual participant. Risk assessments were strategised using the BPS guidelines on risk assessment; *"identify the risk, establish the potential harms and persons potentially affected, evaluate the scale of risk and develop control measures, document the findings in a protocol, and assess the effectiveness by considering the magnitude of potential harm and the likelihood of them happening, then modify as necessary"* (Oates et al., 2021).

As this research recruited some participants from the National Health Service (NHS) psychiatric services, the ethics needed to be reviewed and approved externally by the NHS REC for the research to be conducted. This application was guided by the Health Research Authority (HRA) guidance (Oates et al., 2021) and was submitted via the Integrated Research Application Service (IRAS).

Public and Patient Involvement (PPI)

PPI was not incorporated into the design or development of this study due to substantial time constraints. In retrospect, involving individuals with lived experience of psychosis and caregivers would likely have enhanced the study through co-production, helping refine interview questions, ensuring sensitivity to participant needs, and strengthening the relevance of the research focus (Brett et al., 2014; INVOLVE, 2012). However, the absence of PPI also avoided potential challenges associated with early shaping of the analytic focus. For example, in RTA, the pre-existing narratives introduced during design may subtly influence the researcher's interpretive lens and risk narrowing the analytic openness required for inductive coding (Braun & Clarke, 2019). Whilst the lack of PPI may limit the extent to which the study reflects priorities identified by service-users and carers, reflexive engagement, supervisory consultation, and attention to ethical considerations were used to mitigate this limitation and to ensure that participant voices remained central throughout the research process.

Additional Considerations

Due to the nature of this research, distressing topics arose in majority of participant interviews. Full disclosure that this may happen was given before gaining consent. To mitigate this, the researcher reminded participants of the right to withdraw at any time. The researcher allowed extra time in interviews to take brief moments to pause if needed. This research conducted one-on-one interviews to ensure a private environment that encouraged free speech. All participants were given information to access community support services, such as The Samaritans, as a precaution.

The protection of participants was imperative, and therefore, it was essential to ensure that they had the capacity to give informed consent. The researcher ensured, as far as possible, that the participants were participating in the research for appropriate reasons and that there was no coercion. The researcher ensured that participants were not in an acute phase of their psychosis at the time of the interview, as this would have impaired their ability to consent and engage. Participants were able and willing to participate without detriment to their mental health recovery.

There was full transparency throughout the research, and therefore, deception did not need to be considered. The full protocol and information were given to all participants

Confidentiality and anonymity were afforded to all participants following the initial recording. All identifying data was stored securely until being destroyed at the earliest available opportunity. All participants were advised that they reserved the right to withdraw from engagement with the research at any time.

Researcher Safety

The researcher liaised with teams supporting the participant and requested a recent update on risk history and any risks the participant may currently possess when interviewing participants in acute settings. The researcher carried a lone working device and/or hospital issued alarm where appropriate. The researcher always advised someone of their location and documented the time of entry and the time of completion. The researcher ensured that their chair was positioned closest to the exit, with a clear pathway to it should it have been needed. The researcher followed the guidance and safety procedures as outlined by the service they recruited from.

Data Analysis

One of the key considerations with RTA is whether the analysis should be conducted at a semantic level, which focuses on participants' explicit descriptions, or a latent level, which explores the underlying contextualisation that may shape those accounts. In this study, I applied both levels of analysis. The present study drew upon both the semantic level analysis, which allowed the researcher to capture participants' concrete descriptions, such as those about parenting practices and family interactions, and latent analysis, which allowed for a deeper exploration into how these practices were interpreted in relation to factors such as psychosis, emotion regulation, and familial dynamics.

The analysis included a combination of inductive and deductive reasoning. Using an inductive approach to generate codes from the data meant that I privileged participants' voices and meanings. This meant that themes were strongly grounded in participants' personal accounts of parenting and psychosis. A deductive approach was simultaneously present as existing literary evidence on parenting styles, psychosis, and attachment shaped my lens and influenced the questions I asked of the data. This dual approach is consistent with the understanding that analyses cannot be entirely inductive or theory-free (Braun & Clarke, 2012).

This analytic approach aligns with the study's critical realist position as it recognises the subjectivity of personal narratives as well as the deeper influence that may stem from social and relational mechanisms (Bhaskar, 1978, Danermark et al., 2002). Participants' narratives were viewed as meaningful in and of themselves whilst also considering broader insights such as parenting styles and relational processes alongside the socio-economic contexts in which psychosis emerges.

NVivo (Version 15) (Lumivero, 2024), which is a qualitative analysis software, was used to support the organisation and management of the dataset. NVivo supported as an organisational tool, however all coding and theme developments were shaped by the researcher's reflexive and interpretive engagement with the data (Jackson & Bazeley, 2019). The RTA process was not a rigid, step-by-step process; rather, it was a transient and iterative journey, where movement between phases was ongoing, and the researcher's subjectivity was treated as central to the development of themes.

Phases

Before beginning the formal analysis, I transcribed the interviews using MS Teams' transcription and recording functions. I selected orthographic transcription to capture the verbal content of speech in written form, excluding paralinguistic features such as intonation or emphasis (Braun & Clarke, 2013). I then manually reviewed and corrected the autogenerated transcriptions against the original audio recordings to ensure they were accurate and verbatim. This process preserved the authenticity of participants' accounts and provided the foundation for detailed and contextually grounded coding.

This RTA process began with phase one, which is familiarisation with transcripts. I immersed myself in the data by transcribing, reading, and re-reading the transcripts or reflexive notes (Braun & Clarke, 2006; Bird, 2005). At this stage, any early impressions or reflexive notes are documented. This allowed me to engage actively with the content and meanings within the transcripts.

Phase two involves the initial coding, which entails systematically working through transcripts to generate codes that capture both semantic and latent aspects of meaning (Braun & Clarke, 2019; King, 2004). I applied this process systematically to each transcript, remaining reflexive about how my own perspectives influenced the codes I generated

(Berger, 2015). My approach to this was flexible and organic, and I considered how my perspective influenced the decisions made during this process (Berger, 2015).

Following this, the analysis then shifted into phase three, which is theme development. This is where I organised the codes into broader patterns of meaning as part of an interpretive process, thinking about what each theme might suggest about the participants lived experiences of parenting and psychosis (Braun & Clarke, 2021). I grouped related codes together, exploring how they might form potential themes that reflected participants' experiences.

Phase four sought to review and refine themes. This involved me transitioning between the dataset, the reflexive notes, and the developing themes. I worked and reworked, combined, or discarded potential themes until they felt representative of participants' narratives. Other themes were expanded as the analysis deepened further. Completing this recursive process allowed me to ensure that the themes that were captured in a representative way and allowed me to highlight patterns within the dataset (Lincoln & Guba, 1985).

Phase five encompassed defining and naming the themes to a point of refinement. This allowed me to consider the central concepts and how these may relate to one another. At this point, I clarified what each theme represented, and the themes related to each other, drawing on a critical realist perspective to situate participants' narratives within broader relational and structural contexts (Danermark et al., 2002).

Finally, phase six involved the intricate weaving of analytic narratives with data extracts that represented the voices of participants. I selected extracts that illustrated each theme clearly and wrote the analysis to balance descriptive clarity with interpretive depth. The final part of this phase was to reflect on my positionality as the researcher and analytic choices and to transparently document how meaning was co-constructed through reflexive engagement (Braun & Clarke, 2019; Berger, 2015).

Researcher Reflexivity

Reflexivity is an essential component of using RTA for qualitative research. It is a requirement that demands the researcher to consider their own positioning, experiences, and assumptions can interact with and shape the analytic process and outcomes (Willig, 2013). Immersion encourages better engagement with the data, a deeper understanding of participant accounts, as well as a reminder to remaining attentive to the construction of meaning through language and interaction (Charmaz, 2004). This stance acknowledges how knowledge is coproduced as a direct result of the dynamic interplay between participant and researcher.

Qualitative research recognises that the researcher is scarcely able to remain a neutral observer. Rather, it highlights that the researcher’s presence, questioning styles, and interpretations will have some interplay with participants’ narratives (Stiles, 1993). From this perspective, the researcher becomes embedded in the cyclical process where accounts and identified themes are inevitably shaped by the interaction. This has been emphasised in mental health research where reflexivity has been viewed as crucial in addressing power dynamics and other sensitivities that arise in qualitative interviews with vulnerable populations (Cutcliffe & McKenna, 2004).

Personal Reflexivity

Personal reflexivity necessitates practitioner consideration of how their background, values, culture, and experiences can influence the research process (Finlay, 2003; Shaw, 2010). This includes professional experiences, in this case, specific experiences of working with people who have experienced psychosis, caregivers who are supporting people with a psychosis diagnosis, personal assumptions about the role of parenting, or broader beliefs and familial dynamics and mental health. In being transparent about these things, the likelihood of hidden biases unconsciously shaping interpretations is reduced, increasing the likelihood of credible and authentic analysis (Willig, 2013; Primeau, 2003).

I am a third-year Clinical Psychology Trainee who has worked in inpatient and acute services for approximately six years. During this time, I have gained experience working with a variety of populations, including individuals who have experienced psychosis. During my clinical engagement with people in the acute phase of psychosis, I would frequently engage with caregivers in clinical review processes. In these settings, I noticed how shame and guilt plagued many parents, and how they would share their own personal and difficult experiences. Often, they would share their fears about how their own experiences may have shaped their parenting style. I felt conflicted by the lack of resources and support available for caregivers, which enhanced their experiences of isolation and overwhelm. These observations strongly influenced my decision to pursue this thesis, as I wanted to explore parenting in the context of psychosis in ways that advocate for and bring attention to the voices and needs of caregivers and people experiencing psychosis alike.

A reflexive diary was compiled with any assumptions, emotions, and reactions that arose during each interview and throughout the analysis process. This highlights that researcher subjectivity cannot be removed in its entirety, however, it can be recognised and engaged with thoughtfully (Berger, 2015). This can help to keep the researcher aware of the impact of the presence and how this may influence participants’ willingness to share their own personal experiences (Edge & MacKian, 2010).

Researcher Positionality

Positionality refers to how attributes and beliefs pertaining to the researcher can impact and shape research outcomes, for example, socioeconomic status or culture (Finlay, 2003; Berger, 2015; Willig, 2013). RTA acknowledges that data are co-constructed between participants and researchers and, therefore, transparency around this is essential for credibility.

During the initial planning stages of this study, I was not yet a parent, but during the data collection phase, I became pregnant. I feel that this transition has significantly shaped how I relate to participants. Whilst my earlier position was that of an "outsider" to the parenting role, pregnancy brought me enhanced layers of empathy, sensitivity, and compassion when considering the role of parenting and the challenges that come with caregiving. Acknowledging this shift in positioning and the fluidity of positionality is crucial.

My cultural identity as a White Arab female has also informed my research and analysis, as my understandings of family, parenting, and mental health have invariably been shaped by my culture. This will likely have impacted how I approached topics and interpreted participant accounts. My cultural background may have contributed to points of connectivity with clients, for example, participants with traditional gender roles within caregiving experiences, as well as points of distance, such as differing cultural norms around parenting or stigma associated with psychosis. Recognising these dynamics encouraged me to remain attentive to participants' key concept definitions so I did not assume shared meanings.

My position as a Trainee Clinical Psychologist placed me both in a position of power, and in the role of institutional and professional authority. Even outside of the context of mental health settings, it is possible that participants viewed me as the "expert" which could have shape how their stories were shared with me. In contrast to this, my therapeutic training afforded me skills in listening, empathy, and creating safe spaces which allowed me to better support participants in feeling heard and validated. I was mindful that my training also carries assumptions around what “healthy” family relationships or “good” parenting look like. For this reason, I made a conscious effort to avoid imposing normative judgements upon participants.

In conjunction, these intersecting aspects of my identity, pregnancy, culture, gender, and professional role, would have likely influenced the co-construction and analysis of data. In order to mitigate biases as much as possible, I engaged in ongoing reflexive practice at university, kept a reflexive diary, and routinely critically examined how my assumptions and emotions might have shaped my interpretations. This reflexive positioning was central to ensuring participants’ voices led my interpretations and analysis whilst acknowledging the unavoidable role of researcher interpretations.

Given that psychological constructs such as “warmth,” “control,” and “emotional attunement” are culturally situated, I remained attentive to the risk of interpreting participants’ experiences through Western clinical norms. My positionality as a clinician trained within these frameworks required continual reflexivity to avoid pathologising normative cultural forms of caregiving or communication.

Rigour in Qualitative Research

Ensuring the trustworthiness of qualitative research is essential for confirming confidence in the interpretation and the credibility of findings. In order to achieve this, Lincoln and Guba’s (1985) evaluation criteria were considered throughout this research, which include considering credibility and coherence, transferability and contextualisation, dependability and reflexivity, and confirmability and transparency. These principles were used to support the methodological rigour of the present study on experiences of parenting and psychosis.

Credibility and Coherence

Credibility is a term that refers to the extent to which findings represent participants' perspectives. In keeping with Lincoln and Guba's (1985) and Braun and Clarke's (2021) frameworks, the researcher ensured prolonged exposure and immersion with the data through repeated reading of the transcripts and iterative coding. Peers in thesis workshops were asked to cross-check segments of the anonymised dataset to support credibility and reduce the likelihood of misrepresentation. In keeping with RTA, reflexive engagement was essential as this stems less from verification techniques and more from sustained attentiveness to the process in which themes are co-constructed between the participants and the researcher (Braun & Clarke, 2019, 2021). Yardley (2000) aligns with this as they highlight how rigour in qualitative research, specifically pertaining to severe mental health, requires a balance between prioritising participants' voices and methodological robustness.

Transferability and Contextualisation

According to Lincoln and Guba (1985), transferability refers to the degree to which findings can be meaningfully applied in their contexts. The present study has presented details of participant characteristics, the recruitment process, and relevant contexts such as cultural influences. This enables the readers to consider the applicability of this study to other populations. To help situate this study's interpretations in the relevant context, explicit reflections were made around parenting practices and how they are embedded in relational, societal, intergenerational, and cultural frameworks (Varese et al., 2012).

Dependability and Reflexivity

Dependability is a term that relates to the consistency and reliability of a study's findings (Carcray, 2009). To ensure dependability within the present study, clear documentation of the methodological decision-making was kept. An audit trail of the coding and theme development was maintained throughout, which is consistent with best practice in qualitative research (Nowell et al., 2017) and is in line with guidance from Shenton (2004).

In line with a RTA, formal inter-rater reliability statistics were not calculated. RTA conceptualises coding and theme development as an inevitably interpretive and situated process, with the researcher's subjectivity treated as a resource rather than a source of error (Braun & Clarke, 2019, 2021). Seeking "agreement" between coders can imply that there is a single, correct reading of the data and that researchers and interchangeable, which is incompatible with the study's critical realist and reflexive stance (Braun & Clarke, 2019; Byrne, 2022). Instead, dependability was supported through a documented audit train, ongoing reflexive journaling, and discussion of developing themes in supervision and peer spaces, consistent with recommendations for rigour in qualitative research (Lincoln & Guba, 2985; Nowell et al., 2017).

Confirmability and Transparency

Emphasis on transparency around how the researcher's values, assumptions, and positioning may shape the analytic process is also known as confirmability. Throughout the present study, reflexivity was maintained, and a reflexive log (Appendix O) was kept following each participant interview to capture any personal assumptions or emotional responses that may have arisen (Finlay, 2002). The analytic process was discussed with supervisors and in peer workshops, which provided a space to critically evaluate and further explore how interpretations were shaped by the researcher's positionality and theoretical commitments (Fletcher, 2017).

Transparency was facilitated by detailing analytic decision-making processes, such as theme development (Braun & Clarke, 2021). This demonstrates how the process in which the dataset was interpreted, and it reduces the likelihood of themes emerging as self-evident. Yardley (2000) stated the importance of researcher reflexivity and openness about the choices made in the interpretive process. Thus, the present study has explicitly acknowledged how any prior clinical experiences and assumptions may have shaped the analytic lens.

Impact and Contribution

The term impact refers to how research findings meaningfully contribute to practice and research. This study focused on the lived experiences of caregiver and ILEP in the context of psychosis, and it aimed to provide further insights relevant for clinical practice and family-focused interventions. Byrne (2022) suggests that qualitative research in the context of severe mental health is able to inform services in a way that quantitative research alone cannot be due to it methodological and thematic values.

Dissemination

This study aims to share its findings with all participants upon completion of the research, either individually or in group sessions, depending on participant preference. Additionally, group meetings may be organised to present the findings to the psychological services that facilitated recruitment.

The findings are intended to be disseminated through academic journal publications, with potential submissions to Schizophrenia Bulletin, Schizophrenia Research, and Psychological Medicine. Furthermore, the study aims to present its findings at national and international conferences, such as the International Society for Research in Schizophrenia (SIRS) and British Psychological Society (BPS) conferences.

The research also hopes to disseminate its findings within the NHS services where participant recruitment took place, through workshops and presentations aimed at staff. There may also be efforts to extend these workshops to other NHS Trusts in order to increase the impact of the study on clinical practice and service development.

Chapter 4

Results

Chapter Overview

This chapter presents the findings of this study, taken from qualitative interviews with fifteen participants. Participants include ILEP and caregivers who parented an ILEP. Through the use of RTA (Braun & Clarke, 2006, 2019), four themes with associated subthemes were developed to explore the complex interplay between parenting and psychosis. Themes examine how parenting practices shape emotional climates and relational safety, how role dynamics and family histories influence mental health, and how participants make meaning of their experiences through reflection, resilience, and cultural or spiritual frameworks. This chapter integrates quotes from participant interviews with reflexive and theoretical commentary as a means to highlight the emotional and relational contexts within which psychosis was experienced. This analysis aimed to move away from generalisations and prioritise depth and subjectivity, offering insight into the lived realities of families navigating psychological distress.

Participant Characteristics

This study comprised fifteen participants, inclusive of those with lived experience of psychosis (n=11) and caregivers of ILEP (n=4). No caregivers had lived experience of psychosis, though this was not an exclusion. Participants were recruited over a span of four months (November 2024 - March 2025) via several sources. Recruitment sources comprised adult psychiatric inpatient wards (n=5), Home Treatment Teams (HTT) (n=2), and patient involvement services (n=8) within an NHS trust in the South-East of England.

The sample reflected a wide range of psychiatric diagnoses. The ILEP group was composed of diagnoses including bipolar disorder (n=3), schizoaffective disorder (n=2), paranoid schizophrenia (n=1), delusional disorder (n=1), mania with psychotic features (n=1), non-specified organic psychosis (n=3), and first episode psychosis (n=3), and psychotic disorder due to general medical condition (n=1). Two participants declined to disclose a diagnosis. Among the caregivers who were supporting or had supported ILEP, ILEP had predominantly been diagnosed with a first episode of psychosis or a diagnosis that fell within the spectrum of a psychotic or organic mental illness.

Although the sample included participants from diverse ethnic, cultural, and spiritual backgrounds, the small size limits claims about cultural patterning. The diversity within the sample did, however, support attention to how meanings around care, authority, and help-seeking varied across cultural contexts.

All identifying data has been fully anonymised in line with ethical research practice.

Table 2. Demographic Information for ILEP and Caregivers of ILEP

Participant ID - Pseudonym	**Role**	**Age**	**Gender Identity**	**Sexual Orientation**	**Employment Status**	**Parenting Style**	**ILEP Psychosis Diagnosis**	**Ethnicity**	**Religion/Spiritual Identity/Faith**	**Referral Source**
P1 - James	ILEP	31–35	Male	Heterosexual	Unemployed (seeking employment)	Authoritative	Declined	African	Christianity	Inpatient Ward
P2 - T	ILEP	55–60	Male	Heterosexual	Unemployed (long-term sick)	Authoritative	Bipolar Disorder	White British	No Religion	Inpatient Ward
P3 - Joseph	ILEP	31–35	Male	Heterosexual	Unemployed (long-term sick)	Authoritarian	Paranoid Schizophrenia	Afghanistan	Islam	Inpatient Ward
P4 - Lewis	Caregiver	51–55	Male	Heterosexual	Employed (full-time)	Authoritative	First Episode Psychosis	White British	No Religion	Home Treatment Team
P5 - Tanya	Caregiver	51–55	Female	Heterosexual	Employed (full-time)	Authoritative	First Episode Psychosis	White British	Agnostic	Home Treatment Team
P6 - Troy	ILEP	21–25	Male	Heterosexual	Unemployed (long-term sick)	Authoritative	First Episode Psychosis	White British	No Religion	Inpatient Ward
P7 - Jenni	Caregiver	65–70	Female	Heterosexual	Retired	Authoritative	Psychotic Disorder due to General	White British	Christianity	Patient Involvement

							Medical Condition			
P8 - Ethan	ILEP	61–65	Male	Heterosexual	Unemployed (seeking employment)	Permissive	Declined	White Other (New Zealand)	Other (personal religion)	Inpatient Ward
P9 - Adam	ILEP	18–21	Male	Pansexual	Other (ad-hoc)	Authoritative	First Episode Psychosis	White British	No Religion	Patient Involvement
P10 - Ben	ILEP	70+	Male	Heterosexual	Retired	Permissive (Dad) + Authoritative (Mum)	Bipolar Disorder	White Other	Jewish	Patient Involvement
P11 - Leah	Caregiver	55–60	Female	Heterosexual	Employed (full-time)	Permissive	Psychotic Disorder not Otherwise Specified	British Indian	Christianity	Patient Involvement
P12 - Layla	ILEP	41–45	Female	Heterosexual	Employed (part-time)	Authoritarian	Schizoaffective Disorder	Black British Caribbean	Islam	Patient Involvement
P13 - Gemma	ILEP	55–60	Female	Heterosexual	Employed (part-time)	Authoritarian	Bipolar Disorder	White British	Anglo-Catholic	Patient Involvement
P14 - Mark	ILEP	51–55	Male	Heterosexual	Unemployed (long-term sick)	Authoritarian	Schizoaffective Disorder	White British	Evangelical Christian	Patient Involvement
P15 - Lola	ILEP	21–25	Female	Lesbian	Employed (full-time)	Authoritarian	Delusional Disorder	White British	Spiritual	Patient Involvement

Note: Parenting style refers to the reported style within the family home. Employment status reflects status at the time of the interview.

Themes

Following the development of key themes, the analysis was collated. It presents a narrative that explores how parenting experiences intersect with psychosis. In particular, participants described how parenting climates were implicated in the onset, intensification, and recovery phases of psychosis. The story begins to unfold from early relational dynamics and emotional climates within familial homes, and how evolving interpretations of mental health, caregiving, and identity have changed over time. This analysis captures the challenges and protective factors embedded within familial contexts. Four themes and associated subthemes were constructed to reflect participants' complex experiences. Table 3 presents the thematic structure.

Table 3. A Breakdown of the Themes and Subthemes

Theme	Subthemes
Theme 1: Emotional Climate and Relational Safety	1.1 Criticism and Control 1.2 Inconsistency and Unpredictability
Theme 2: Parenting Style as a Pathway to Mental Health and Psychosis	2.1 Permissiveness and Role Reversal
Theme 3: Meaning-Making and Identity Reconstruction	1.2 From Blame to Understanding 1.3 Resilient Narratives
Theme 4: Trauma, Belief, and the Emotional Ecology of Psychosis	4.1 Trauma, Grief, Intergenerational Wounds 4.2 Cultural and Spiritual Interpretations of Distress 4.3 Love That Holds, Unconditional Presence and Emotional Support

Introduction to Findings

The stories participants shared spanned across experiences of trauma, caregiving, meaning-making, and growth and were shaped by emotionally rich and deeply personal discussions. These themes show how parenting patterns are related to psychosis trajectories, as described by participants, from onset through later periods of relapse and recovery.

The findings are presented under four main themes: *Emotional Climate and Relational Safety; Parenting as a Pathway to Mental Health and Psychosis; Meaning-Making and Identity Reconstruction; and Trauma, Belief, and the Emotional Ecology of Psychosis.* Together these themes capture the behavioural, emotional, and relational dimensions of parenting in the context of psychosis and explore how participants processed, interpreted, and reformulated these experiences over time (see Table 3). Each theme highlights interconnected aspects of family life, parenting styles, emotional safety, and meaning-making.

Verbatim quotes were used throughout the analysis with pseudonyms to identify participants as well as their roles (ILEP or caregiver). Being inclusive of both perspectives allowed for a more nuanced understanding of parenting and mental health, highlighting relational complexities, intergenerational echoes, and moments of rupture and repair.

In keeping with the study aims and the RTA approach, caregiver and ILEP interview were analysed as a single dataset rather than in separate parallel analyses. Role (caregiver/ILEP) was retained and signposted in the write up, and role-specific patterns were attended to within themes, but the primary focus was on shared and contrasting meanings across the whole dataset. Given the small and uneven number of caregivers, conducting separate theme structures risked producing thin, under-developed caregiver themes and overstating group differences. Analysing accounts together supported a more integrated understanding of how parenting and psychosis were narrated across perspectives, whilst still allowed important divergences between caregivers and ILEP to be highlighted within each theme. Themes are presented sequentially with reflexive commentaries woven throughout to aid and situate interpretations.

Theme 1: Emotional Climate and Relational Safety

This theme explores how emotional climates within families can shape participants' sense of safety and vulnerability. Throughout narratives, emotional attunement, or a lack thereof, was central to how participants experienced relationships, and, for some, how psychotic distress later emerged. Several participants placed these climates just before, or around the onset of their first episode or later exacerbations of psychosis.

Subtheme 1.1: Criticism and Control

Many of the ILEP participants described experiences of feeling criticised or controlled within their caregiver-ILEP relationships. Whilst it was noted that caregivers often acted from a place of care or concern, the emotional impact described by ILEP was one of restriction, invalidation, and feeling silenced. They shared how these experiences shaped their sense of emotional safety and autonomy growing up.

Ben recalled a particular memory where parental involvement crossed over into what felt like, for him, intrusion:

> *"The incident that stands out... Dad apprehended the postman before I could and took my results and opened them himself. I remember him bringing them back to the house,*

> *I was absolutely furious with him for that... I know my brother used to say that sometimes our parents act like they own us." (Ben, ILEP)*

Ben's words felt like a reflection of how actions that can be intended to protect or manage expectations can sometimes be experienced as controlling. Ben's enduring frustration in his account revealed how such moments left him feeling diminished rather than supported, shaping a sense of care that carried the weight of criticism and control.

For Adam, academic encouragement was experienced as a heavy pressure in times when he was already struggling emotionally:

> *"We're in the car and I was told, "how come you didn't win anything?" and it's just sort of... well, I'd been having a bit of a hard time, but I didn't say that. I think I just sat there and cried." (Adam, ILEP)*

Here, Adam described crying silently, feeling unable to explain his feelings. This felt like it revealed a gap between parental intention and emotional understanding. Adam's silence suggested how control and criticism could sometimes be felt through what was left unsaid, as well as through words themselves, leaving his raw emotions unacknowledged.

T spoke of feeling blamed when his mother's tone became critical:

> *"Mum was great, but she was always like, 'you're the problem, it's you'". (T, ILEP)*

The palpable tension in T's account captured how love and criticism could exist simultaneously. He described the emotional toll and impact of being singled out, demonstrating how criticism, even when not constant, could shape a child's sense of self and safety within the relationship.

For Joseph, control came through rigid and strict boundaries rather than overt criticism:

> *"They don't let me go outside and play"*

And when asked if this was throughout adulthood too or just childhood, he added:

> *"Always." (Joseph, ILEP)*

Joseph's matter-of-fact tone suggested an air of acceptance as opposed to distress, yet his story revealed a consistent lack of autonomy. I wondered if, even without hostility, the steady presence control shaped how he experienced freedom and independence within his family home.

Lola spoke about how criticism sometimes escalated into volatility and emotional withdrawal:

> *"She just doesn't speak about anything at all… she just gets very volatile, starts shouting, saying that she wishes she never had me and my sister." (Lola, ILEP)*
>
> *"There's never me talking about my feelings at all… It's like, 'No, I'm your parent. You're the younger one. Respect it.'" (Lola, ILEP)*

Lola's words reflected a lack of emotional safety where silence and shouting simultaneously created distance between family members. I felt that her description of being told to "respect" parental authority revealed how hierarchy was used to maintain control, which left little space for emotional expression or dialogue.

Layla echoed these experiences of feeling silenced:

> *"She was very like black and white… children should be heard and not seen… I just felt like she kind of oppressed me and like I couldn't voice my views and opinions." (Layla, ILEP)*

Layla spoke about how rigid communication stifled her voice, despite her mother's actions being unintentionally harmful. Layla's story mirrored the complexity in many participants' stories, where care, control, and criticism often coexisted in ways that felt difficult for them to disentangle.

For some participants, they felt that criticism and control were expressed through outright hostility and violence.

Mark described his experiences vividly:

> *"My parents always used to rage and flip the hand on me and beat the **** out of me generally." (Mark, ILEP)*
>
> *"What I grew up with is not actually psychologically survivable." (Mark, ILEP)*

Mark also spoke of the crippling pressure of perfectionism within his family home:

> *"I was continually expected to make them proud and be good and work hard… but I can't get one [a good job] because I'm not allowed to be better than my dad." (Mark, ILEP)*

For Mark, parental control carried a physical weight as well as an emotional one, leaving a lasting impact on his feelings of safety and lasting sense of pressure. His narrative revealed the more extreme end of experiences within this theme, where criticism and control left deep emotional scars.

Finally, Adam shared how his father's emotional restraint shaped his own ways of coping:

> *"I don't think I'd really ever seen… I don't think I'd ever seen my dad cry… you internalise it and think… I should just get on with it… try and be the perfect child." (Adam, ILEP)*

Adam described learning to suppress his emotions by following in his father's footsteps. I felt this showed how criticism and control were sometimes carried forward though silence and emotional withdrawal rather than through words or rules alone.

Some behaviours described as controlling or emotionally reserved must also be understood within cultural frameworks in which parental authority, obedience, and emotional restraint are normative and valued (Chao, 1994; Rothbaum & Morelli, 2005).

As narrated, critical or controlling exchanges sometimes amplified threat appraisals and self-doubt, which participants linked to intensification of voices or suspiciousness. Participants' stories scarcely implied blame, but instead, they revealed the complexities of parenting under pressure, where care and control were deeply intertwined. What stood out across participants' experiences was the lasting emotional burden and weight of criticism and control, whether it be experienced as silence, restriction, criticism, or volatility. These were not just fleeting childhood memories; they were enduring impressions that shaped participants' sense of self, safety, and autonomy long after childhood had ended. These dynamics were not presented as sole causes, but as the relational contexts within which psychotic distress was navigated.

Subtheme 1.2: Inconsistency and Unpredictability

Several participants described childhood environments marked by emotional inconsistency and unpredictability. Whilst caregivers often demonstrated love and care, their responses could shift unexpectedly, leaving ILEP feeling unsure of how to interpret or anticipate emotional reactions. In the context of parenting under pressure, such unpredictability shaped participants' sense of relational safety and stability. Participants connected unpredictability with feeling "on edge", sleep loss, and vigilance, which they felt fed into psychotic misinterpretations during later vulnerable periods.

Lola reflected on moments where her needs for comfort and reassurance felt dismissed:

> *"My aunt… would come round like 3 times a week and be all controlling and stuff. I remember being like 6 and hating it… I've got vivid memories of begging my mum to stop having her around… She was like, 'You can't tell me what to do. I'm the adult.'" (Lola, ILEP)*

Lola described a sense of longing for her mother to hear and respond to her distress, yet her pleas were met with assertions of authority as opposed to the emotional attunement she was seeking. The unpredictability in sometimes experiencing comfort and others feeling dismissed appeared to undermine her sense of security, leaving Lola unsure of when and how her feelings would be acknowledged.

James also spoke about sudden and confusing shifts in his father's behaviour:

> *"Maybe he wants me to grow up slightly, so he started beating me (laughs)." (James, ILEP)*

He later reflected on the emotional and physical impact of this change:

> *"He started that sickness… From that day I have been physically sick." (James, ILEP)*

James' words carried a sense of bewilderment, suggesting how abrupt changes in caregiving behaviours can leave lasting imprints on an individual's body and mind. This unpredictability shaped James' sense of safety and contributed to an ongoing effort to make sense of these early experiences, particularly when love and harm came from the same person.

Instability also appeared within ILEP emotional states and social tolerance, not only in caregiver behaviour. Routine events could suddenly become overwhelming. For example, Tanya describes her son George's discomfort in social settings:

> *"Even like with George's birthdays when he was small…he was very overwhelmed by that party, he didn't really want to be a part of that… you'd find him in his bedroom playing with his cars on his floor instead." (Tanya, Caregiver)*

This illustrates bidirectional unpredictability. Tanya recalled needing to adjust her parenting in response to George's shifting emotional needs, recognising moments when expectations had to be softened to prevent overwhelm. This example arose from George's fluctuating mood and social tolerance. It demonstrated how routine events could become overwhelming without warning. This constant recalibration reflected the emotional labour involved in parenting when a child's responses could not always be predicted and easily tended to and soothed. In that sense, emotional unpredictability was presented as bidirectional, prompting constant shifts in an attempt to remain attuned with one another.

These accounts emphasise that inconsistency does not necessarily equate to neglect or lack of care. Instead, they reveal how emotional unpredictability, whether through sudden conflict, withdrawal, or fluctuating expectations, shaped participants' sense of safety and trust within their families. Such experiences align with research suggesting that inconsistent caregiving can create uncertainty in children’s emotional worlds, impacting their ability to anticipate and regulate relational dynamics (Main & Solomon, 1990; Schore, 2003).

Interpretation and Reflexive Commentary

Home environments that were marked by control, criticism, or emotional unpredictability left enduring impressions of insecurity and invalidation, leading to suppressed emotions. Other participants described less overt misattunements, such as emotional reserve or rigid expectations. In these scenarios, care was often present, but the relational warmth experienced felt limited. These dynamics often reflected intergenerational histories, cultural expectations and the associated pressures of parenting under strain as opposed to the simple absence of love or parental concern.

The emotional tone of the home, specifically whether it was defined by volatility, silence, or sudden and unexpected shifts, shaped how participants related to their own distress as well as others. Relational safety was a theme that emerged as a protective factor when it was present and available, and a source of vulnerability when it was absent or felt unstable.

As a researcher, I felt mindful that clinical terms such as “dysregulation” might risk oversimplifying the human complexities of these stories. Hearing deeply emotive accounts of conflict and loss stirred my own emotional responses at times. This prompted me to reflect on my positionality and the need to balance empathetic engagement with analytic distance. I utilised journaling, peer support, and supervision to allow me to remain critically aware of how my perspectives may have shaped interpretations whilst I was aiming to present participants’ voices with sensitivity and care.

Theme 2: Parenting Style as Pathway to Mental Health and Psychosis

Parenting styles emerges as a key influence on how ILEP made sense of their mental health experiences. Rather than solely focusing on the presence or absence of care, participants' stories revealed how patterns such as overprotection, role confusion, and permissiveness shaped the emotional climate in which psychosis later unfolded. Participants link these styles to how early parenting styles related to how psychosis was recognised, responded to, and stabilised later within families. These parenting approaches were rarely straightforward and often reflected caregivers' own histories, intentions to protect, or attempts to compensate for earlier trauma, revealing the complexities behind parenting under pressure.

Subtheme 2.1: Permissiveness and Role Reversal

Some participants described experiences where parental boundaries felt blurred or reversed. At times, parents appeared permissive, offering freedom and little guidance. Whereas in other narratives, ILEP felt as though they were taking on adult roles beyond their developmental capabilities. These experiences were often described as carrying emotional weight, shaping how participants understood care, responsibility, and safety in their formative years.

Ethan recalled his mother's markedly liberal parenting style and being given significant autonomy from a young age:

> *"You know, when you asked about a liberal mother or what… What's the definition of my mother, you know, extremely, extremely liberal…" (Ethan, ILEP)*

He went on to reflect on time spent with a family friend who exposed him and his brother to inappropriate situations:

> *"My mother had a friend… unfortunately, it turned out that he was a bit of a sex offender type person… I've always wondered whether it had anything to do with my brother's psychosis." (Ethan, ILEP)*

Ethan stated that he did not find this overtly traumatic, but he did acknowledge the lack of parental containment and protection in hindsight. His account suggested how permissive parenting, whilst often grounded in trust or a wish to avoid control, could leave children navigating risks beyond their means without clear boundaries.

For some caregivers, their permissiveness was reflected as a deliberate departure from the strictness or punishment they had known in their own childhoods. Jenni explained:

> *"She would always let you know if things were wrong… I'd never been able to do that as a child. I would have just been hit." (Jenni, Caregiver)*

Jenni wanted to give her children the emotional openness she had been denied. She later wondered whether this might have left them without enough structure or without sufficient structure. Jenni's narrative reflected a tension described by several caregivers, between wanting to offer their children freedom and worrying about whether that freedom could sometimes become uncontained.

Other participants spoke of role reversal arising from practical pressures such as single parenting. Lola recalled:

> *"From about 12 years old, there's been immense pressure on me… from the age of like 14, I'd be picking [my sister] up from school… changing my life to babysit and always being expected to do things." (Lola, ILEP)*

For Lola, her early caregiving responsibilities created a sense of pressure that shaped how she later coped with stress and identity challenges. She attributed these experiences to feeling she had to grow up quickly, with little space to express her own needs.

Layla also recalled being given a significant amount of adult responsibility in childhood:

> *"I had to take on a lot of responsibility from a young age… I was a latchkey kid… fending for me and my brother." (Layla, ILEP)*
>
> *"It was just a responsibility of sort of getting my brother to and from school and… and doing household chores and stuff like that." (Layla, ILEP)*
>
> *"I was, yeah, 5–6 I would say, me and my brother would go home by ourselves." (Layla, ILEP)*

Layla spoke about this matter-of-factly, yet her words revealed a childhood where she was relied upon heavily. This blurring of parent-child roles seemed to shape her sense of practical responsibility, as well as her sense of safety and emotional containment growing up.

Leah described a different form of permissiveness, where she intentionally avoided the strictness of her own upbringing:

> *"My relationship with my daughter was more like sisters really, like a friend, because my parents were very controlling." (Leah, Caregiver)*

Leah reflected that whilst this closeness was certainly well-intentioned, she sometimes felt that it blurred general boundaries. For her, parenting with too few limits risked creating uncertainty for her daughter about roles and expectations within the family.

Finally, Adam spoke about learning emotional suppression from his mother and grandmother:

> *"I think maybe we both did and I think the other important thing is that so it was my mum's mum who became unwell… she'd say take herself off and express herself... you think well you know I shouldn't talk about it I shouldn't express myself like that I must keep this face on and it just I guess hurt all of us so." (Adam, ILEP)*

Adam's reflections did not describe a clear role reversal but rather a family pattern where emotions were shared yet unspoken. His account highlighted how silence itself could become a legacy, shaping how feelings were managed and expressed across generations.

Across these stories, permissiveness and role reversal rarely stemmed from neglect or indifference; rather, they reflected the complex realities of parenting amid structural pressures, intergenerational legacies, and personal histories. Yet participants often linked these blurred boundaries to later emotional strain, suggesting that when children carry adult roles too early or navigate freedom without containment, it can leave lasting imprints on how they experience safety, responsibility, and mental health. In several accounts, blurred roles coincided with reduced containment during early warning signs, preceding or accompanying later psychotic exacerbations.

Interpretation and Reflexive Commentary

This theme highlights how parenting styles facilitated emotional well-being and shaped the contexts in which psychotic distress was understood. Across the narratives, parenting was rarely described in simple terms, rather, it emerged as deeply influenced by parents' own personal histories, trauma legacies, and intentions to protect and repair what had been missing in their own childhoods. This helped clarify which parenting moves felt protective during psychosis.

Permissiveness and role reversals most frequently arose from single-parent narratives, emotional hardships, or a drive to avoid punitive or dysfunctional patterns from the past. ILEP participants reflected on how complete freedom without boundaries, or adult responsibilities taken on before they were developmentally ready, shaped their sense of safety and containment and thus their emotional expression. Through this theme, a paradox occurred: parental attempts to offer trust and autonomy too early frequently left ILEP feeling exposed, burdened or unsure on clear on the bounds of responsibility and care.

From a reflexive standpoint, I felt struck by how participants balance critique and empathy. ILEP were forthcoming in sharing that they felt the intentions behind permissive or blurred parenting stemmed from good intentions and care, even as they linked these dynamics to later emotional strain. Caregivers spoke openly about their regrets and uncertainties, particularly in the absence of external support.

Theme 3: Meaning-Making and Identity Reconstruction

As participants revisited their experiences of parenting and mental health, many spoke not only to describe what happened but also to make sense of it, to reframe the past and, in some cases, to transform earlier narratives of blame into more nuanced understandings. Meaning-making, particularly in the context of psychosis, is rarely linear. It reflects ongoing attempts to integrate complex experiences into coherent life stories and, at times, to hold pain and compassion together.

Subtheme 3.1: From Blame to Understanding

Participants often began their stories by describing pain, frustration, or confusion around parenting experiences. However, over time, many revisited these memories with greater nuance. Rather than staying in positions of anger or blame, they reflected on the wider circumstances shaping their families and the emotional realities of parenting under strain. The shift did not erase the difficulties they faced but revealed how meaning-making allowed them to hold complexity in ways that felt less one-dimensional.

For Tanya, understanding her son's early struggles involved acknowledging his difference to others and the efforts he exerted to fit in:

> *"He's probably always felt different, but always tried to fit in." (Tanya, Caregiver)*

Her words carried no judgment, either towards herself or her son; rather, they revealed a quiet compassion. Tanya's reflections suggested that maintaining a compassionate stance created a space for her to consider her son’s experiences more openly, without rushing toward simplistic explanations.

Some caregivers spoke about regrets they held whilst also recognising the limits of what was possible at the time. Jenni reflected:

> *“You kind of wish you could do it all again properly, but you only get one go.” (Jenni, Caregiver)*

Rather than blaming herself, Jenni seemed to acknowledge the weight of parenting amid the pressures and imperfections. Her words hinted at a shift from self-criticism toward acceptance, demonstrating how meaning-making allowed her to reframe her experiences with more gentleness toward herself.

For some ILEP, this shift toward understanding involved recognising moments of care within family relationships that had once felt conflicted. Troy reflected:

> *“I think my parents have been very supportive and they understand me… there’s never been a push or like… an opposite force.” (Troy, ILEP)*

Troy’s story suggested that what once may have felt like passivity came to be understood as a kind of acceptance, a willingness to let him be himself without confrontation.

Others, like Gemma, reflected on the struggles her parents faced alongside her own:

> *“I think that at a similar time my mum was having a hard time too, actually… I guess things were difficult for them as well.” (Gemma, ILEP)*

This recognition moved her away from earlier feelings of resentment. By situating her parents' behaviour within the context of their own difficulties, Gemma's narrative carried empathy for everyone involved rather than focusing solely on what was lacking.

Layla, too, revisited her childhood experiences with greater perspective:

> *"Some things I'm glad that she made me do… now I keep my house tidy, and you know I know how to cook and clean." (Layla, ILEP)*

Whilst Layla had spoken elsewhere about feeling burdened by adult responsibilities, here she reframed some of those moments as shaping skills and independence that became valuable later in life.

Adam also reflected with complexity on his parents' intentions and his own tendencies:

> *"They've always wanted what's best… but again, with my perfectionism and autism, I think I'd take things out of context." (Adam, ILEP)*

Rather than seeing family dynamics in purely causal terms, Adam seemed to integrate multiple strands. For example, his parents' care, his own personality, and the misunderstandings between them, into a more balanced understanding.

Across these accounts, participants described moving from positions of blame or certainty toward interpretations that allowed for compassion, complexity, and even, at times, forgiveness. This did not deny the impact of early difficulties but revealed how meaning-making was able to offer new ways to consider the past, way that were less about fault and more about understanding what it meant to live, parent, and grown under their individual circumstances.

Subtheme 3.2: Resilient Narratives

Alongside memories of hardship and emotional strain, many participants spoke about resilience, about findings ways to survive, adapt, and grow from experiences that had once felt overwhelming. Their stories revealed how humour, advocacy, empathy, and hope became resources for reclaiming their identity beyond illness and adversity.

Gemma reflected on her own experiences of mental health crisis with a focus on what she had gained rather than what she had lost:

> *"If anything, it's made me more aware… I can spot it in others now, and I'm the one they come to. That feels good." (Gemma, ILEP)*

Here, Gemma reframed her difficulties as a source of relational insight and care for others. Rather than centring pathology or shame, her narrative emphasised agency, empathy and compassion, and a sense of purpose rooted in shared understanding.

For Ethan, humour offered another pathway to resilience:

> *"Sometimes you've just got to laugh. I mean, the voices told me my mum was a lizard. How else do you deal with that?" (Ethan, ILEP)*

Ethan’s humour did not trivialise his psychotic experiences, rather suggested a psychologically adaptive stance. Laughter allowed him to integrate frightening and confusing phenomena into his life story in ways that reduced fear and created distance from stigma.

Leah’s reflections showed how resilience could extend beyond the personal toward advocacy and systemic change:

> *“I started speaking at parent groups, just to tell people you’re not alone. This isn’t your fault.” (Leah, Caregiver)*

By sharing her story with others, Leah transformed personal pain and turmoil into collective support. Her words illustrated how meaning-making can move outward, shaping communities of care and challenging narratives of blame or isolation often associated with psychosis.

Even amongst participants still facing ongoing challenges, resilience emerged through shifts in self-perception. As Lola explained:

> *“I still have bad days, but I’m not ashamed anymore. That’s the biggest thing.” (Lola, ILEP)*

Lola’s story acknowledged the persistence of distress whilst highlighting the importance of self-acceptance. Her words captured how identity reconstruction was not about erasing hardships but about reclaiming authorship over its meaning.

Spanning these narratives, resilience appeared not as denial or uncritical optimism, but as a deliberate re-authoring of experiences. Through humour, advocacy, empathy, and self-compassion, participants resisted identities rooted solely in illness or suffering, creating space for growth, connectivity, and hope.

Interpretation and Reflexive Commentary

This theme elucidates how participants actively reworked their experiences of parenting and psychosis over time. Many participants shifted from anger or confusion toward empathy, a broader perspective, or acceptance. This interpretive shift did not squash or erase earlier pain, rather, it allowed participants to situate it within broader family histories and personal growth.

Throughout, meaning-making scarcely felt linear. Some participants described compassion emerging in conjunction with enduring pain. Other participants highlighted resilience whilst acknowledging ongoing distress. Healing often appeared uneven or unfinished and appeared to be reframed through ordinary day-to-day acts as opposed to singular moments of clarity.

As a researcher, I noticed how giving participants an opportunity to retell their narratives created space for integration despite circumstances remaining unchanged. Being aware of theoretical perspectives of trauma studies and attachment theory allowed me to contextualise these narratives whilst resisting neat categorisations. I felt that meaning-making arose as an act of agency, holding suffering and compassion together, finding a semblance of coherence whilst avoiding the denial of complexity, and resisting identities that are solely situated in illness or harm.

Theme 4: Making Sense of Suffering and Survival

This theme explores how participants linked psychosis, parenting, and mental health to wider experiences of trauma, grief, and intergenerational strain. For many, psychosis was not experienced as an isolated event, rather, it was situated within histories and parenting, including within loss, emotional pain, and silence across generations. This shaped how psychotic symptoms were interpreted, disclosed, and coped with.

Subtheme 4.1: Trauma, Grief, and Intergenerational Wounds

Across participants' narratives, trauma and grief were described as shaping caregiving relationships and experiences of psychosis. These stories revealed how unresolved losses or relational ruptures left emotional imprints that travelled through families, shaping how love, care, and safety were experienced.

Lewis reflected on the loss of his mother in early childhood and how caregiving roles shifted within his family:

> *"My mum died when I was little. I was brought up by my dad and my sister, she's nine years older than me and she had a massive input because I was quite young."* (*Lewis, Caregiver)*

Lewis highlighted the pain of early loss and the importance of substitute caregivers. His story demonstrated how bereavement shaped family dynamics and, eventually, his own parenting stance. Lewis showed how grief can ripple across generations in ways that are painful as well as informative.

Other participants described where experiences of trauma and fear were embedded within family relationships themselves. James offered a strikingly raw account:

> *"He hit nails in the back of my head… you can still see it… From that day I have been physically sick." (James, ILEP)*

James connected this moment of bodily harm to the onset of his physical and emotional distress. His words reflected how early experiences of violence left enduring marks, not only on his physical body but also on his sense of safety within relationships, particularly when such events remained unacknowledged or unrepaired.

For Jenni, trauma shaped parenting more indirectly through dissociation:

> *"What I was saying to you earlier where she would sort of say, but you've said this mum, or you did this when I was younger. And I'll say I don't remember… the dissociating was a big problem for them." (Jenni, Caregiver)*

In this quote, Jenni speaks to the impact her trauma and dissociation had on her relationship with her children. She acknowledged misunderstandings around dissociative experiences and how these were raised many years later, suggesting a potential underlying psychological distress that shaped the relational dynamic. Jenni's words revealed how the aftershocks of trauma can disrupt family communication, sometimes leaving emotional gaps between parents and children even when love and care are present.

Not all participants linked distress directly to family experiences. Troy reflected instead on his internalised shame, which he described as traumatic:

> *"I think the voice in my head gives me a fair amount of… the biggest one is shame… but it comes from the psychosis… not from anyone else." (Troy, ILEP)*

Troy held an opposing belief, that his experience of internalised shame stemmed only from psychosis itself, rather than relational injury. His perspectives contrast with others who connected distress to family dynamics, reminding us that the meanings attached to trauma, emotion and illness are deeply personal and varied.

Gemma's story revealed layers of grief, loss, and trauma across her childhood:

> *"My nan… she killed herself… she took an overdose of [prescribed medication]." (Gemma, ILEP)*

> *"We didn't get to go to her funeral… if I'd have been my mum and dad, I would have taken us… to have that final sort of goodbye." (Gemma, ILEP)*

She later described a traumatic sexual assault:

> *"It wasn't a particularly nice incident… I was the one that got blamed for it when in fact it was his fault, not mine. And it went around the whole school and I was bullied for it." (Gemma, ILEP)*

Gemma spoke about being denied the chance to attend her grandmother's funeral and the silencing of her own trauma as a teenager. Her reflections revealed how grief and harm became compounded when mourning and emotional support were absent, leaving experiences unspoken and unresolved.

Finally, Lewis reflected on the emotional reserve within his family:

> *"My dad was a typical bloke born just before the Second World War… emotions, although I definitely know I was loved, my dad wouldn't really do emotions." (Lewis, Caregiver)*

Here, Lewis pointed to the intergenerational legacies shaping emotional expression, where love was present but rarely verbalised. His account illustrated how cultural and historical context influenced family relationships, sometimes leaving emotions contained rather than shared.

In conjunction, these narratives revealed how trauma, loss, and intergenerational wounds shape parenting and the emotional ecology in which psychosis risk was present. Whether through bereavement, violence, silence, or emotional distance, participants highlighted how suffering often travelled across generations when pain remained unspoken and unsupported.

Subtheme 4.2: Cultural and Spiritual Interpretations of Distress

Several participants described turning to cultural and spiritual frameworks when trying to make sense of their mental health experiences. They located these meanings within family life, specifically in parental expectations, household routines, and how caregivers frame early signs of distress. For some participants, faith offered comfort, structure, and a sense of belonging, whilst for others, it carried elements of pressure and ambiguity. Participants' narratives revealed how spiritual and cultural traditions became interwoven with experiences of suffering, sometimes as a source of strength and at other times complicating the search for meaning.

Joseph reflected on growing up in a home where religious practice shaped daily life:

> *"We go to school, we recite Quran,"* he shared, followed by, *"They always come find us and push us to pray." (Joseph, ILEP)*

As a child, he recalls feeling frustrated by the pressure of the routine religious practices. Yet, looking back, he described feeling grateful for the structure and emotional regulation that faith brought into his life. His words illustrated the duality of religious frameworks, once experienced as demanding yet, in retrospect, offering consistency and moral grounding that supported his sense of stability. In parenting terms, the same caregiver-led routines were narrated as both containing due to the structure and constraining due to the pressure. This shaped how distress was discussed and managed at home.

Gemma reflects on a dual response to her faith here. On the one hand, Gemma speaks to how religion makes her feel confident and allows her to view herself positively, alluding to emotional reassurance offered by faith:

> *"It made me feel quite… it does feel make me feel good about myself and I practice good… I do practice what's preached, I guess." (Gemma, ILEP)*

However, on the other hand, Gemma feels that when she became unwell with psychosis, her religious beliefs felt distorted:

> *"When I went through my psychotic episode… I think it played with my imagination." (Gemma, ILEP)*

Gemma's account captured how spiritual frameworks could serve as a protective factor as well as feel destabilising. Whilst her religion gave her confidence and meaning, she felt that psychosis disrupted these familiar structures, turning sources of comfort into areas of confusion. Participants contrasted their own faith-based coping with family conversations about help-seeking, noting that parental interpretations influenced whether distress was named, normalised, or kept private.

These narratives illustrate that attachment-related concepts such as safety, regulation, and responsiveness can manifest through culturally embedded routines, and belief systems, rather than the overt emotional expressiveness emphasised in Western attachment theory (Keller, 2013; Mesman et al., 2016).

Taken together, these narratives revealed how faith and culture shaped the emotional ecology of psychosis in ways that were neither wholly positive nor negative. Spiritual frameworks could reduce isolation, provide routine, and offer moral guidance. However, on the other hand they could also feel demanding or become entangled with distress when illness altered their meanings. Participants' reflections underscored the importance of engaging with spiritual and cultural narratives without romanticising or reducing their impact, recognising the complexity they bring to how suffering is understood and lived. This theme demonstrates how parenting through culturally anchored practices can shape emotion, discussions, and pathways to care across the course of psychosis. For some, these frameworks buffered shame and isolation, whereas for others, they became entangled with symptom content, influencing their help-seeking and recovery trajectories as participants grew to understand them.

Subtheme 4.3: Love That Holds, Unconditional Presence and Emotional Support

Amid narratives of trauma, grief, and emotional strain, participants also spoke about the power of love, acceptance, and emotional presence. These accounts revealed how caregiving, even in its imperfect and understated forms, could become a stabilising force in times of crisis. For many, the sense of containment through touch, routine, or simple presence shaped feelings of safety and recovery in lasting ways. Such presence was often described as reducing panic, anchoring reality-testing, and supporting engagement with care, particularly during active psychotic distress.

Lewis reflected on the profound sense of security he experienced as a child:

> *"I think the luckiest ace card I've ever been given in my life, more than anything else, was being born to my parents… if you need to feel safe and loved, my God, yeah. The man had A's in it. It was phenomenal. So yeah, I'm just trying to do the same with Liam." (Lewis, Caregiver)*

For Lewis, childhood love became a blueprint for his own parenting, shaping how he aimed to offer his son the same unwavering care he had received. His words suggested that experiences of safety and nurture early in life can ripple forward into future generations, fostering relational continuity ever after earlier losses.

Tanya shared an evocative account of her view of her family as a tightly held emotional unit. One that is marked by unconditional love and reciprocal protection:

> *"We're a nucleus, right. And you can't get in this bit (pointing to inner part). This is reserved." (Tanya, Caregiver)*

Her metaphor captured the sense of loyalty and closeness within her family, a "reserved" space of unconditional care that she saw as central to their resilience when facing mental health challenges.

Ben's experience adds a nuanced perspective by demonstrating that love, warmth, containment and safety can still be experienced even with a detached parenting style. He reflected:

> *"...in my choices and girlfriends and in my wife are all carrying that deeper relationship with women, they were slightly detached and that served me well. My wife's fantastic. She's a bit like Mum... just a little detached..." (Ben, ILEP)*

Ben spoke of his mother being emotionally reserved and concurrently deeply caring. He did not experience her expressions of love as overt, but he noted always feeling the presence of her warmth. This was a dynamic he later sought this dynamic in adult relationships. His account suggested that love need not always be demonstrative to be deeply felt.

Others spoke about parental efforts that were imperfect but present. Jenni said:

> *"I probably didn't always say the right thing. But I said something. I didn't ignore it."* (*Jenni, Caregiver)*

For Jenni, showing up and responding, even when unsure what to say, mattered more than getting it right all the time. Her reflections highlighted how small but consistent acts of care can communicate emotional availability in ways that children carry with them long after.

Troy expressed a similar sentiment about parental acceptance:

> *"Acceptance is probably the biggest emotion to feel…especially from your parents… the biggest positive emotion is acceptance." (Troy, ILEP)*

Troy spoke of acceptance from his parent as a feeling, but more importantly, as a foundational relational experience, an emotional bedrock supporting his sense of self through difficult times. He expressed a deep appreciation for his parents' consistent availability and emotional resilience.

Lola's reflections gave me pause for thought about how expressions of love and affection inform and contribute to the creation of our psychological worlds, and how they can, in turn, be shaped by it. She thought openly in our discussion about how early experiences of physical and emotional distance have impacted how she interacts with loved ones in her adult life:

> *"No, [I never got hugs] ... We still don't do that. I'll find it very awkward to hug people these days… never shown affection." (Lola, ILEP)*

Adam experienced a psychiatric hospital admission in childhood. In this quote, he reflects on how his mother's emotional availability and presence in a time of crisis became a stabilising presence:

> *"My mum left her job to care for me when it was all not great… if she was not with me, then I'd panic, then I'd go into distress… if I didn't have her at all… I would have been much sooner into that second admission." (Adam, ILEP)*

Adam feels that this decreased his level of distress and prolonged the onset of a second admission. He later reflected on her physical and emotional availability during this time:

> *"I think I know that my mum was constantly there. She sat outside the room the entire time when I was kicking off, when I was all right, she was always there… Now looking back on that, that's obviously a big deal – to know that someone sat there for, you know, 14 weeks, fighting your corner and constantly trying to help in any way they could, even if it was from outside of a room." (Adam, ILEP)*

His account highlighted how even a silent presence can communicate profound care and protection, leaving an enduring sense of not being alone.

Leah reflected on how caregiving often involved small but consistent acts of nurture:

> *"I would run my bath and put her in my bath, and then I would bath her and that made her happy. You know, I'll say, come on. I'm going to wash your hair and then brush your hair and then give her the bath. And I think I I spent days before and then she could pick herself up after that.." (Leah, Caregiver)*

For Leah, routines of touch and care became a way to soothe her daughter and create stability in times of uncertainty. She spoke about needing to build her own understanding of what was going on around them so that she could better support her daughter:

Leah recalls feeling overwhelmed by the nuance of psychosis and the volume of new information that was being shared with her to try to help her make sense of her daughter's first episode:

> *"I thought to myself, if I cannot come to my understanding, I won't be able to cope and I might have a breakdown… so I did all my mental health courses, counselling, psychology stuff." (Leah, Caregiver)*

Leah described moving from overwhelm toward knowledge and reflection, showing how caregiving often involved learning new ways to navigate complex emotional landscapes.

Finally, Layla reflected on how her relationship with her mother transformed through illness and recovery:

> *"That's when our relationship really improved because she was there for me 110%." (Layla, ILEP)*
>
> *"Definitely just having that assurance that, oh, mum, she does care… the encouragement, the attention, the love… it was paramount in my recovery. Yeah, it really was." (Layla, ILEP)*

For Layla, her mother's consistent presence during the crisis repaired earlier ruptures and became central to her recovery. Her story demonstrated that even after earlier difficulties, love and care received later in life can provide profound opportunities for healing.

Together, these narratives showed that love in the context of psychosis was rarely about perfection. Instead, it was about presence, care, and acceptance, sometimes quiet, sometimes understated, but always remembered as a protective force in lived marked by uncertainty and distress. Participants framed these acts as protective factors in the course of psychosis, remembered as pivotal during periods of instability.

Interpretation and Reflexive Commentary

For some participants, trauma and bereavement shaped the emotional tone of family life, leaving generational pain spanning decades. Others sought comfort in religion or spirituality, seeking meaning and identity, though sometimes these frameworks became embedded in moments of acute distress. The final subtheme, *Love That Holds, Unconditional Presence and Emotional Support,* offered powerful and emotive counterpoints. It highlighted moments of emotional presence and care that provided participants with psychological safety during periods of distress and uncertainty. The love described in these stories was rarely about perfection, rather, it was just about presence, quietly, imperfectly, and with lasting impacts.

At times, engaging with these stories was emotionally demanding. I noticed my assumptions about safety and parenting being challenged by accounts where love coexisted alongside silence or harm, or where protection appeared to be more of a presence than words or actions. I questioned whether terms such as “trauma” might flatten cultural and personal nuance in some cases. This was a gentle reminder that my role was not to counsel or resolve contradictions but to hold them open, allowing narratives to remain complex, ambivalent, and unfinished.

Interpreting these parenting accounts also required attentiveness to cultural variation within the sample. Participants described caregiving practices that drew on religious routines, collective responsibility, emotional reserve, and hierarchical family structures, patterns that are normative and adaptive in many cultural contexts but not always well captured by mainstream psychological frameworks. Much of the theory that informs clinical understandings of parenting and psychosis, particularly attachment theory and parenting-style typologies, has been developed from predominantly White, Western, middle-class samples and tends to privilege autonomy, open emotional expression, and dyadic attunement as markers of "healthy" caregiving (Keller, 2013; Rothbaum et al., 2000). In contrast, several participants located care in predictability, duty, protection, and shared faith practices. This meant that behaviours that may look "controlling" or "emotionally distant" in Western models were sometimes experienced as supportive, containing, or culturally appropriate within participants' families. Reading the data sensitively therefore required resisting automatic alignment with Western norms and remaining open to culturally grounded meanings of safety, authority, and care.

I remained close to participants' languages and meanings, as this felt essential in supporting me to keep my interpretations open. Holding space for grief, love, trauma, harm, protection, or anything else that came up was essential to honour the complexity participants entrusted me with

Chapter 5

Discussion

Aims, Research Questions, and Overview

This study, ‘The Exploration of Parenting and Psychosis: Individuals with Lived Experience of Psychosis/Caregiver Retrospective Subjective Experiences of Parenting’, explored how adults with a psychosis diagnosis and caregivers retrospectively make sense of parenting within family relationships. The overarching aim was to explore how features of parenting, often characterised as warmth/care and monitoring/control, were experienced and interpreted over time, and how these were situated within broader emotional, relational, and cultural contexts. Three specific aims guided this research to elicit ILEP accounts of being parented, to elicit caregiver accounts of parenting a child who later in life received a psychosis diagnosis, and to explore how participants understood parenting in relation to psychosis.

Grounded in qualitative, RTA, this research addressed three questions: (1) *How do participants retrospectively describe parenting experiences within their family relationships?,* (2) *How do participants understand the role of parenting in relation to experiences of psychosis,* and (3) *What broader social, emotional, or cultural factors are seen as influencing these parenting experiences or mental health outcomes?* These questions were intentionally open, consistent with a critical-realist stance, to privilege participants’ meaning-making over causality inferences.

Across interviews, four themes shaped and organised the analysis. Theme 1, *Emotional Climate and Relational Safety*, which captured participants' views on the emotional tone of home life, including criticism, control, and inconsistency. It also captured parenting features that act as a bridge to mental health and psychosis, for example, permissiveness and role reversal, which participants linked to threat appraisals, withdrawal, sleep disruptions, and difficulties with reality-testing around the onset and later exacerbations. Theme 2, *Parenting Style as a Pathway to Mental Health and Psychosis,* reflected how these parenting patterns were linked by participants to threat appraisals, withdrawal, sleep disruptions, and difficulties with reality-testing around the onset and later exacerbations of psychosis. Theme 3, *Meaning-Making and Identity Reconstruction,* brought together participants' reflections on how they interpreted, reframed, and integrated their experiences over time, including shifts from blame towards understanding and the development of resilient narratives. Theme 4, *Trauma, Belief, and the Emotional Ecology of Psychosis,* encompassed accounts of trauma, grief, and intergenerational wounds; cultural and spiritual interpretations of distress; and the protective role of love, unconditional presence, routine, and containment, which participants described as supporting stabilisation and re-engagement. These patterns align with and extend prior evidence that demonstrates that insecure attachment and low parental care/high control are more common in psychosis samples (Korver-Nieberg et al., 2014; Parker, 1983; Enns et al., 2002), that childhood adversity is associated with psychosis risk (Varese et al., 2012), and that high expressed emotion predicts relapse whereas warm parenting is deemed to be protective (Ma et al., 2021). These findings nuance the literature by showing how warmth and control can co-exist within the same relationships and shift with stress and context, rather than mapping neatly onto fixed parenting styles.

Diversity within the sample played an important role in shaping how parenting, safety, and distress were understood. Participants drew on cultural, spiritual, and familial frameworks that did not always align with dominant Western psychological models. For example, attachment theory, originally developed from largely White, Western, middle-class samples (Ainsworth et al., 1978; Bowlby, 1969/1982), emphasises autonomy, verbal emotional expression, and dyadic attunement as markers of security. However, several participants described caregiving grounded in collectivist values, intergenerational caregiving, role fluidity, and non-verbal expressions of warmth, aligning with critiques that Western attachment constructs do not adequately capture culturally normative caregiving practices (Rothbaum et al., 2000; Keller, 2013). In some cultural contexts, practices that might be labelled as “controlling,” “authoritarian,” or “permissive” in Western frameworks are culturally interpreted as protection, respect, religious duty, or family cohesion (Chao, 1994; Kagitçibaşi, 2007). These accounts highlight the need for culturally sensitive applications of attachment and parenting theory that recognise multiple pathways to relational safety and developmental security, rather than treating deviations from Western norms as deficits.

At the same time, diversity in this study was patterned rather than universal. All participants were UK-based and engaged with NHS services, and the sample contained only one matched dyad and a small number of caregivers, so conclusions speak most directly to families negotiating psychosis within UK service systems and racialised, faith-diverse but structurally constrained contexts. Within this frame, the data sit alongside longstanding critiques that attachment theory, as originally operationalised, may over-privilege Western, middle-class ideals of dyadic sensitivity and autonomy (Rothbaum et al., 2000; Keller, 2013; Mesman et al., 2016). Participants’ accounts suggested that safety also arose through extended kin networks, practical provision, and faith and community structures, indicating that attachment constructs are one useful lens rather than a universal template. This emphasis on everyday routines, collaborative problem-solving, and family communication echoes the focus of early family-management work in psychosis (Falloon et al., 1982, 1985, 1987), while underscoring the need to adapt such interventions in culturally responsive ways.

Taken together, the findings address the research question by (a) describing parenting as dynamic and contingent rather than static traits, (b) situate parenting as a relational context in which psychotic experiences were understood, tolerated, and managed (not a singular cause), and (c) highlighting culture, spirituality, and intergenerational histories as lenses through which families named distress, chose supports, and negotiated their recovery pathways. These insights build on attachment, trauma, and systemic perspectives that locate psychosis within histories of safety, loss, and connection (Bowlby, 1982/1969, 1982; Varese et al., 2012), and provide clinically useful touchpoints around warmth, containment, boundaries, and meaning-making for family-inclusive and trauma-informed care.

Parenting in the Shadow of Psychosis

This theme focuses on three areas, the emotional climate of the home (warmth/control and a sense of safety), transactional dynamics linking stress, sleep and threat appraisal to distress, and protective routines under structural pressures.

Emotional Climate and Relational Safety

Across participants' accounts, early family climates were described as shifting combinations of care, criticism, control, and silence, contexts in which psychotic experiences were understood and managed over time rather than attributing oversimplified causes. The pattern aligns with work associating low care/high control parenting features (i.e., low warmth/affection with high psychological or behavioural control; the PBI's "affectionless control", overlapping with Baumrind's (1966, 1971) authoritarian patterns of high demandingness/low responsiveness) to poorer adult mental health outcomes, and, in some studies, to psychosis risk and reduced functioning (Parker, 1983; Enns et al., 2002; Sevilla-

Llewellyn-Jones et al., 2019), alongside evidence that attachment insecurity is prevalent in psychosis, consistent with attachment theory (Korver-Nieberg et al., 2014; Bowlby, 1988). Experiences were heterogeneous and context-dependent for example, participants spoke about mothers, fathers, step-parents, grandparents, siblings and wider family taking on caregiving roles. This pattern converges with Review Aim 2 and extends it by showing how warmth and control co-exist and shift with context rather than mapping neatly onto fixed styles.

Cultural and faith norms such as respectability and duty, neighbourhood safety, stigma, and migration histories shaped how care, control, and communication were expressed and interpreted. In contexts where there was a more collectivist approach, close monitoring and high academic expectations were understood as care, whereas in more individualistic settings, the same practices could feel more intrusive or, in some circumstances, controlling (Bornstein, 2012; Kâğıtçıbaşı, 2005; Park, 2016; Lansford, 2022). Where caregivers laid out stricter rules or restricted curfews, sometimes due to neighbourhoods feeling unsafe or under strain, this was experienced by some as protection, whereas for others, it was a restriction. This is consistent with ecological evidence that socioeconomic stress can shape parenting (Conger & Donnellan, 2007; Roubinov & Boyce, 2017). In families where migration history, discrimination and living in areas with lower ethnic density were relevant, there was linked to caution and, at times, silence about symptoms. Some communities provided practical support and shared meaning-making (Morgan & Gayer-Anderson, 2016; Baker et al., 2021; Selten et al., 2019). These accounts scarcely framed caregivers as either good or bad, rather they situated caregiving in within the pressures, values, and resources available at the time. These patterns align with evidence that high-conflict or high arousal climates can amplify threat appraisals and disrupt sleep, processes associated with relapse risk and difficulty evaluating anomalous experiences (Kapur, 2003; Reeve et al., 2015; Ma et al., 2021). These lived experiences are best read as plausible pathways rather than causes.

Transactional Dynamics and Plausible Processes

The data, read alongside prior work, point to three pathways: (a) under stress, everyday events can feel unusually important or threatening (Kapur, 2003), (b) disrupted sleep destabilises mood and thinking, and (c) negative self-views, together with periods of feeling detached from one's feelings or surroundings, can fuel suspicious thoughts and distressing voices (Reeve et al., 2015). The dynamics were transactional, for example, ILEP states shifting due to sudden overwhelm and withdrawal and caregiver responses co-evolved over time, consistent with developmental transactional models and participants' narratives of ongoing recalibration (Sameroff, 2009). Several caregivers linked their moment-to-moment adjustments to the young person's sensory sensitivities. In these cases, this flexibility was recalled as attempted attunement under uncertainty. It is important to note that low care/high control parenting features are commonly associated with a variety of psychopathologies, not only psychosis (Enns et al., 2002); however, in this study, such climates were situated within psychosis narratives, shaping how experiences were understood and managed across accounts.

Connecting Recalled Parenting with Family-Climate Evidence

Participants' retrospective accounts of early caregiving, akin to what the PBI (Parker, 1983) captures, aligned with the family-climate literature on expressed emotion. Criticism and hostility are linked to relapse risk, whereas warmth can be protective (Ma et al., 2021). In practice, people described the micro interactions through which these climates were lived (tone of voice, rules and repairs after conflict, everyday routines), helping to connect perceived parenting with observable day-to-day family processes.

Protective Patterns within Structural Context

Alongside these potential risks, namely high-conflict and critical family climates, inconsistent responses, and periods of heightened arousal and disrupted sleep, participants recalled moments of rupture and repair, apologies, humour, or a quiet presence after conflict that seemed to help rebuild trust and connection within the relationship again. As potential buffers to risk, predictable routines, consistent warmth, and sensitive responsiveness were remembered as stabilising influences that may lower background arousal and support emotion regulation (Butler et al., 2019; Freeman et al., 2017; Reeve et al., 2018). Lastly, several accounts placed parenting under structural pressure such as financial strain and migration-related stress, racism and discrimination, parental health problems, and limited-service knowledge or access, echoing evidence that socioeconomic adversity shapes psychosis risk contexts and caregiving bandwidth (Morgan & Gayer-Anderson, 2016). Extended family, faith communities, and peers were sometimes described as supportive tools that bolstered caregiver capabilities, other times, they introduced competing expectations. Given the small qualitative sample, these patterns should be read as tentative and illustrative rather than definitive. This aligns with Aim 3, adversity as a contextual moderator. Routines, warmth, and sensitive responsiveness appeared protective when structural stress was high.

Parenting as a Pathway to Mental Health and Psychosis

The second theme looked at how parenting functioned as a pathway between stressors and outcomes, through everyday boundary setting, role negotiation, and co-regulation. Under strain, some participants recalled permissiveness, or freedom without containment, and role reversal or feeling parentified in ways that exceeded their developmental stage. Systemic accounts anticipate such patterns (Minuchin's structural family theory; Minuchin, 1974) for example, boundary diffusion or rigidity under external pressures, and attachment-informed perspectives similarly highlight difficulties where co-regulation is inconsistent, and autonomy can be experienced as trust. Empirically, the care-control balance matters, evidence suggests that high control and low warmth parenting features are associated with poorer adult outcomes, whereas warmth and clear expectations are related to better emotional functioning (Parker, 1983; Enns et al., 2002; Gorostiaga et al., 2019; Fang et al., 2024; Ford et al., 2023). In some families, adaptations that looked permissive from the outside were narrated as deliberate flexibility in response to a children overwhelm. In line with this, participants linked more permissive climates to uncertainty around when or how to intervene and to a sense that early changes could be overlooked, whilst structured, warm caregiving experiences were recalled as containing, supporting help-seeking and meaning-making without shame. There were two elements of bidirectionality that felt noteworthy: unpredictability could sometimes originate in ILEP shifts in emotional states, and caregivers would recalibrate in real-time, and reframing over time, this was where experiences that once felt permissive were later understood as insufficient containment during vulnerable periods. Not all firm limit-setting experiences were described as negative; a minority described clear rules or direct feedback as protective, signalling care and guarding against risk, as well as enabling opportunities. Here, participants emphasised a gap between their caregivers' intention to protect and motivate, and the actual impact, such as feeling silenced. Practically speaking, these narratives point to malleable levers that align with the wider evidence-base and guidance, for example, to reduce criticism and hostility, to increase warmth, restore predictable routines and sleep, and renegotiate roles and boundaries in developmentally sensitive, non-blaming, and culturally responsive ways (NICE, 2014; Ma et al., 2021), whilst recognising the structural conditions that shape what families can realistically achieve (Morgan & Gayer-Anderson, 2016). To avoid pathologising culturally patterned forms of care such as collective duty, interpretations remain anchored in participants' meanings. Where terms like criticism or control are used, they reflect the lived impact rather than a judgment of cultural value. This theme builds directly upon Aim 2 by specifying how boundaries, role clarity, and co-regulation may influence help-seeking and reality-testing, complementing quantitative patterns reported in the review.

Making Sense of Suffering and Survival

This theme brings together three strands, trauma and grief, and how they shape communication, cultural and spiritual frames, and their impact on help-seeking, and "Love That Holds" what warmth looks like in everyday practice.

Trauma, Grief, and Intergenerational Wounds

Accounts of bereavement, interpersonal violence, and unresolved ruptures featured prominently throughout this theme. Early parental loss altered caregiving roles and emotional availability. Violence and frightening behaviours within the family home left enduring bodily and relational traces as well as dissociative coping in ILEP as well as caregivers, later complicating communication. Where funerals were missed or harms minimised, participants described grief becoming unspoken, with pain spanning across generations as distance, volatility, or narrow emotional range at home. Such patterns align with evidence that cumulative adversity is associated with later psychotic experiences and with models in which early relational environments calibrate stress responsivity and threat interpretation (Varese et al., 2012).

There was often a divergence between intention and impact. Caregivers framed urgency, strictness, or emotional reserve as protection, whereas ILEP sometimes experienced this as silencing or absence. This gap helps to explain how similar behaviours could be experienced as containing or constraining depending on timing and context. At the same time, participants recalled micro-repairs, apologies after conflict, practical care in crises, and quiet presence outside closed hospital room doors. These did not erase familial difficulties, but they were recalled as buffers that reduced relational threat and supported re-engagement. This may tentatively support existing literary evidence that demonstrates that criticism and hostility can predict relapse, whereas warmth is protective (Ma et al., 2021). Not all participants located distress within family life. Some attributed core feelings, such as shame, to psychosis itself, underscoring heterogeneity in how meaning is made. This corroborates Aim 3 from the literature review, whilst adding detail on how unspoken grief and ruptures shape family communication.

Cultural and Spiritual Interpretations of Distress

Families drew upon faith and cultural norms to organise daily life and to make sense of unusual experiences. Religious routines, for some, were described as containing and constraining. In parenting terms, the same practice could be experienced as supportive or burdensome when it limited conversations associated with psychosis. Participants described moments when psychosis distorted familiar spiritual frameworks, turning what was once a comfort into sources of confusion, which subsequently influenced whether help was sought within services, community, or prayer.

These accounts positioned culture as a living context rather than background. Intergenerational parental practices and expectations shaped what was tolerable to speak about within the family home, shaping how potential early warning signs were framed. This is consistent with wider research on social determinants, negotiations around belief, and help-seeking practices within material constraints, for example, financial strain and discrimination and how this may impact caregiving bandwidth (Morgan & Gayer-Anderson, 2016). These accounts align with earlier studies that demonstrate that what counts as "care" in parenting can vary from one culture to another. These results sit with previous research showing that cultural meanings and structural conditions shape how "care" and "control" are expressed and understood, and this in turn can influence when families seek help and who is at greater risk of relapse (Bornstein, 2012; Kâğıtçıbaşı, 2005; Park, 2016; Lansford, 2022; Conger & Donnellan, 2007; Roubinov & Boyce, 2017; Morgan & Gayer-Anderson, 2016; Baker et al., 2021; Selten et al., 2019). In other words, what looks caring in one context may feel controlling in another, and factors like financial pressures or neighbourhood safety can also shape these experiences. This links back to the review's contextual standards, showing how cultural meanings and structural pressures shape whether practices feel containing or constraining.

Love That Holds, Unconditional Presence and Emotional Support

Alongside trauma and constraints, participants repeatedly identified unconditional presence and practical caregiving as stabilising during acute distress. Caregiver presence was identified in ordinary acts such as waiting outside a hospital room, preparing meals, providing transport, handling forms, and sitting nearby throughout the night. Such care was described as relieving panic, anchoring reality-testing, facilitating routine and enabling engagement with care. Several participants stressed that emotional reserve is not an absence of love; rather, for some families, steadiness and provision were the principal languages of care in their relationships. Over time, relationships often improve through repeated small acts of repair that re-establish safety.

These descriptions offer further understanding of what warmth looks like in a day-to-day practice, building on research on expressed emotion (Ma et al., 2021). They offer clarification that effective support was not uniform and what might feel warm and containing for one individual, might feel intrusive to another. What mattered was whether the presence and boundary-setting were experienced as attunement to each individual.

In summary, the findings extend the wider argument that the relationship between parenting and psychosis is carried through meaning, safety, and repair. For example, how families name experiences, how they hold space for each other when things are frightening, and how small but reliable acts of care accumulate into stability over time. This extends the review’s finding that warmth relates to better outcomes by illustrating the everyday forms that "warmth with structure” can take.

Strengths

This study brings together ILEP and caregiver perspectives on parenting in the context of psychosis, allowing convergences and tensions to be articulated rather than inferred. The dual vantage point strengthens the ecological validity of the analysis by situating warmth/care and monitoring/control within lived family dynamics. The use of semi-structured interviews afforded flexibility for participants to lead the conversation, which was crucial for capturing how meanings around parenting, trauma, beliefs, and psychosis were negotiated over time.

Analytically, an RTA approach supported close attention to participants' language and to patterned meanings across heterogeneous family forms and cultural frames (Braun & Clarke, 2006, 2019). The emphasis on reflexivity and depth aligns with RTA's epistemology and this study's aims to privilege participants' meaning-making over causal claims. Credibility was enhanced through reflexive journaling, supervision, and peer discussion, which helped bring to light any assumptions and keep interpretations anchored in the data (Braun et al., 2016). The sample provided conceptual variation for example, different caregiving roles and diverse cultural and spiritual framings, increasing information power relative to the study aims (Malterud et al., 2016). This diversity shaped the themes by pulling the analysis away from fixed parenting typologies and toward processes that appeared across groups, for example, how love, control, and safety were negotiated within differing cultural, spiritual, and structural contexts.

A further strength is this study's contextual specificity, for example, exploring how participants situated parenting within structural pressures like finances and migration stress, and within cultural and spiritual practices. This moves beyond broad labels such as high control, to the micro-practices families remembered as containing or constraining. This offers clinically useful points to touch on without pathologising culturally patterned care.

Limitations

Findings rely on retrospective self-reports, which is vulnerable to recall bias and reframing over time (Hardt & Rutter, 2004). Whilst retrospective accounts can validly capture salient experiences, they do not establish chronology or causality. In line with this study's aims, interpretations are presented as plausible pathways, not determinants. The single time-point design limits insight into how relationships and meanings change across phases of illness and recovery.

The sample was based in the UK and was self-selecting, which may privilege those willing and able to discuss family life and psychosis in an interview setting. Moreover, although this study includes caregivers and ILEP, the study only contained one matched dyad and no observational data. This study's data does not triangulate with quantitative indices such as the PBI. These choices were deliberate, to foreground meaning-making within an RTA framework. Small, information-rich samples and depth over breadth are consistent with RTA guidance, but they do constrain inferences about mechanisms and directionality (Braun & Clarke, 2019, 2021).

The interpretation of parenting features also required cultural sensitivity, as widely used psychological frameworks such as attachment theory and parenting-style models tend to be rooted in Western, middle-class norms and do not always adequately reflect culturally specific expressions of caregiving, authority, or protection described by participants (Keller, 2013; Rothbaum et al., 2000). In this sense, the findings support critiques that attachment constructs can misclassify culturally normative practices as "insensitive" or "controlling" when they are experienced locally as protective and caring, reinforcing the need to read attachment theory as a partial lens rather than a universal standard.

Given my dual position as a clinician and a researcher, power and social desirability may have shaped disclosures (Berger, 2015; Finlay, 2002). Reflexive practices helped to mitigate this; however, they do not remove the asymmetry inherent to research interviews. The interview guides were not co-constructed or piloted with caregivers or ILEP, which is a missed opportunity for participatory refinement. This falls short of best practice outlined in the UK Standards for Public Involvement (UK Public Involvement Standards Developed Partnership, 2019).

Future Research

Future work should track how meanings, roles, and routines change over time, using longitudinal and dyadic/triadic designs to examine transactional patterns that were evident in participants' accounts. Mixed-methods design could triangulate qualitative meaning-making with repeated measures of sleep, routine, family climate, expressed emotion, and stress appraisal, clarifying where care feels containing versus constraining (Kapur, 2003; Reeve et al., 2015; Ma et al., 2021). Ecological momentary assessment and brief diary methods would help to capture the state shifts and real-time caregiver responses, testing the bidirectionality suggested here (Sameroff, 2009).

Future research should examine whether childhood parenting features such as warmth/care, monitoring/control, consistency and repair, role reversal/parentification, and household routines are prospectively linking to later psychosis-related outcomes. The most informative design would be a longitudinal and multi-informant design, following children that are high-risk of psychosis into adolescents and adulthood and triangulating ILEP reports, caregiver reports, and observational indices of family climate. Key outcomes would include positive-symptom distress, reality-testing difficulties, help-seeking, relapse and admission, and functioning/quality of life.

Mechanisms should be modelled explicitly and cautiously: do lower warmth/higher control and inconsistent boundaries relate, over time, to heightened stress appraisal of everyday events (Kapur, 2003), sleep disruption with downstream effects on mood and suspiciousness (Reeve et al., 2015), or negative self-schemas/attachment insecurity (Korver-Nieberg et al., 2014)? Studies could test contextual moderators such as socioeconomic adversity, discrimination, migration-related stress, given their potential to shape parenting opportunities and later psychosis risk contexts (Morgan & Gayer-Anderson, 2016).

Mixed-method and qualitative approaches could develop timelines more closely for example, life histories, to see how ILEP made sense of early family climates and whether those meaning influences later interpretations of unusual experiences and speed or help-seeking.

Clinical Implications

Clinical implications point to modest, actionable practices in childhood that may shape later coping without inferring causality. Services can name and normalise family climate as a context for meaning-making, offering non-blaming psychoeducation that links stress, poor sleep, and heightened threat appraisal to later difficulty evaluating unusual experiences (Kapur, 2003; Reeve et al., 2015). Warmth with structure is worth coaching alongside the benefits of consistent routines with fair limits, and repair conversations after conflict, particularly given the evidence that criticism and hostility relate to relapse (Ma et al., 2021; Parker, 1983; Enns et al., 2002). Existing parenting programmes already target these skills, for example, Triple P and attachment-focused interventions aim to reduce coercive cycles and build warmth, responsiveness, and problem-solving, which could be adapted to emphasise sleep routines and rupture-and-repair consistent with these findings (Sanders et al., 2014). Clinicians might also attend to role boundaries, gently addressing parentification or permissiveness whilst recognising protective intentions in constrained contexts. In psychosis care, these elements can be integrated with NICE-recommended family interventions, which content tailored to context is delivered in a non-blaming way, while recognising the small, qualitative nature of this study and the need for further evaluation (NICE, 2014; Pharoah et al., 2010).

Reflexive Note

Writing about experiences of parenting and psychosis required continual attention to language that neither blames nor strips parenting of relevance. I noticed that I pulled towards simple explanations. Journaling and supervision helped me to stay close to participants' meanings, treating parenting as part of the ecology in which later unusual experiences were interpreted and managed, not as a singular cause. I feel that I became more attentive to structural limits on "ideal parenting" and how warmth, boundaries, and repair were remembered as protective. This shaped the discussion's emphasis on small, repeatable practices in childhood that may support later stability and recovery.

Conclusion

This study suggests that how children are parented, particularly the balance of warmth and control, consistency and repair, role clarity, routines, and cultural and spiritual meanings that arose in family life, can shape how psychotic experiences are later understood, disclosed, and managed. The accounts do not argue causality, rather they point to developmental pathways through which family climates in childhood become the formative stages for later self-beliefs and help-seeking behaviours. Taken together with existing literary evidence (Parker, 1983; Enns et al., 2002; Korver-Nieberg et al., 2014; Reeve et al., 2015; Ma et al., 2021; Morgan & Gayer-Anderson, 2016; NICE, 2014), these findings identify malleable features of parenting that are feasible to support in childhood and potentially consequential in adulthood, a practical pathway between family life earlier on and how psychosis is lived and treated later.

At the same time, the diversity within this UK sample, across ethnicity, migration histories, faith, and family structures, suggests that these malleable features are better understood as flexible principles ("warmth with structure", repair, and collaborative meaning-making) rather than fixed behavioural prescriptions grounded in Western norms of attachment or parenting. Participants described relational safety emerging through different configurations of extended family, community, and faith, indicating that there are multiple culturally patterned routes to protection. This both complements and gently critiques attachment-based accounts and aligns with the spirit of family-management work in psychosis (e.g., Falloon et al., 1982, 1985, 1987), which focuses on supporting families to build routines, communication, and problem-solving in ways that fit their own values and circumstances.

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Appendices

Appendix A: Caregiver Semi-Structured Interview Guide

Caregiver Semi-Structured Interview Questions

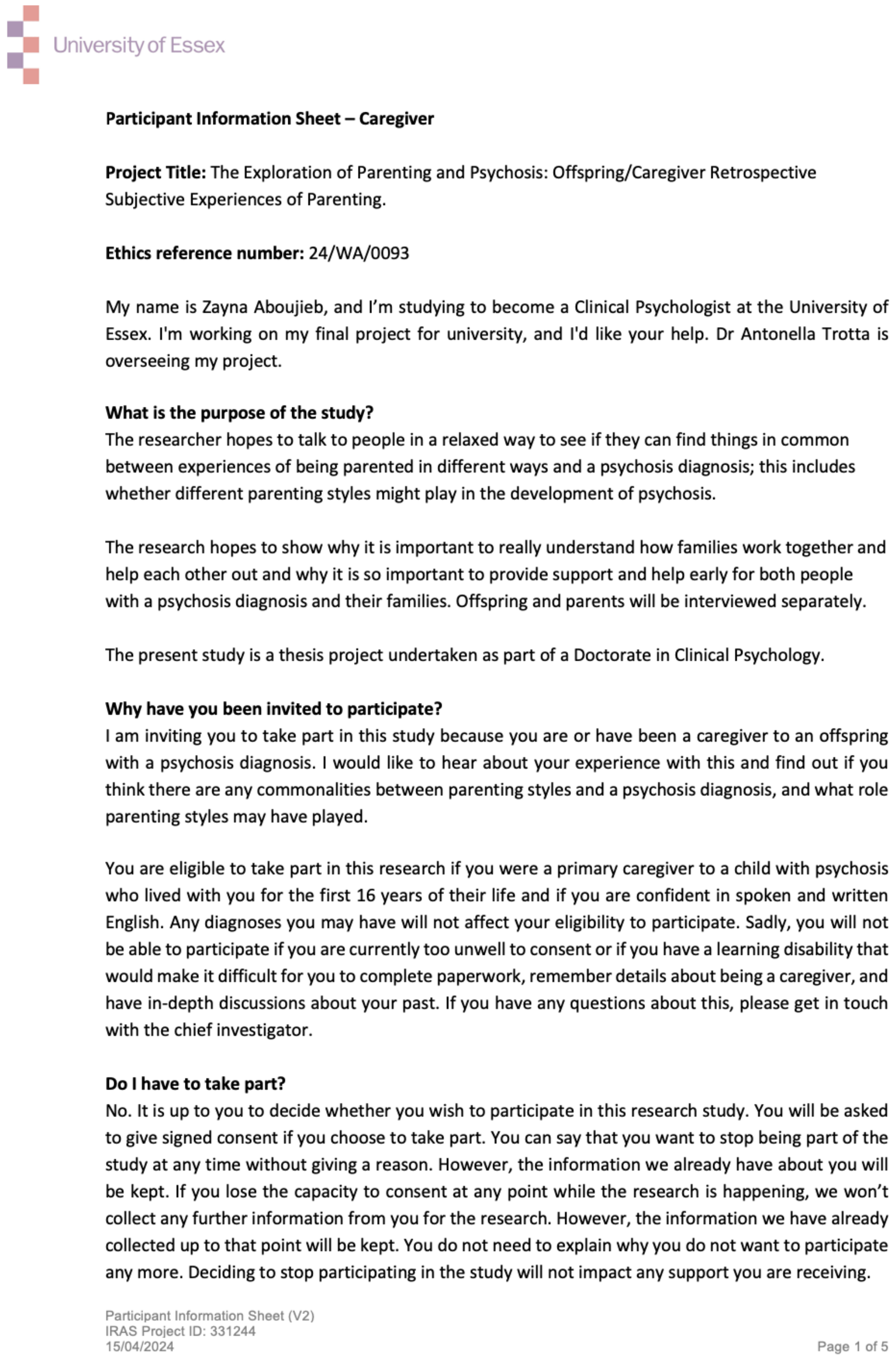
No.	**Question**
1	How did your child's experiences of psychosis develop?
2	Examples of noted parenting style: Could you give examples of the noted parenting style? (use the chosen parenting style completed in self-report demographics form) e.g. what were some of the recollections you had when you selected noted parenting style
3	What kind of support did you receive as a parent of a child with psychosis, or if none, what would you have liked to have received?
4	As a parent, what were some of the positive and difficulties that you experienced parenting a child with psychosis? (Was this your first experience with psychosis, stress management)
5	The relationship between parent and child (make sure there is a focus on some positives, e.g., the celebration of achievements, how stress was managed, how emotion was expressed)
6	How did the broader social context in which your child was brought up affect your child's psychosis, e.g. outside of the home, school, religious or cultural influences? (do you feel that any factors may have contributed to your child's difficulties, for example, at school, any differences they may have had from others)
7	What do you feel would be important to share with caregivers who are parenting a child with psychosis? This can be things that you learnt, advice you received that was either helpful or unhelpful, or things that you would have liked to have known earlier on that you now know.

Appendix B: Individuals with Lived Experience of Psychosis Semi-Structured Interview Guide

Individuals with Lived Experience of Psychosis Semi-Structured Interview Questions

No.	Question
1	How did your experiences of psychosis develop?
2	Examples of noted parenting style: Could you give examples of the noted parenting style? (use the chosen parenting style completed in self-report demographics form) e.g. what were some of the recollections you had when you selected noted parenting style
3	The relationship between parent and child (make sure to also focus on some positives, e.g., the celebration of achievements, how stress was managed, how emotion was expressed).
4	How did the broader social context in which you were brought up affect your psychosis, e.g. outside of the home, school, religious or cultural influences? Do you feel anything contributed to the development of psychosis? (do you feel that any factors may have contributed to your difficulties, for example, at school, any differences you may have had from others)
5	What do you think is the role of parenting in the development of psychosis? (stress management, how was psychosis understood within your family)
6	What do you feel would be important to share with caregivers who are parenting a child with psychosis? This can be things that you learnt, advice you received that was either helpful or unhelpful, or things that you would have liked to have known earlier on that you now know.

Appendix C: Caregiver Participant Information Sheet



University of Essex

Participant Information Sheet – Caregiver

Project Title: The Exploration of Parenting and Psychosis: Offspring/Caregiver Retrospective Subjective Experiences of Parenting.

Ethics reference number: 24/WA/0093

My name is Zayna Aboujieb, and I'm studying to become a Clinical Psychologist at the University of Essex. I'm working on my final project for university, and I'd like your help. Dr Antonella Trotta is overseeing my project.

What is the purpose of the study?
The researcher hopes to talk to people in a relaxed way to see if they can find things in common between experiences of being parented in different ways and a psychosis diagnosis; this includes whether different parenting styles might play in the development of psychosis.

The research hopes to show why it is important to really understand how families work together and help each other out and why it is so important to provide support and help early for both people with a psychosis diagnosis and their families. Offspring and parents will be interviewed separately.

The present study is a thesis project undertaken as part of a Doctorate in Clinical Psychology.

Why have you been invited to participate?
I am inviting you to take part in this study because you are or have been a caregiver to an offspring with a psychosis diagnosis. I would like to hear about your experience with this and find out if you think there are any commonalities between parenting styles and a psychosis diagnosis, and what role parenting styles may have played.

You are eligible to take part in this research if you were a primary caregiver to a child with psychosis who lived with you for the first 16 years of their life and if you are confident in spoken and written English. Any diagnoses you may have will not affect your eligibility to participate. Sadly, you will not be able to participate if you are currently too unwell to consent or if you have a learning disability that would make it difficult for you to complete paperwork, remember details about being a caregiver, and have in-depth discussions about your past. If you have any questions about this, please get in touch with the chief investigator.

Do I have to take part?
No. It is up to you to decide whether you wish to participate in this research study. You will be asked to give signed consent if you choose to take part. You can say that you want to stop being part of the study at any time without giving a reason. However, the information we already have about you will be kept. If you lose the capacity to consent at any point while the research is happening, we won't collect any further information from you for the research. However, the information we have already collected up to that point will be kept. You do not need to explain why you do not want to participate any more. Deciding to stop participating in the study will not impact any support you are receiving.

What will happen to me if I take part?

If you agree to participate, you will be given a copy of this information sheet and asked to sign a consent form. When asked to consent, you will also be asked to complete a demographics questionnaire, which asks for information about you, such as your age and whether you have a psychosis diagnosis, as well as other things. This will happen over the phone or via video-call technology such as Microsoft Teams, which will take about 30 minutes. You will then be asked to participate in a one-to-one, relaxed interview, which is more like a chat. This will happen in person on an NHS Trust site or via video-call technology such as Microsoft Teams. Interviews will take at most 1 hour. Interviews will be recorded. You will only be interviewed once.

I will ask you a series of questions about what you remember about your experiences of parenting a child with psychosis. These questions will also ask about how these experiences may have affected you and if you think there might be anything in common between parenting styles and psychosis. If you want to see specific examples of the topics I will ask about, I can give you some now before you decide to participate. You do not have to answer any questions if you feel uncomfortable**.** If you want to stop the interview, you can do so anytime without giving us any reason. As the interview is quite relaxed, it would be difficult to tell you exactly what will come up in the conversation, but as discussed before, you can withdraw at any point up until I start analysing the data.

What are the possible disadvantages and risks of taking part?

We will be asking you about your experiences of parenting a child with psychosis. If you become distressed during the interview, you can withdraw and say you don't want to participate anymore at any time. After the interview, there will be time to speak with me about any concerns you might have had. There are extra support resources below should you feel you need more support.

If you need more support after participating in the study, we recommend that you go to a clinician you trust as your first port of call, such as your GP, as they will be in the best position to offer help.

The Samaritans Helpline:
Telephone: 08457 90 90 90
Available 24 hours a day, seven days a week.
Confidential and non-judgemental emotional support whenever you need to talk.

NELFT 24/7 Mental Health Direct:
Telephone: 0800 995 1000
24/7, 365 days a year, a service that allows you to speak to a mental health professional.

Saneline:
Telephone: 0300 304 7000
Available from 16:00 – 22:00
Out-of-hours telephone helpline offering specialist emotional support, guidance, and information to anyone affected by mental illness, including family, friends, and carers.

Mind Infoline:
Telephone: 0300 123 3393
Available from 09:00 – 18:00, Monday to Friday (Not including bank holidays)
Information and signposting service

Parenting Mental Health:
Parenting Mental Health supports caregivers who are struggling to cope with the impact of their child's mental health. To learn more about their services, please visit https://www.parentingmentalhealth.org/contact-us. They also have a Facebook support group that you can join by visiting **https://www.facebook.com/groups/teenagedepressionandanxiety**.

COPE:
COPE is a voluntary peer-led support group for families, friends, and carers of people with serious mental health illnesses who experience psychosis. Please click this link to find out more information about this group http://cope-support.org/. You can also contact them directly by clicking on this link http://cope-support.org/contact-us/

For urgent help, if you are having suicidal thoughts, please visit https://www.nelft.nhs.uk/i-need-help, click on the top tab labelled 'If You Need Urgent Help' and click on the 'Suicide Prevention' hyperlink for support options and resources.

What are the possible benefits of taking part?
If you take part, you will be helping to grow the research within this field. The results from this study could be compared to other similar studies. This would allow researchers to gain a bigger and better view of the topics explored. This can help us understand the personal challenges and strengths experienced in early life. It will also help us think about risk factors and early intervention and support. You will be gifted a £20 voucher to thank you for participating.

How will we use information about you?
We will need information from you for this research project. This information will include your name, age, sex, diagnosis, profession/job title and ethnicity. The only people who can access your personal information are my supervisor and me. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a pseudonym (a fake name) instead. We will keep all information about you safe and secure. An audio recording of the interview will be collected by video-call technology or a Dictaphone (a recording device), and the chief investigator, Zayna Aboujieb, will transcribe (type-up) the interview. The transcription will be completely anonymous, and names will be removed, or a pseudonym will be given.

Once we have finished the study, we will keep some of the data to check the results. We will make sure that reports do not include any information that can be linked back to you.

What are your choices about how your information is used?
You can stop being part of the study without giving a reason, but we will keep information about you that we already have.

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

You can learn more about how we use your information by asking one of the research team – please email za22450@essex.ac.uk or Antonella Trotta at atrott@essex.ac.uk.

The sponsor's data protection officer can be contacted by emailing dpo@essex.ac.uk

Will my information be kept confidential?

Yes, all information you give us is kept strictly confidential. Only the chief investigator interviewing you will have access to personal information about you, and no other party will have access to information that is identifiable or can be linked back to you. However, if you tell us something that makes us think you or someone else is at serious risk of harm, we must share this information. In certain circumstances, this may entail notifying safeguarding services or the police. I will make sure to be honest and open with you if this needs to happen.

When the interview is typed up, all personal details, like specific names of people and places, will be removed, anonymising the transcription. A fake name will be used at the point of transcription and to identify your data. Quotations of interviews will also be included in the study's write-up; however, these will be kept to a minimum, and confidentiality will be ensured. Extra care and steps will be taken to ensure no offspring or caregiver can identify one another's information. Any identifiable quotes will be removed, and this will be a key point for supervisors to double-check. This anonymity process will be completed whether you join the research as a pair as well as if you join as an individual.

All the information about you will be anonymous; no one else will be able to identify you in any documents or the final report. All information collected will be securely held at the University of Essex. We will handle your data and make sure that it follows the rules of the Data Protection Act 2018. Your data will be stored for potential future research for up to three years from the end date of the study. After this, the information will be deleted from the university computers, and any paper records will be destroyed.

What should I do if I want to take part?

If you would like to participate in the research study, please email the chief investigator, Zayna Aboujieb. You will then be given a copy of this sheet and be asked to sign a consent form.

What will happen to the results of the research study?

The results of the study will be reported in a Doctoral thesis. They may also be published in scientific journals and presented at scientific conferences. You will not be identified in any report or publication.

Who is funding the research?

The study is organised by Zayna Aboujieb, a DClinPsy student at the University of Essex, and is funded by the Essex Partnership University NHS Trust.

Who has reviewed the study?

The study has been reviewed by the Research Ethics Committee for the NHS, and the Health Research Authority (HRA) sets the expectations and rules for this project.

Ethics reference number:

Concerns and Complaints

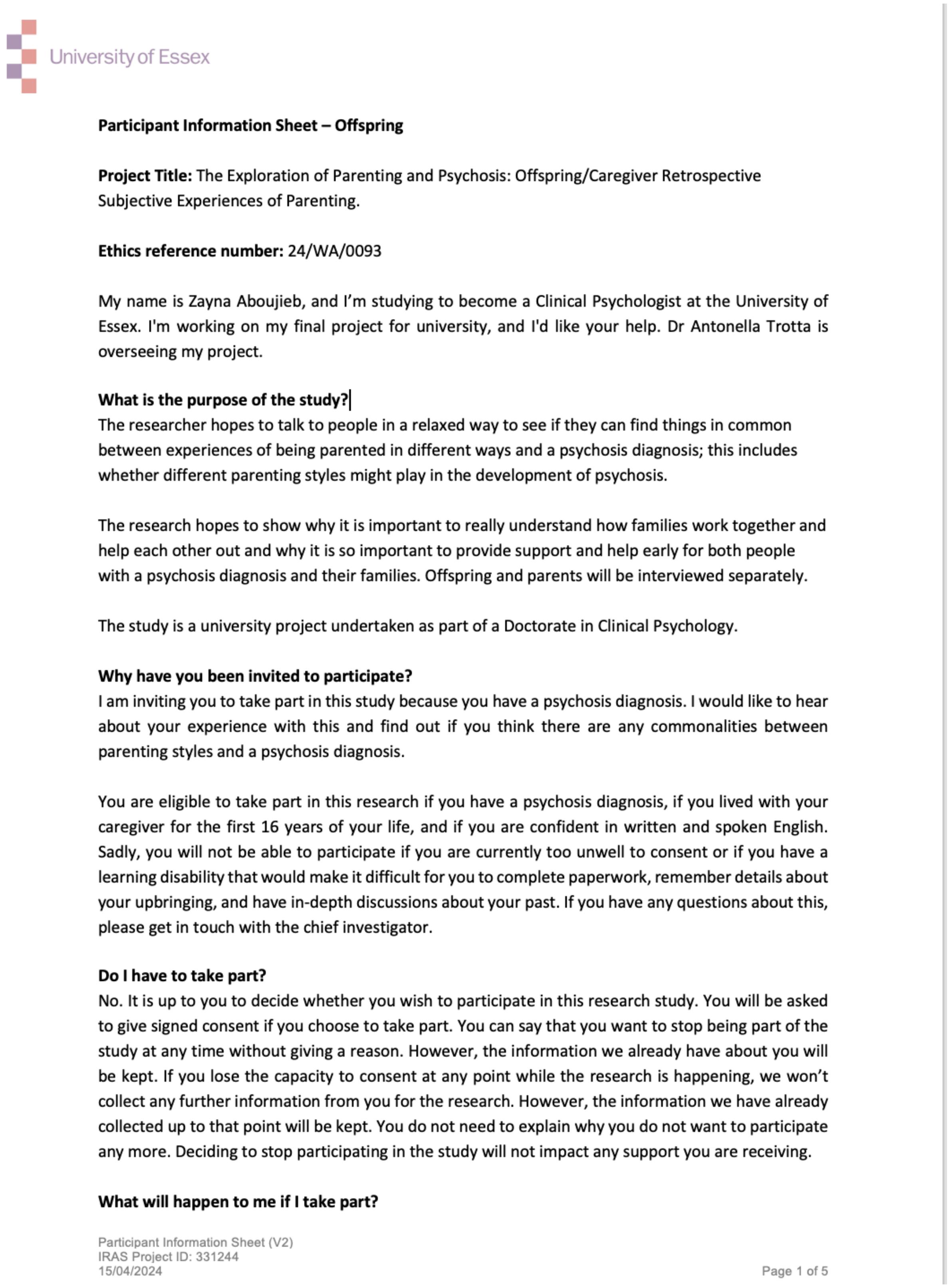
If you have any concerns about any aspect of the study or have a complaint, in the first instance, please get in touch with the project's chief investigator, Zayna Aboujieb, using the contact details below. If you are still concerned, you think your complaint has not been addressed to your satisfaction, or you feel that you cannot approach the chief investigator, please get in touch with the supervisor responsible for this project, Dr Antonella Trotta (atrott@essex.ac.uk) or the department Director of Research for the School of Health and Social Care Professor, Camille Cronin (Camille.cronin@essex.ac.uk). If you are still unsatisfied, please get in touch with the University's Research Governance and Planning Manager, Sarah Manning-Press (sarahm@essex.ac.uk). Please include the ethics reference number, which can be found at the top of this document.

Name of the Researcher/Research Team Members

Zayna Aboujieb
Email: za22450@essex.ac.uk
Dr Antonella Trotta
Email: atrott@essex.ac.uk

School of Health and Social Care
University of Essex
Colchester Campus
Wivenhoe
CO4 3SQ

Appendix D: Individuals with Lived Experience of Psychosis Participant Information Sheet



University of Essex

Participant Information Sheet – Offspring

Project Title: The Exploration of Parenting and Psychosis: Offspring/Caregiver Retrospective Subjective Experiences of Parenting.

Ethics reference number: 24/WA/0093

My name is Zayna Aboujieb, and I'm studying to become a Clinical Psychologist at the University of Essex. I'm working on my final project for university, and I'd like your help. Dr Antonella Trotta is overseeing my project.

What is the purpose of the study?

The researcher hopes to talk to people in a relaxed way to see if they can find things in common between experiences of being parented in different ways and a psychosis diagnosis; this includes whether different parenting styles might play in the development of psychosis.

The research hopes to show why it is important to really understand how families work together and help each other out and why it is so important to provide support and help early for both people with a psychosis diagnosis and their families. Offspring and parents will be interviewed separately.

The study is a university project undertaken as part of a Doctorate in Clinical Psychology.

Why have you been invited to participate?

I am inviting you to take part in this study because you have a psychosis diagnosis. I would like to hear about your experience with this and find out if you think there are any commonalities between parenting styles and a psychosis diagnosis.

You are eligible to take part in this research if you have a psychosis diagnosis, if you lived with your caregiver for the first 16 years of your life, and if you are confident in written and spoken English. Sadly, you will not be able to participate if you are currently too unwell to consent or if you have a learning disability that would make it difficult for you to complete paperwork, remember details about your upbringing, and have in-depth discussions about your past. If you have any questions about this, please get in touch with the chief investigator.

Do I have to take part?

No. It is up to you to decide whether you wish to participate in this research study. You will be asked to give signed consent if you choose to take part. You can say that you want to stop being part of the study at any time without giving a reason. However, the information we already have about you will be kept. If you lose the capacity to consent at any point while the research is happening, we won't collect any further information from you for the research. However, the information we have already collected up to that point will be kept. You do not need to explain why you do not want to participate any more. Deciding to stop participating in the study will not impact any support you are receiving.

What will happen to me if I take part?

If you agree to participate, you will be given a copy of this information sheet and asked to sign a consent form. When asked to consent, you will also be asked to complete a demographics questionnaire, which asks for information about you, such as your age and diagnosis, as well as other things. This will happen over the phone or via video-call technology such as Microsoft Teams, which will take about 30 minutes. You will then be asked to participate in a one-to-one, relaxed interview, which is more like a chat. This will happen in person on an NHS Trust site or via video-call technology such as Microsoft Teams. Interviews will take at most 1 hour. Interviews will be recorded. You will only be interviewed once.

I will ask you a series of questions about what you remember about your experiences of psychosis and your experiences of being parented as a child. These questions will also ask how these experiences may have affected you. If you want to see specific examples of the topics I will ask about, I can give you some now before you decide to participate. You do not have to answer any questions if you feel uncomfortable**.** If you want to stop the interview, you can do so anytime without giving us any reason. As the interview is quite relaxed, it would be difficult to tell you exactly what will come up in the conversation, but as discussed before, you can withdraw at any point up until I start analysing the data.

What are the possible disadvantages and risks of taking part?
We will be asking you about your experiences of psychosis and your experiences of being parented as a child. If you become distressed during the interview, you can withdraw and say you don't want to participate anymore at any time. After the interview, there will be time to speak with me about any concerns you might have had. There are extra support resources below should you feel you need more support.

If you need more support after participating in the study, we recommend that you go to a clinician you trust as your first port of call, such as your GP, as they will be in the best position to offer help.

The Samaritans Helpline:
Telephone: 08457 90 90 90
Available 24 hours a day, seven days a week.
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Telephone: 0300 304 7000
Available from 16:00 – 22:00
Out-of-hours telephone helpline offering specialist emotional support, guidance, and information to anyone affected by mental illness, including family, friends, and carers.

Mind Infoline:
Telephone: 0300 123 3393

Available from 09:00 – 18:00, Monday to Friday (Not including bank holidays)
Information and signposting service

For urgent help, if you are having suicidal thoughts, please visit https://www.nelft.nhs.uk/i-need-help, click on the top tab labelled 'If You Need Urgent Help' and click on the 'Suicide Prevention' hyperlink for support options and resources.

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If you take part, you will be helping to grow the research within this field. The results from this study could be compared to other similar studies. This would allow researchers to gain a bigger and better view of the topics explored. This can help us understand the personal challenges and strengths experienced in early life. It will also help us think about risk factors and early intervention and support. You will be gifted a £20 voucher to thank you for participating.

How will we use information about you?
We will need information from you for this research project. This information will include your name, age, sex, diagnosis, profession/job title and ethnicity. The only people who can access your personal information are my supervisor and me. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a pseudonym (a fake name) instead. We will keep all information about you safe and secure. An audio recording of the interview will be collected by video-call technology or a Dictaphone (a recording device), and the chief investigator, Zayna Aboujieb, will transcribe (type-up) the interview. The transcription will be completely anonymous, and names will be removed, or a pseudonym will be given.

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What are your choices about how your information is used?
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Yes, all information you give us is kept strictly confidential. Only the chief investigator interviewing you will have access to personal information about you, and no other party will have access to information that is identifiable or can be linked back to you. However, if you tell us something that makes us think you or someone else is at serious risk of harm, we must share this information. In certain circumstances, this may include notifying safeguarding services or the police. I will make sure to be honest and open with you if this needs to happen.

When the interview is typed up, all personal details, like specific names of people and places, will be removed, removing all identifiable information about you from the transcriptions. A fake name will be used at the point of transcription to identify your data. Quotations of interviews will also be included in the study's write-up; however, these will be kept to a minimum, and confidentiality will be ensured. Extra care and steps will be taken to ensure no offspring or caregiver can identify one another's information. Any identifiable quotes will be removed, and this will be a key point for supervisors to double-check. This anonymity process will be completed whether you join the research as a pair as well as if you join as an individual.

All the information about you will be anonymous; no one else will be able to identify you in any documents or the final report. All information collected will be securely held at the University of Essex. We will handle your data and make sure that it follows the rules of the Data Protection Act 2018. Your data will be stored for potential future research for up to three years from the end date of the study. After this, the information will be deleted from the university computers, and any paper records will be destroyed.

What should I do if I want to take part?
If you want to participate in the research study, please email the chief investigator, Zayna Aboujieb. You will then be given a copy of this sheet and be asked to sign a consent form.

What will happen to the results of the research study?
The results of the study will be reported in a Doctoral thesis. They may also be published in scientific journals and presented at scientific conferences. You will not be identified in any report or publication.

Who is funding the research?
The study is organised by Zayna Aboujieb, a DClinPsy student at the University of Essex, and is funded by the Essex Partnership University NHS Trust.

Who has reviewed the study?
The study has been reviewed by the Research Ethics Committee for the NHS, and the Health Research Authority (HRA) sets the expectations and rules for this project.

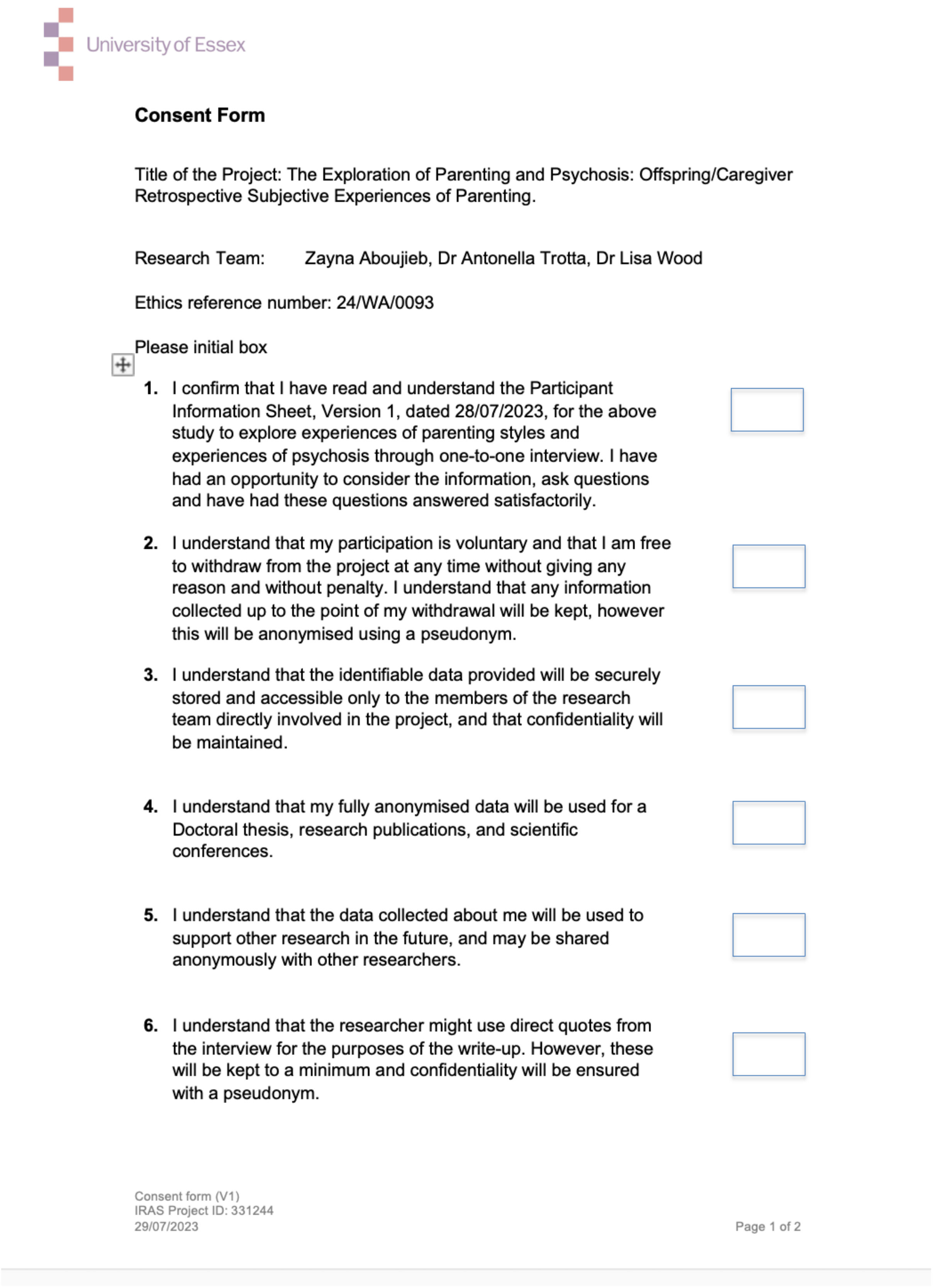
Ethics reference number:

Concerns and Complaints
If you have any concerns about any aspect of the study or have a complaint, in the first instance, please get in touch with the project's chief investigator, Zayna Aboujieb, using the contact details below. If you are still concerned, you think your complaint has not been addressed to your satisfaction, or you feel that you cannot approach the chief investigator, please get in touch with the supervisor responsible for this project, Dr Antonella Trotta (atrott@essex.ac.uk) or the department Director of Research for the School of Health and Social Care Professor, Camille Cronin (Camille.cronin@essex.ac.uk). If you are still unsatisfied, please get in touch with the University's Research Governance and Planning Manager, Sarah Manning-Press (sarahm@essex.ac.uk). Please include the ethics reference number, which can be found at the top of this document.

Name of the Researcher/Research Team Members
Zayna Aboujieb
Email: za22450@essex.ac.uk
Dr Antonella Trotta
Email: atrott@essex.ac.uk

School of Health and Social Care
University of Essex
Colchester Campus
Wivenhoe
CO4 3SQ

Appendix E: Informed Consent Form



University of Essex

Consent Form

Title of the Project: The Exploration of Parenting and Psychosis: Offspring/Caregiver Retrospective Subjective Experiences of Parenting.

Research Team: Zayna Aboujieb, Dr Antonella Trotta, Dr Lisa Wood

Ethics reference number: 24/WA/0093

Please initial box

1. I confirm that I have read and understand the Participant Information Sheet, Version 1, dated 28/07/2023, for the above study to explore experiences of parenting styles and experiences of psychosis through one-to-one interview. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that any information collected up to the point of my withdrawal will be kept, however this will be anonymised using a pseudonym. ☐
3. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained. ☐
4. I understand that my fully anonymised data will be used for a Doctoral thesis, research publications, and scientific conferences. ☐
5. I understand that the data collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
6. I understand that the researcher might use direct quotes from the interview for the purposes of the write-up. However, these will be kept to a minimum and confidentiality will be ensured with a pseudonym. ☐

7. I understand that my interview to be audio recorded for the purposes of transcription and I give my consent for this to happen. Audio recordings will be deleted once transcriptions have been completed to ensure anonymity. ☐

8. I agree to take part in the above study. ☐

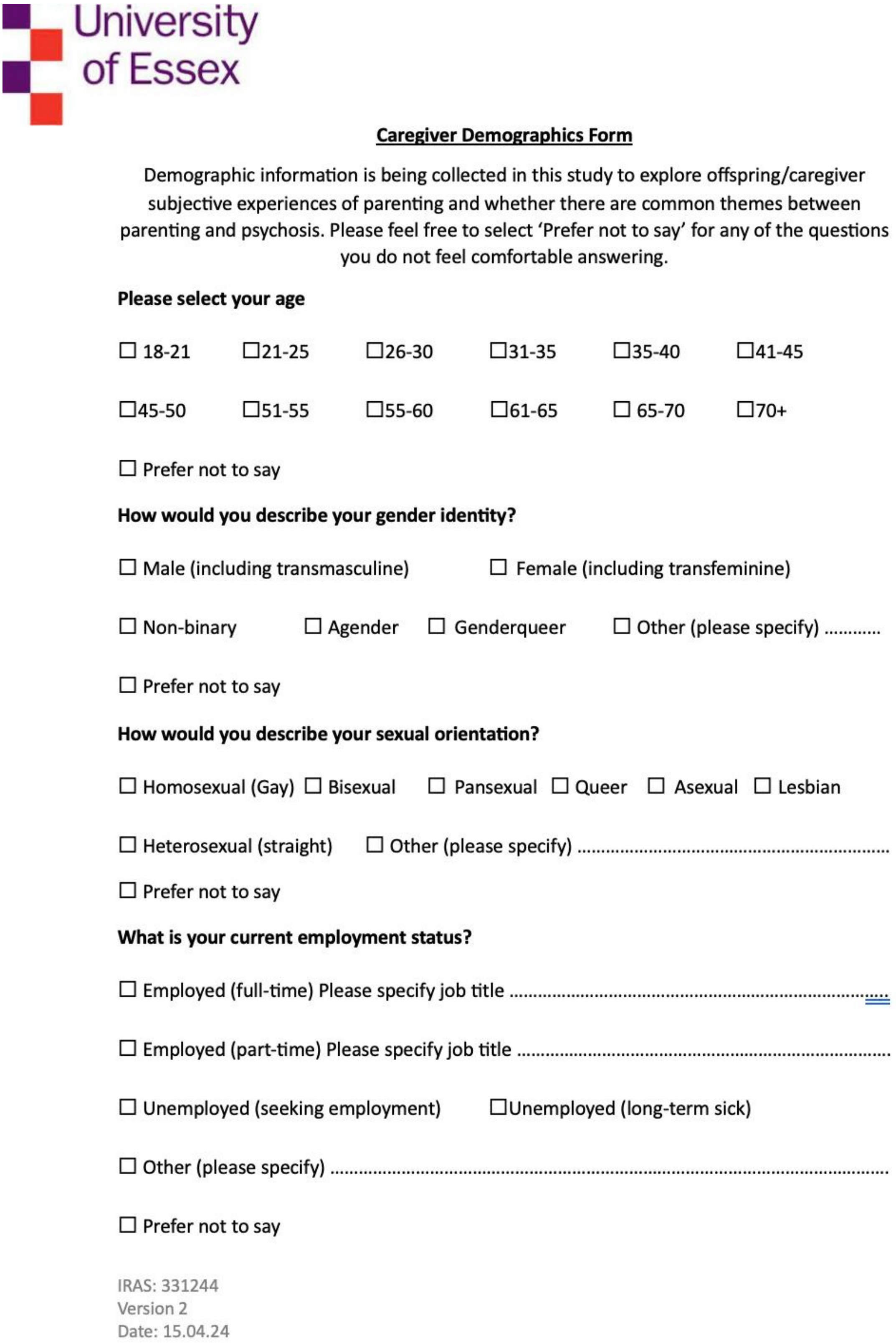
Participant Name	Date	Participant Signature
__________________________	___________	__________________________
Researcher Name	Date	Researcher Signature
__________________________	___________	__________________________

Participant Pseudonym/ID Number

____

1 copy for researcher 1 copy for participant

Appendix F: Caregiver Demographics Questionnaire



University of Essex

Caregiver Demographics Form

Demographic information is being collected in this study to explore offspring/caregiver subjective experiences of parenting and whether there are common themes between parenting and psychosis. Please feel free to select 'Prefer not to say' for any of the questions you do not feel comfortable answering.

Please select your age

☐ 18-21 ☐21-25 ☐26-30 ☐31-35 ☐35-40 ☐41-45

☐45-50 ☐51-55 ☐55-60 ☐61-65 ☐ 65-70 ☐70+

☐ Prefer not to say

How would you describe your gender identity?

☐ Male (including transmasculine) ☐ Female (including transfeminine)

☐ Non-binary ☐ Agender ☐ Genderqueer ☐ Other (please specify) ....

☐ Prefer not to say

How would you describe your sexual orientation?

☐ Homosexual (Gay) ☐ Bisexual ☐ Pansexual ☐ Queer ☐ Asexual ☐ Lesbian

☐ Heterosexual (straight) ☐ Other (please specify) ....

☐ Prefer not to say

What is your current employment status?

☐ Employed (full-time) Please specify job title ....

☐ Employed (part-time) Please specify job title ....

☐ Unemployed (seeking employment) ☐Unemployed (long-term sick)

☐ Other (please specify) ....

☐ Prefer not to say

IRAS: 331244
Version 2
Date: 15.04.24

Which county or borough do you currently live in?

……

☐ Prefer not to say

Which of the following parenting style descriptions best describes your experience of parenting your child?

a) Permissive: I had few demands of my child and displayed high responsiveness. I was very loving yet provided few guidelines and rules. I did not expect mature behaviour from my child and felt more like a friend than a parental figure.

b) Authoritative: I was nurturing, responsive, and supportive, yet set firm limits for my child. I attempted to manage their behaviour by explaining rules, discussing, and reasoning. I listened to my child's viewpoint but didn't always accept it.

c) Authoritarian: I was extremely rigid and used tough rules to manage my child's behaviour. I was distant and demanding, which left my child struggling with mental health and self-esteem issues.

d) Uninvolved: I was not responsive to my child's needs. I made few or no demands of my child, and I was often indifferent, dismissive, or, at times, completely neglectful.

☐ A) Permissive ☐ B) Authoritative ☐ C) Authoritarian ☐ D) Uninvolved

Do you have a psychosis diagnosis?

☐ Yes ☐ No ☐ Prefer not to say

At what age did your offspring experience their first episode of psychosis?

……

What occupation did you have when your offspring was a child?

……

☐ Prefer not to say

Did your offspring live with you when they were a child? If so, until what age?

……

☐ Prefer not to say

What was your home postcode when your offspring was a child? Please choose the home you lived in for the longest.

………

☐ Prefer not to say

How would you describe your ethnicity?

☐ White British/English, Welsh, Scottish, Northern Irish ☐ Irish

☐ Gypsy/Irish Traveller ☐ Roma ☐ White European ☐ Mixed White Background

☐ Other White Background (please specify) ………………………………………………………………………

☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese

☐ Other Asian Background (please specify) ………………………………………………………………………

☐Mixed Asian & British

☐ Mixed Asian & Other Background (please specify) ……………………………………………………………

☐Caribbean ☐African ☐ Mixed Black African & British

☐ Mixed Black Caribbean & British ☐ Mixed African & Caribbean

☐ Mixed Black & Other background

☐ Other Black background (please specify) ………………………………………………………………………

☐ Any Other Mixed Ethic Background (please specify) ……………………………………………………………

☐ Other Ethnic Background (please specify) ………………………………………………………………………

☐ Prefer not to say

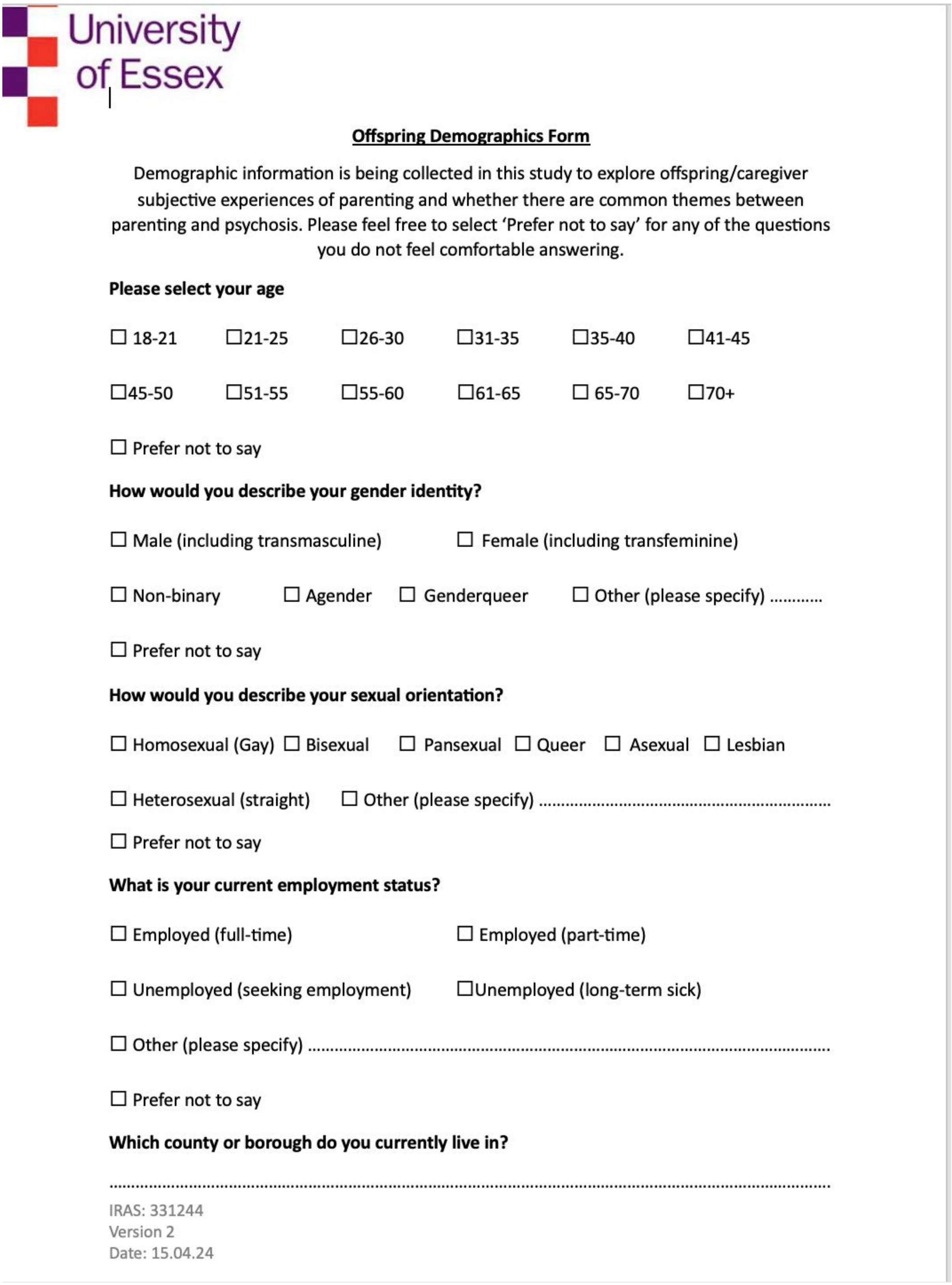
Please select the option that best represents your Religious/Faith/Spiritual identity.

☐ Christianity ☐Islam ☐Jewish ☐Hinduism ☐Buddhism ☐Sikh

☐Agnostic ☐Atheist ☐No religion ☐Spiritual

☐Other (please specify) ………………………… ☐ Prefer not to say

Appendix G: Individuals with Lived Experience of Psychosis Demographics Questionnaire



University
of Essex

<u>Offspring Demographics Form</u>

Demographic information is being collected in this study to explore offspring/caregiver subjective experiences of parenting and whether there are common themes between parenting and psychosis. Please feel free to select 'Prefer not to say' for any of the questions you do not feel comfortable answering.

Please select your age

☐ 18-21 ☐21-25 ☐26-30 ☐31-35 ☐35-40 ☐41-45

☐45-50 ☐51-55 ☐55-60 ☐61-65 ☐ 65-70 ☐70+

☐ Prefer not to say

How would you describe your gender identity?

☐ Male (including transmasculine) ☐ Female (including transfeminine)

☐ Non-binary ☐ Agender ☐ Genderqueer ☐ Other (please specify) ....

☐ Prefer not to say

How would you describe your sexual orientation?

☐ Homosexual (Gay) ☐ Bisexual ☐ Pansexual ☐ Queer ☐ Asexual ☐ Lesbian

☐ Heterosexual (straight) ☐ Other (please specify) ....

☐ Prefer not to say

What is your current employment status?

☐ Employed (full-time) ☐ Employed (part-time)

☐ Unemployed (seeking employment) ☐Unemployed (long-term sick)

☐ Other (please specify) ....

☐ Prefer not to say

Which county or borough do you currently live in?

....

IRAS: 331244
Version 2
Date: 15.04.24

☐ Prefer not to say

Which of the following parenting style descriptions best describes your caregiver's parenting style?

a) Permissive: I had few demands of my child and displayed high responsiveness. I was very loving yet provided few guidelines and rules. I did not expect mature behaviour from my child and felt more like a friend than a parental figure.

b) Authoritative: I was nurturing, responsive, and supportive, yet set firm limits for my child. I attempted to manage their behaviour by explaining rules, discussing, and reasoning. I listened to my child's viewpoint but didn't always accept it.

c) Authoritarian: I was extremely rigid and used tough rules to manage my child's behaviour. I was distant and demanding, which left my child struggling with mental health and self-esteem issues.

d) Uninvolved: I was not responsive to my child's needs. I made few or no demands of my child, and I was often indifferent, dismissive, or, at times, completely neglectful.

☐ A) Permissive ☐ B) Authoritative ☐ C) Authoritarian ☐ D) Uninvolved

Which psychosis diagnosis do you have?

………

☐ Prefer not to say

Approximately how often do you experience symptoms of psychosis?

………

☐ Prefer not to say

Have you accessed inpatient mental health services?

☐ Yes ☐ No ☐ Prefer not to say

Is this your first episode of psychosis?

☐ Yes ☐ No ☐ Prefer not to say

At what age did you experience your first episode of psychosis?

………

☐ Prefer not to say

What occupation did your caregiver(s) have when you were a child?

………

………

☐ Prefer not to say

Did you live with your primary caregiver(s) as a child? If so, until what age?

………

☐ Prefer not to say

What was your home postcode as a child? Please choose the home you lived in for the longest.

………

☐ Prefer not to say

How would you describe your ethnicity?

☐ White British/English, Welsh, Scottish, Northern Irish ☐ Irish

☐ Gypsy/Irish Traveller ☐ Roma ☐ White European ☐ Mixed White Background

☐ Other White Background (please specify) ……………………………………………………………………

☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese

☐ Other Asian Background (please specify) ……………………………………………………………………

☐Mixed Asian & British

☐ Mixed Asian & Other Background (please specify) ………………………………………………………

☐Caribbean ☐African ☐ Mixed Black African & British

☐ Mixed Black Caribbean & British ☐ Mixed African & Caribbean

☐ Mixed Black & Other background

☐ Other Black background (please specify) ……………………………………………………………………

☐ Any Other Mixed Ethic Background (please specify) ………………………………………………………

☐ Other Ethnic Background (please specify) ……………………………………………………………………

☐ Prefer not to say

Please select the option that best represents your Religious/Faith/Spiritual identity.

☐ Christianity ☐Islam ☐Jewish ☐Hinduism ☐Buddhism ☐Sikh

☐Agnostic ☐Atheist ☐No religion ☐Spiritual

☐Other (please specify) ……………………….. ☐ Prefer not to say

Appendix H: Recruitment Poster

University of Essex

IRAS NO: 331244

V2 13/04/24

PARTICIPANT REQUEST

CALLING ALL

People with a psychosis diagnosis who would like to talk about their childhood experiences of being parented and their childhood experiences of psychosis

AND/OR

Individuals who have parented a child with a psychosis diagnosis who would like to share their experiences of parenting

RESEARCH SUMMARY

Research Title: A Qualitative Exploration of Parenting Styles and Experiences of Psychosis: Offspring/Parent Retrospective Subjective Experiences of Parenting.

The researcher hopes to talk to people in a relaxed way to see if they can find things in common between experiences of being parented in different ways and a psychosis diagnosis.

The research hopes to show why it is important to really understand how families work together and help each other out and why it is so important to provide support and help early for both people with a psychosis diagnosis and their families.

WHAT WOULD I HAVE TO DO?

1. Email expressing your interest

Please see this poster's 'WANT TO PARTICIPATE?' section for details on how to get involved.

2. 30 minute meeting

This meeting will happen online using MS Teams or on the phone. You'll get some info about what's going on and be asked to agree to the research by signing a form. After that, you'll need to fill out a questionnaire that's related to the topic.

3. 60 minute one-to-one interview

You'll get an invite to a one-hour chat where we'll ask you questions about your past experiences with parenting and psychosis. This chat can happen online through MS Teams or in person at your local NHS office.

AT A GLANCE

CHALLENGES

- You may be asked about difficult experiences
- You may find it difficult to talk about your past experiences

BENEFITS

- You will be helping us to understand psychosis better and add to the research that's already out there
- **You will receive a £20 voucher to thank you for your time and effort**

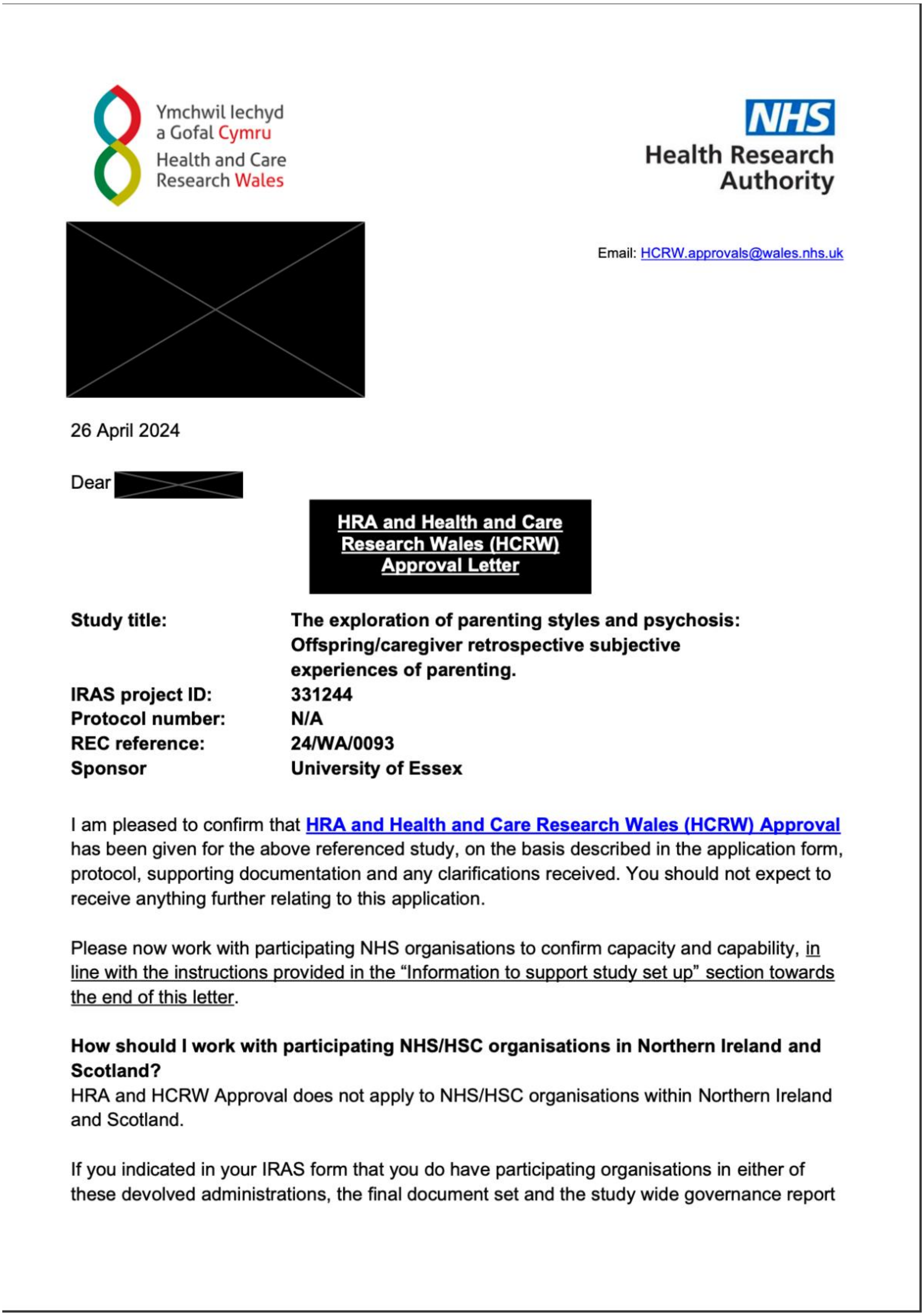
WANT TO PARTICIPATE?

GET IN CONTACT!

za22450@essex.ac.uk

Please use the above email address to contact Zayna Aboujieb, the lead researcher for this study, and let us know that you're interested in participating.

Appendix I: Health Research Authority Confirmation Letter



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

[redacted]

Email: HCRW.approvals@wales.nhs.uk

26 April 2024

Dear [redacted]

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title: **The exploration of parenting styles and psychosis: Offspring/caregiver retrospective subjective experiences of parenting.**
IRAS project ID: **331244**
Protocol number: **N/A**
REC reference: **24/WA/0093**
Sponsor **University of Essex**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **331244**. Please quote this on all correspondence.

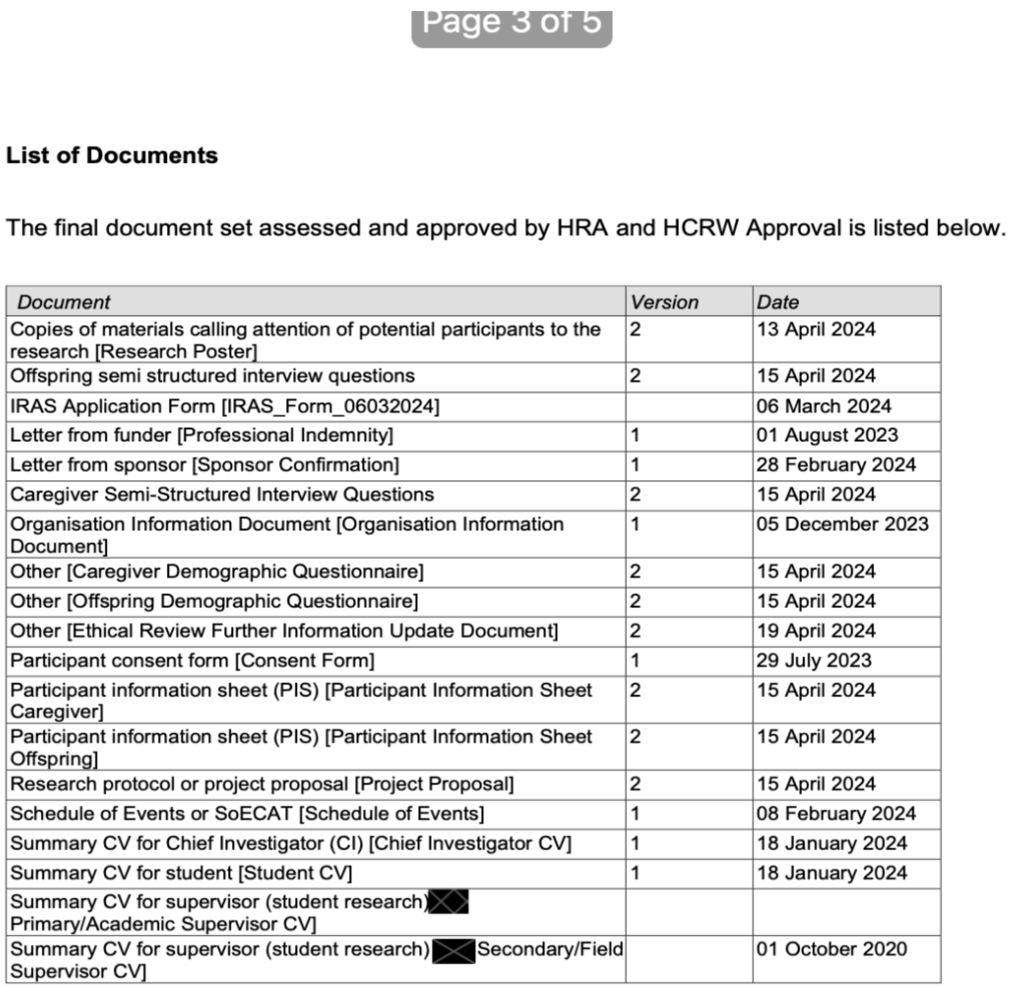
Yours sincerely,

[redacted]

Approvals Specialist

Email: HCRW.approvals@wales.nhs.uk

Copy to: [redacted]



List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Research Poster]	2	13 April 2024
Offspring semi structured interview questions	2	15 April 2024
IRAS Application Form [IRAS_Form_06032024]		06 March 2024
Letter from funder [Professional Indemnity]	1	01 August 2023
Letter from sponsor [Sponsor Confirmation]	1	28 February 2024
Caregiver Semi-Structured Interview Questions	2	15 April 2024
Organisation Information Document [Organisation Information Document]	1	05 December 2023
Other [Caregiver Demographic Questionnaire]	2	15 April 2024
Other [Offspring Demographic Questionnaire]	2	15 April 2024
Other [Ethical Review Further Information Update Document]	2	19 April 2024
Participant consent form [Consent Form]	1	29 July 2023
Participant information sheet (PIS) [Participant Information Sheet Caregiver]	2	15 April 2024
Participant information sheet (PIS) [Participant Information Sheet Offspring]	2	15 April 2024
Research protocol or project proposal [Project Proposal]	2	15 April 2024
Schedule of Events or SoECAT [Schedule of Events]	1	08 February 2024
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	1	18 January 2024
Summary CV for student [Student CV]	1	18 January 2024
Summary CV for supervisor (student research)[redacted] Primary/Academic Supervisor CV]		
Summary CV for supervisor (student research) [redacted] Secondary/Field Supervisor CV]		01 October 2020

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

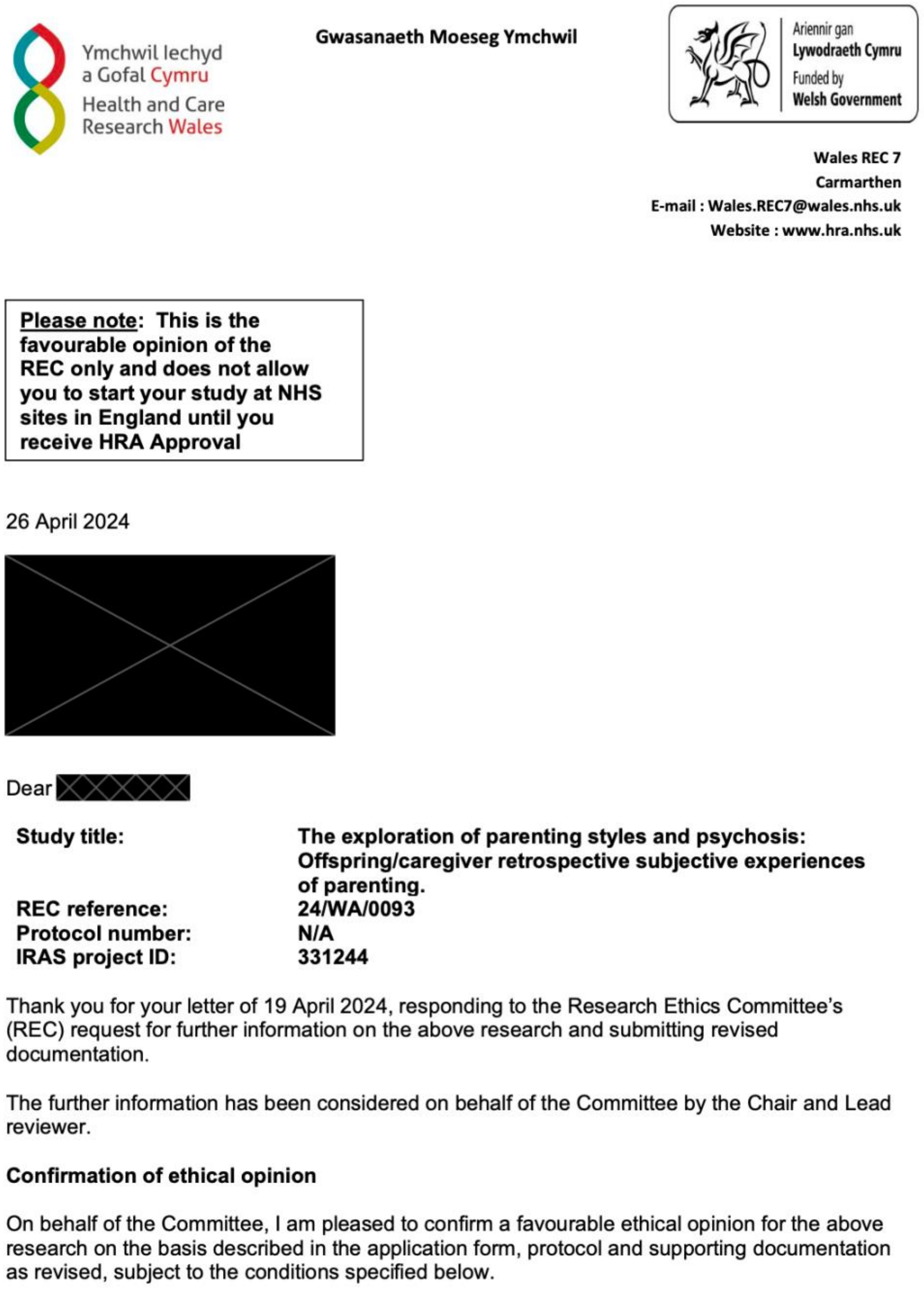
Types of participating NHS organisation	**Expectations related to confirmation of capacity and capability**	**Agreement to be used**	**Funding arrangements**	**Oversight expectations**	**HR Good Practice Resource Pack expectations**
Research activities and procedures as per the protocol and other study documents will take place at participating NHS organisations.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed. Due to the nature of the activities involved, organisations will be expected to provide that confirmation to the sponsor • Within 35 days of receipt of the local information pack • After HRA/HCRW Approval has been issued. If the organisation is not able to formally confirm capacity and capability within this timeframe, they must inform the sponsor of this and provide a justification. If the sponsor is not satisfied with the justification, then the sponsor may escalate to the National Coordinating Function where the participating NHS organisation is located.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other agreement to be used with participating NHS organisations of this type.	No application for external funding will be made.	A Principal Investigator should be appointed at participating NHS organisations.	Where an external individual who does not already hold an NHS employment contract will be conducting any of the research activities that will be undertaken at this site type then they would be expected to hold an Honorary Research Contract. External staff holding pre-existing NHS employment contracts should obtain a Letter of Access. These should confirm Occupational Health Clearance. These should confirm [enhanced/standard] DBS checks [and appropriate barred list checks].

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix J: Research Ethics Committee Confirmation Letter



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

Gwasanaeth Moeseg Ymchwil

Ariennir gan
Lywodraeth Cymru
Funded by
Welsh Government

Wales REC 7
Carmarthen
E-mail : Wales.REC7@wales.nhs.uk
Website : www.hra.nhs.uk

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

26 April 2024

[redacted]

Dear [redacted]

Study title:	**The exploration of parenting styles and psychosis: Offspring/caregiver retrospective subjective experiences of parenting.**
REC reference:	**24/WA/0093**
Protocol number:	**N/A**
IRAS project ID:	**331244**

Thank you for your letter of 19 April 2024, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

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

Confirmation of ethical opinion

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

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

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

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

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

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

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a public registry before the first participant is recruited and no later than six weeks after. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

A 'public registry' means any registry on the WHO list of primary registries or the ICMJE list of registries provided the registry facilitates public access to information about the UK trial.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

Where a deferral is agreed we expect the sponsor to publish a minimal record on a publicly accessible registry. When the deferral period ends, the sponsor should publish the full record on the same registry, to fulfil the condition of the REC favourable opinion.

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Where the study is registered on ClinicalTrials.gov, please inform deferrals@hra.nhs.uk and the Research Ethics Committee (REC) which issued the final ethical opinion so that our records can be updated.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter. Where a deferral is agreed, a minimum research summary will still be published in the research summaries database. At the end of the deferral period, we will publish the full research summary.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: Research summaries - Health Research Authority (hra.nhs.uk)

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

After ethical review: Reporting requirements

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

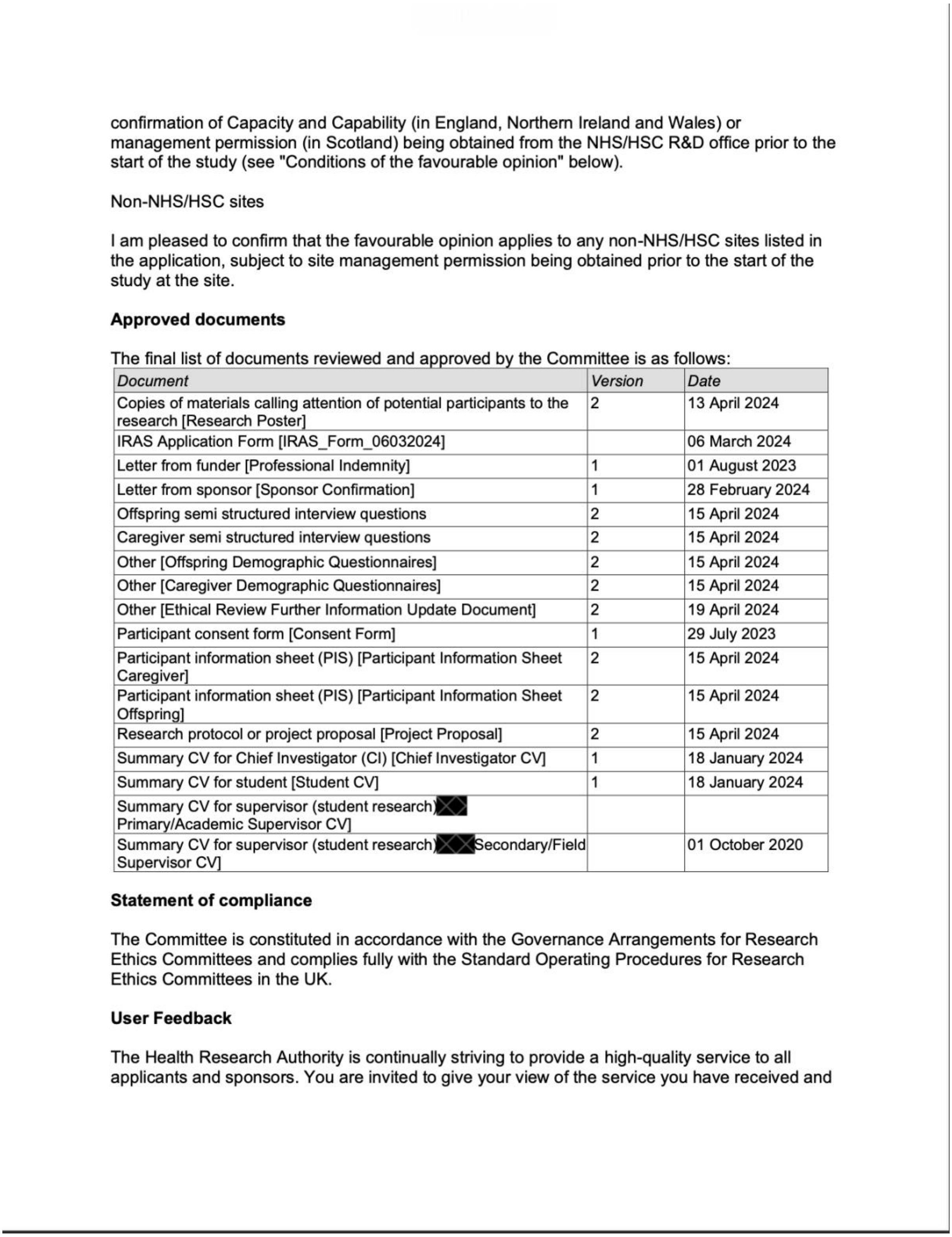
- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at Managing your approval - Health Research Authority (hra.nhs.uk)

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to



confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

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

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Research Poster]	2	13 April 2024
IRAS Application Form [IRAS_Form_06032024]		06 March 2024
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Summary CV for supervisor (student research)[redacted] Primary/Academic Supervisor CV]		
Summary CV for supervisor (student research)[redacted]Secondary/Field Supervisor CV]		01 October 2020

Statement of compliance

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

User Feedback

The Health Research Authority is continually striving to provide a high-quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: Quality assurance - Health Research Authority (hra.nhs.uk)

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: Learning - Health Research Authority (hra.nhs.uk)

IRAS project ID: 331244   Please quote this number on all correspondence

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

Yours sincerely

[redacted]

Chair

E-mail: Wales.REC7@wales.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

After ethical review guidance for sponsors and investigators –
Non CTIMP Standard Conditions of Approval]

Appendix K: PRISMA Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	

Section and Topic	Item #	Checklist item	Location where item is reported
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	
Study characteristics	17	Cite each included study and present its characteristics.	
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	
	23b	Discuss any limitations of the evidence included in the review.	
	23c	Discuss any limitations of the review processes used.	

Section and Topic	Item #	Checklist item	Location where item is reported
	23d	Discuss implications of the results for practice, policy, and future research.	
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	
Competing interests	26	Declare any competing interests of review authors.	
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

Appendix L: Example of Completed MMAT for Abbasapour et al., 2021

MMAT Appraisal

Full citation:

Abbasapour, A., Bahreini, M., Akaberian, S., & Mirzaei, K. (2021). Parental bonding styles in schizophrenia, depressive and bipolar patients: a comparative study. BMC Psychiatry, 21, 169. https://doi.org/10.1186/s12888-021-03177-3

Study overview

Field	**Information**
Aim	To evaluate and compare parental bonding (Care and Control dimensions; PBI) among adult outpatients with schizophrenia, bipolar disorder, and major depressive disorder in Bushehr, Iran.
Design	Quantitative, cross-sectional comparative (descriptive) study.
Setting	Three public psychiatric clinics and one private psychiatric centre in Bushehr, Iran (outpatient services). Data collected Sept–Dec 2018.
Participants	N = 130 adults: schizophrenia n=43, bipolar disorder n=43, major depressive disorder n=44. DSM-5 diagnoses established by psychiatrist during routine outpatient assessment. Inclusion: age ≥18; not in acute phase; lived with parents for first 16 years; no serious parental mental illness; no known systemic/neurological disease. Exclusion: illiterate; hospitalization within past 6 months; intellectual disability; declined consent.
Sampling	Quota sampling by diagnosis group across clinics; target group sizes based on sample size calculations from prior studies.
Measures	Parental Bonding Instrument (PBI; 25 items; Care and Control/Overprotection). Persian psychometrics reported (content validity index 0.81; Cronbach's α ~0.79–0.88). PBI completed separately for mother and father retrospectively for first 16 years of life. Cut-offs used to classify four PBI quadrants.
Outcomes/Analysis	Descriptive statistics; normality via Shapiro–Wilk; between-group comparisons using Kruskal–Wallis (continuous) and Chi-square (categorical); α=0.05.

Mixed Methods Appraisal Tool (MMAT, 2018/2019) – Quantitative Descriptive Domain
Screening questions (for all study types)

Question	Judgement	Notes/Justification
S1. Are there clear research questions?	Yes	Aim explicitly stated: to compare parental bonding styles (PBI) across schizophrenia, bipolar disorder, and major depressive disorder.
S2. Do the collected data allow to address the research questions?	Yes	PBI data collected for mother and father; diagnoses established; analysis compares groups using appropriate tests.

Domain: Quantitative descriptive studies

MMAT Criterion	Judgement (Yes/No/Can't tell)	Rationale	Evidence from paper
4.1 Is the sampling strategy relevant to address the research question?	Yes	Quota sampling by diagnosis ensures sufficient numbers in each group to permit planned comparisons.	Methods: Quota sampling used with sample size justification per prior studies; clinics visited and eligible patients invited (Sept–Dec 2018).
4.2 Is the sample representative of the target population?	No	Clinic-based quota sample (non-probability) of outpatients; exclusion of acute cases, illiterate individuals, and those recently hospitalized limits representativeness.	Design/participants: outpatient clinics in one province; inclusion/exclusion criteria narrow the frame; no probability sampling reported.
4.3 Are the measurements appropriate (i.e., valid and reliable)?	Yes	PBI is widely used; psychometric properties for Persian context reported (CVI 0.81; Cronbach's α 0.79–0.88). DSM-5 diagnoses by psychiatrist.	Measures section reports validity and reliability; DSM-5 diagnostic assessment described.
4.4 Is the risk of nonresponse bias low?	Yes	Of 147 screened, 130 were eligible and all consented	Results: 'We assessed 147… 130 eligible and

		and completed questionnaires; attrition not reported.	therefore provided consent… All the participants answered all the questions.'
4.5 Is the statistical analysis appropriate to answer the research question?	Yes	Normality tested; appropriate nonparametric tests (Kruskal–Wallis; Chi-square) used for group comparisons with α=0.05.	Data analysis: Shapiro–Wilk for normality; Kruskal–Wallis and Chi-square applied.

MMAT summary

Overall appraisal: This study meets most MMAT criteria for quantitative descriptive designs. Strengths include a clearly stated aim, an appropriate instrument with reported psychometrics, DSM-5 diagnoses, and suitable analyses. Main limitations concern external validity (non-probability, single-province outpatient sample with restrictive inclusion/exclusion) and potential recall bias inherent in retrospective PBI reporting. Confounding was not adjusted beyond group comparisons, which may limit causal interpretation.

Appendix M: MMAT-Aligned Summary Table of Included Studies

MMAT reference frame: Qualitative; Quantitative randomised; Quantitative non-randomised; Quantitative descriptive; Mixed methods (MMAT 2018). This table summarises design, sample, measures, and key findings based on the provided extraction. Detailed MMAT criterion ratings (Yes/No/Can't tell). Examples of justifications for one study are recorded in Appendix L.

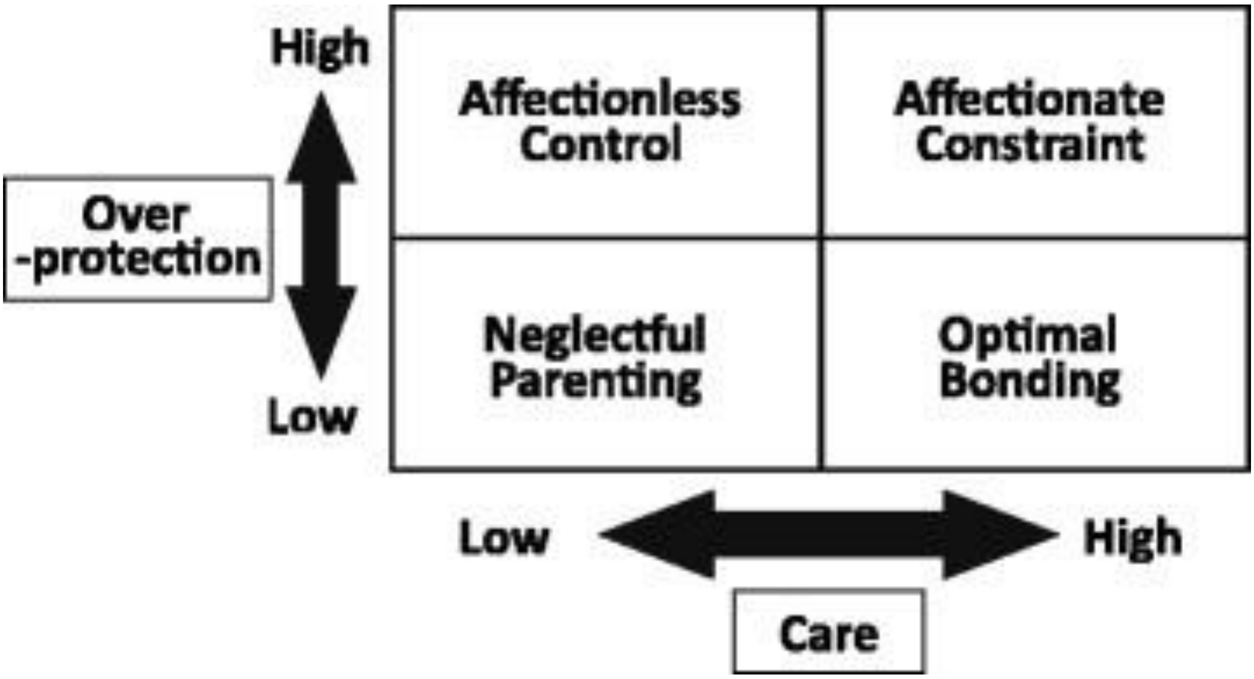
Author (Year)	MMAT Category	Design	Sample (n)	Population / Diagnosis	Parenting Measure(s)	Psychosis Outcome(s)	Key Finding (parenting ↔ psychosis)	Key Stats (if reported)	Adversity/ Stress Measured
Abbasapour et al. (2021)	Quantitative – Descriptive (cross-sectional)	Retrospective; Cross-sectional	130	Adults with psychosis; Schizophrenia, Bipolar Disorder	PBI (Parental Bonding Instrument)	Social/occupational functioning	Higher care with appropriate control linked to better social and occupational functioning.	$p < .05$; OR not reported	No
Gomes et al. (2023)	Quantitative – Descriptive (cross-sectional)	Retrospective; Cross-sectional (clinical vs. control)	200 (100 clinical; 100 control)	Clinical vs. control; Schizophrenia, Bipolar Disorder	CTQ; PBI	Clinical status; trauma levels	Low care/high control more prevalent in clinical groups; increased childhood trauma.	$p < .01$; Cohen’s $d = .45$	Yes (CTQ)
Peh et al. (2020)	Quantitative – non-randomised (cohort)	Prospective; Longitudinal cohort	164 clinical, 510 controls	Youths at ultra-high risk; Prodromal psychosis	Parental Bonding Questionnaire	Onset of psychotic symptoms	Maternal authoritarian parenting predicted psychotic symptom onset.	HR = 1.76, 95% CI [1.30–2.38]	Not stated
Parker et al. (1979)	Quantitative – Descript	Retrospective;	867	Psychiatric outpatient	PBI	Resilience/psychiatric vulnerability	Higher parental care with moderate control	Not reported	No

	ive (cross-sectional)	Cross-sectional		s; various psychiatric disorders		(psychosis-specific associations weak)	linked to greater resilience; associations with psychotic disorders specifically were weak.		
Pollard et al. (2023)	Quantitative – Descriptive (cross-sectional)	Retrospective; Cross-sectional	84	Adults with psychosis; First episode	PBI	Symptom severity	Maternal low care and high control associated with greater symptom severity.	p < .01	No
Raudino et al. (2013)	Quantitative – non-randomised (cohort)	Prospective; Longitudinal cohort	924	Adolescents; varied clinical outcomes	Parental Style Interview	Paranoia and delusions	Authoritarian/neglectful parenting predicted paranoia and delusions.	p < .05; significant associations between attachment/bonding and later outcomes	Not stated
Sevilla-Llewellyn-Jones et al. (2019)	Quantitative – Descriptive (cross-sectional)	Retrospective; Cross-sectional	72	Clinical adults; Schizophrenia spectrum disorder	PBI	Personality pathology; relapse risk	Maternal affectionless control linked to severe personality pathology; PBI bonding styles predicted relapse risk.	Not reported (predictive relationship noted)	No

Shahimi et al. (2013)	Quantitative – non-randomised (cohort)	Prospective; Longitudinal	884	Adolescents; psychoticism (trait)	Self-report scales (parenting/warmth/control)	Psychoticism (trait)	Lower warmth and/or inconsistent/strict control linked to higher psychoticism.	p < .05; significant group differences	Not stated
Weintraub et al. (2021)	Mixed methods	Mixed methods; Cross-sectional	123	Parents and adolescents with mood disorders; psychosis and mood disorders	Parenting questionnaire	Psychosis risk in context of stress	Authoritarian parenting predicted psychosis under high stress.	Interaction p < .01	Yes (stress interaction)
Raffagnato et al. (2021)	Quantitative – Descriptive (cross-sectional)	Retrospective; Cross-sectional	125	Adolescents; varied clinical diagnoses	PBI; Child Behaviour Checklist; self-report	Psychopathology (adolescent)	Parenting style associated with psychopathology.	p < .01	Not stated

Abbreviations: PBI = Parental Bonding Instrument; CTQ = Childhood Trauma Questionnaire.

Appendix N: Parental Bonding Tool Quadrants



Appendix O: Reflective Log – Participant 1

I found that I was taking my time with asking questions, particularly those around parenting, as I didn't want to sound blaming or shaming. I felt that, had it been perceived as blaming, the participant would have, understandably, become defensive. I later understood that the participant had experienced multiple bereavements in a very short period of time. This sadly happened just after he had migrated, and he described profound loss and isolation. He did not have the finances to return for the burial. Within a few weeks of this happening, the participant experienced his first episode of psychosis.

I felt emotionally connected to the loss of his parents, as I had lost a parent recently. I found myself flitting into therapist mode, where I thought about support provisions, his support network, and his extended family. I felt a deep sadness for him. When he further divulged that he has no family or friends in England, and how isolating this must be in such a traumatic time. I noticed he used avoidance and humour to mask his emotions when complex topics were broached.

I noticed how connected he was to his religion, and he spoke about how, when he was psychotic, he fixated more on religion, and I wondered if that may feel conflicting for him, as his religion was his comfort and part of his distress. I saw his face light up when he spoke about family Christmases, and then quickly withdraw when he talked about his siblings and how he has not spoken to them recently as a means to protect them from knowing what he is experiencing at the moment in an inpatient hospital.

At times, I questioned whether cultural and language barriers may have impacted his understanding of the intention behind the questions, though this was mitigated through explorative conversations.

He expressed feeling like he had little to no understanding of the psychotic experience he had. At the beginning of the interview, I perceived him to be guarded around these experiences, which I understood as the fear of stigma. At times, I discussed the experiences of others, and he began to speak more of his experiences and think about which things aligned with his experiences.

The participant appeared to be still making sense of his experiences. At the beginning of the interview, he said that he felt he was born with psychosis. He later blamed his father and a particular assault where his father repeatedly hit him on the back of the head with a piece of wood that splintered into his scalp. At the end of the interview, he noted struggling to understand his psychotic experience from a biological perspective, as no one else in his family has mental health problems.

I was acutely aware of my privilege during this interview. Not only the fortune of my freedom, my education, and my support networks, but he referred to believing that I would earn a lot of money, and he compared this to how his parents had enough money financially, but only to be comfortable, not to be considered rich. This made me feel somewhat embarrassed by my privilege and very aware of how different cultures perceive financial success.

Though this participant gave full consent, expressed excitement about engaging in the interview, and would receive reimbursement for his time, I couldn't help but feel uncomfortable. I found it difficult to ask something of someone who is currently so vulnerable. I felt like a burden, and like I was taking something from him during a time when he should be focusing his efforts and energy on himself, his well-being, and his near future.