University of Southampton

Faculty of Environmental and Life Sciences

School of Psychology

Attachment in Psychosis; Intra- and Interpersonal processes affecting recovery

by

Jacqui Louise Tiller

ORCID ID 0000-0002-5929-7756 https://orcid.org/0000-0002-5929-7756

Thesis for the degree of Doctor of Clinical Psychology

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Abstract

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Psychosis is a significant mental health presentation characterised by difficulties in affect, behaviour, and cognition. Untreated psychosis has detrimental impacts individually and societally. Further understanding of the intra- and interpersonal processes affecting recovery is required. Individual barriers and facilitators to accessing support for psychosis requires further exploration. Insecure attachment styles have been linked to psychosis, however research examining the impact of these on emotional regulation, help-seeking, service engagement, and outcomes across clinical samples is limited.

Within this thesis, the systematic review examined studies exploring barriers and facilitators for individuals' accessing Early Intervention for Psychosis services. Three themes from seven studies that met the inclusion criteria emerged: Knowledge, Stigma and Relationships. The presence or absence of these interpersonal factors influenced access to Early intervention services for individuals with psychosis. Addressing these barriers is crucial for reducing the duration of untreated psychosis and improving recovery outcomes. Attachment is an intra-personal process likely to affect support-seeking beliefs and behaviours. The empirical study within this thesis investigated the role of attachment on emotional regulation, help-seeking, service engagement, and recovery outcomes for people with psychosis. Sixty-five participants were recruited via two pathways (Community and NHS routes). Insecure attachment predicted difficulties with emotional regulation, help-seeking, service engagement, and clinical and recovery outcomes for individuals with psychosis.

Collectively, these findings highlight the importance of understanding factors which may hinder access to early intervention services and ongoing support for psychosis and negatively impact recovery. I present a guide for future research and clinical implications, including the need to assess barriers to access and the role of attachment in routine clinical practice to mitigate these obstacles at the earliest opportunity.

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Research Thesis: Declaration of Authorship

Print name: Jacqui Louise Tiller

Title of thesis: Attachment in Psychosis; Intra- and Interpersonal processes affecting recovery

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signature: Date:03/11/2023

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Dedicated to my dad, in loving memory.

Definitions and Abbreviations

BEAQ	Brief Experiential Avoidance Questionnaire
BPS	British Psychological Society
CASP	Critical Appraisal Skills Programme
CERQ	Cognitive Emotional Regulation Questionnaire
CORE-10	Clinical Outcomes in Routine Evaluation Outcome Measure
DUP	Duration of untreated Psychosis
ERQ	Emotional Regulation Questionnaire
FEP	First Episode Psychosis
HAO	Hope Agency Opportunity Measure
HSM-T	Help-Seeking Measure-Trait
I-TAS	Inpatient-Treatment Alliance Scale
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PAM-R	Psychosis Attachment Measure – Revised
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PSYRATS	The Psychotic Symptoms Rating Scale
R-GPTS	Revised-Green Paranoia Thought Scale
SPSS	Statistical Package for Social Sciences

Chapter 1 What are the barriers and facilitators to accessing Early Intervention for Psychosis services? A systematic literature review

The following paper has been prepared in line with the ‘Psychology and Psychotherapy: Theory, Research and Practice’ journal author guidelines.

1.1 Abstract

Purpose: Psychosis is a significant mental health condition which when left untreated can have detrimental impacts for individuals and their wider systems. This review aimed to understand the inter-personal factors influencing individuals’ access to Early Intervention for Psychosis (EIP) services.

Method: A systematic review was conducted of relevant databases (PsychINFO, MEDLINE, CINAHL & PsychARTICLES) using predefined search terms for ‘psychosis’, ‘early intervention’ and ‘barriers and facilitators’ to identify eligible studies. Qualitative studies meeting inclusion criteria were selected to investigate individuals’ experiences of accessing Early Intervention for Psychosis services. Methodological quality of included papers was assessed.

Results: Thematic synthesis analysis identified three themes across the seven research studies: Knowledge, Stigma and Relationships. Lack of knowledge about psychosis resulted in delays in symptom identification and served as a barrier for access, whilst increased knowledge served as a facilitator. Mental health stigma was also a barrier with individuals identifying it as a reason to avoid help-seeking. Supportive relationships with family and mental health professionals facilitated access whilst absence of meaningful relationships served as a barrier.

Conclusions: Routine clinical practice must acknowledge and address these barriers through further education and routine assessment of their presence or absence. Ensuring efficient access to services will reduce the impact of the duration of untreated psychosis. Further qualitative research is needed to explore individuals’ experiences of how mental health professionals and systems have responded to these barriers and to consider how current clinical practice can be adapted to continue to alleviate these barriers and reinforce the facilitators.

Key words: Barriers, Facilitators, Access, Early Intervention, Psychosis, Thematic Synthesis, Individual Experiences

Practitioner Points

- A thematic synthesis of qualitative studies exploring barriers and facilitators to accessing early intervention for psychosis services yielded three key themes: knowledge, stigma, and relationships
- Limited knowledge about psychosis and services, perceived and self-stigma, and the absence of supportive relationships, can all delay access to recommended treatments and therefore recovery
- Training for practitioners likely to have contact with people early in the course of illness (e.g., General Practitioners) should prioritise early symptom recognition and psychoeducation
- Continuity of relationships with clinicians is likely to be important in retaining service engagement once people have made contact with services

1.2 Background

Psychosis is characterised by significant changes in an individual's perceptual, cognitive, affective and behavioural experiences. Psychosis symptoms can include hallucinations, delusions, and changes in the person's sense of reality (National Institute for Health & Care Excellent [NICE] (2014). Common clinical diagnoses associated with psychosis include schizophrenia, delusional disorder and schizoaffective disorder (Cooke, 2014).

First episode psychosis (FEP) has a significant impact on an individual's functioning - vocationally and interpersonally (Penn et al., 2004; Read et al., 2005) and is extremely costly at the societal level (Salomon et al., 2012). Heightened levels of psychological distress and negative quality of life are also identified in carers (Poon et al., 2017). The duration of untreated psychosis (DUP) is defined as the length of time from symptom onset to first treatment. DUP is negatively associated with illness trajectory and recovery outcomes, with longer DUP resulting in worsened prognosis (Fridgen et al., 2013; Kular et al., 2019 & Marshall et al., 2005). Treatment delays for individuals with psychosis are common, with typical waits of one to two years resulting in significant personal and societal impacts (Penttila et al., 2014). A key part of reducing DUP is through prioritising access to services for those with FEP. Access is the process through which individual's, or their support systems reach out for appropriate help and support for their presenting difficulties, usually through primary care services (Burn & Mudholkar, 2020). Within the United Kingdom, the 'pathways to care' model is influential in determining access to services for mental health care (Goldberg, 1991; Gask et al., 2012).

Once initial access to services is made, engagement of the individual who requires support is key. Meaningful engagement is developed with an emphasis on the therapeutic relationship (Tait et al., 2002). This relationship involves key psychological processes such as providing empathy, negotiating goals and coping strategies (Tait et al., 2002). Meaningful, ongoing engagement with services for those with psychosis is crucial for ensuring effective treatment and support is provided subsequently improving outcomes (Bourke et al., 2021).

The clinical implications of DUP and the important role of accessing and maintaining engagement with early intervention services for individuals with FEP cannot be overstated. Overall life expectancy for individuals with psychotic disorders is reduced by 10-15 years compared to the general population (Simon et al., 2018). Given the detrimental impact of psychosis for individuals, families, and the wider societal consequences a reduction in DUP is considered a global priority (World Health Organisation, 2001). Early intervention for Psychosis (EIP) services were designed to reduce treatment delays and improve outcomes for people with psychosis.

1.2.1 Early Intervention Services

Within the United Kingdom, national guidelines recommend individuals experiencing FEP should have access to specialised services designed to decrease DUP, provide tailored assessment and treatment to improve recovery and minimise the impact of FEP on day-to-day functioning (NICE, 2014). EIP services were designed with an increased level of flexibility and adaptability to meet the needs of FEP populations. Appointments are offered within a short timeframe and clinicians having reduced caseloads to increase their ability to develop trusting relationships and respond promptly to clinical need (NICE, 2016). This has been received positively by service users (Cox & Miller, 2021; Lester et al., 2011). In comparison to outcomes prior to EIP service implementation, EIP services have been shown to improve symptom, educational and vocational outcomes for FEP (Larsen et al., 2011). Small to medium effect sizes were identified for EIP outcomes compared to treatment as usual, suggesting early intervention had small to moderate impacts on functioning and recovery (Correll et al., 2018). Such improvements across clinical and functional outcomes have been demonstrated longitudinally, with early intervention being associated with positive outcomes at 5-year follow up (Larsen et al., 2011).

Despite such improvements to EIP services, delays to accessing appropriate help and support are still identified. Difficulties for individuals in seeking appropriate help are associated with DUP (Connor et al., 2016). O’Connell and colleagues (2022) completed a systematic review investigating the factors impacting successful implementation of early intervention services. They identified several barriers and facilitators to implementation, including challenges at systemic, service, and staff levels. Knowledge and understanding of these barriers is crucial for adapting practice and reducing the impact of DUP within the FEP population.

Despite understanding of the barriers and facilitators to EIP service implementation, there are no current published reviews synthesising the barriers and facilitators to accessing EIP services from individuals' personal perspectives. Focusing on the experiences of individuals with FEP and the factors affecting their access to EIP services is fundamental if they are to receive care in a timely manner, reducing DUP, improving illness trajectory and recovery outcomes. A deeper understanding of the factors influencing access will also be vital for improving clinical understanding and insight into practices which are beneficial. This systematic review aimed to address this gap in the literature.

1.2.2 Aims of review

The aims of this review were to:

1. Systematically identify studies exploring individuals' experiences of accessing early intervention for psychosis services for FEP.
2. Determine the quality of the research available.
3. Integrate and synthesise the findings using a thematic synthesis approach to improve our understanding of the barriers and facilitators influencing access to EIP services for individuals with FEP and consider clinical and service implications.

1.3 Method

1.3.1 Search Procedure

This review was conducted in line with the preferred reporting guidelines for systematic reviews and meta-analyses (PRISMA; Moher et al, 2009). The review protocol was pre-registered on the International Prospective Register of Systematic Reviews (Registration ID: CRD42022377155). Four electronic databases were searched on the 17th of November 2022 (PsycINFO, Medline, CINAHL & PsycArticles). Free text and subject headings were used (where applicable) to improve search accuracy (Boland et al., 2017).

Some databases utilise subject headings to identify other terms which represent the same concept. Table 1 highlights the search strategies used across databases.

Table 1

Free Text and Subject Headings used for the search strategy

	Terms for psychosis	Terms for early intervention	Terms for barriers & facilitators
Free Text	Schizo* OR Psychotic* OR Psychosis* OR "Schizophren* spectrum*" OR "Acute psychosis"	"Early Onset" OR "First Onset" OR "First Episode"	Barrier* OR Challenge* OR Obstacle* OR Access* OR Facilita* OR Enabl* OR Disengag* OR Engag*
Medline subject headings	MM "Schizophrenia" OR MM "Psychotic Disorders"	_†	_†
PsychINFO subject headings	"Schizophrenia" OR "Psychosis"	"Early Intervention" OR "First Episode (Disorders)"	_†
PsychARTICLES	"Schizophrenia" OR "Psychosis"	"Early Intervention" OR "First Episode (Disorders)"	_†
CINAHL	"Schizophrenia" OR "Psychotic Disorders"	"Early Intervention"	_†

_† No relevant subject headings available

ProQuest, Ethos and the British Library databases were searched to identify grey literature. Grey literature was included to improve the comprehensive nature of the research and to reduce risk of publication bias (Boland et al., 2017).

1.3.2 Inclusion and Exclusion Criteria

Studies were selected for this review in line with the PICoS framework (*Population, phenomena of Interest, Context, Study Design*; Butler et al., 2016). Studies included individuals who were accessing EIP services and examined barriers and facilitators to accessing these services. Table 2 highlights study eligibility criteria. The search strategy was not limited by publication date or status. This was to ensure a balanced summary of the available evidence and reduce the possibility of publication bias (Paez, 2017).

Table 2

Inclusion & Exclusion Criteria utilising the PICoS Framework

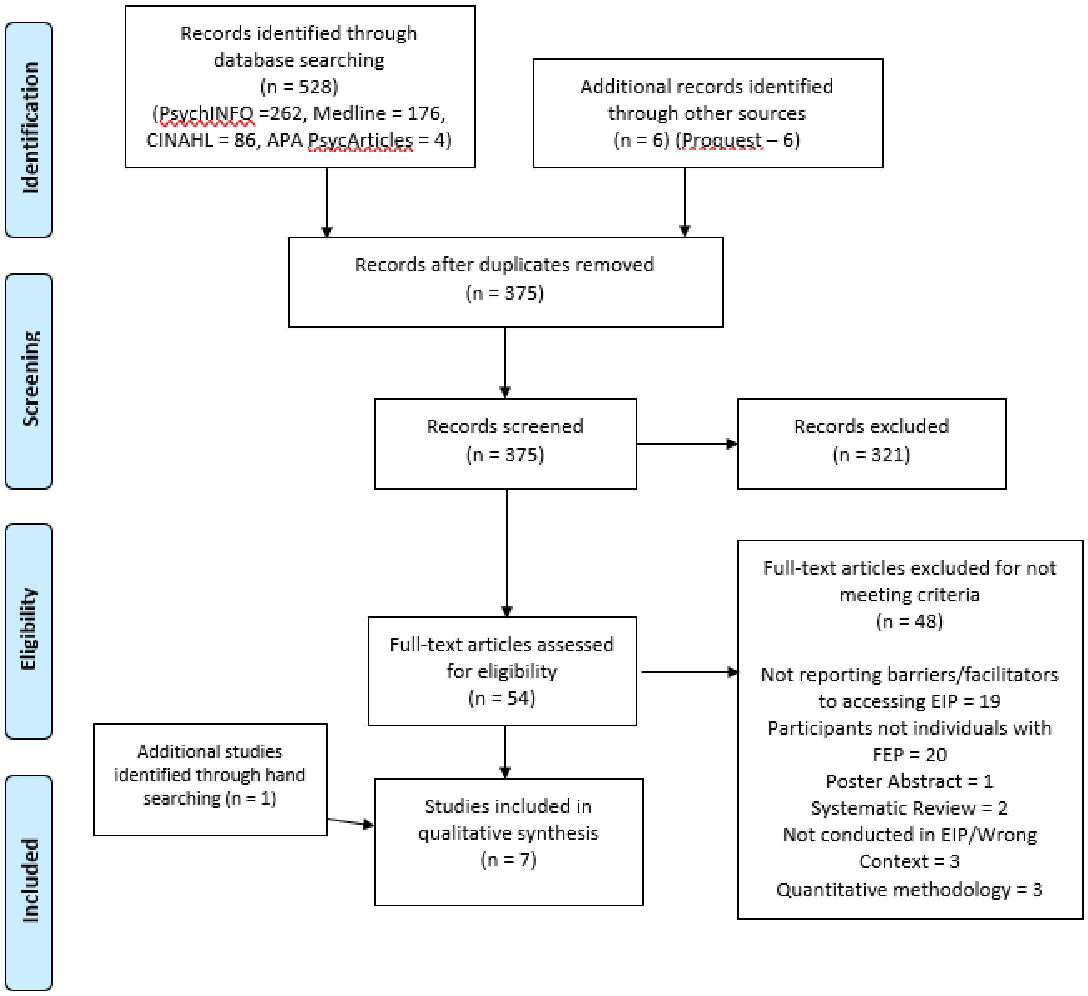
	Inclusion	Exclusion
Population	Participants ≥ 14 years’ old First Episode Psychosis or psychosis-type experiences (e.g., Schizophrenia, Schizoaffective disorder, FEP, Drug induced psychosis)	Participants < 14 years’ old Participants identified as experiencing: - at risk mental states, - prodromal experiences of psychosis - prolonged psychosis - co-morbid mental health condition in addition psychosis. Carers or family members as participants Staff as participants Service provider views/accounts
Phenomena of **I**nterest	Views/Perspectives on barriers and/or facilitators for access to Early Intervention services.	Did not discuss individuals’ experiences relevant to accessing early intervention for psychosis services (e.g., difficulties relating to engagement, disengagement, help-seeking once services have been accessed)
Context	Early Intervention for Psychosis Services (or other countries equivalent) Early access to care for psychosis	Community Mental Health Teams Inpatient treatment settings
Study Design	Empirical research studies - Published and Unpublished	Book reviews Commentaries Books Book chapters Not written in the English Language

1.3.3 Study Selection, Data Extraction and Analysis Plan

Results were collated from the main database and grey literature searches using Rayyan, a reference management software (Ouzzani et al.,2016). Duplicate studies were removed (*n*=159), and remaining titles and abstracts screened against eligibility criteria. Ten percent of abstracts were double rated by a second independent reviewer (*n*=38), with good agreement (84.2%; Fleiss et al., 2013). Full-text screening was completed with 54 papers and a final total of nine papers were identified. Upon completion of full-text screening qualitative research only was extracted to allow for capturing a rich novel understanding of individuals' experiences of the barriers and facilitators to accessing EIP. Three quantitative papers were excluded. Reference lists of final selected papers were hand searched to find any additional relevant papers. One further paper was identified and included, finalising a total of seven papers suitable for review. Figure 1 shows the paper selection process.

Figure 1

PRISMA diagram for paper selection



1.3.4 Critical Appraisal of Qualitative Research

Critically appraising included studies is considered essential during the systematic review process (Higgins & Altman, 2008). The Critical Appraisal Skills Programme (CASP; Long et al., 2020) checklist is used routinely, and recommended as a key quality assessment tool for qualitative research which can effectively capture and evaluate the required elements of the research identified during the search process (Nadelson & Nadelson, 2014). The CASP has 10-items designed to evaluate key elements of qualitative research. This includes the clarity and appropriateness of the research question posed, sampling and methodology, data collection and analyses, and conclusions and significance of contribution. This checklist allows for a standardised approach to quality assessment and rates papers using 3 responses: “Yes”, “No” or “Can’t tell”. A “Can’t tell” response was awarded if a paper failed to provide sufficient information thus making it impossible to ascertain if criteria was met. The CASP does not suggest an overall scoring system. For the purposes of this review and in line with previous research the number of “Yes” responses for each paper was totalled out of 10 (Al-Dirini et al., 2012; Long et al., 2020). All papers within this review scored at least 7/10.

1.3.5 Synthesis

Qualitative data can be synthesised utilising two methodologies: integrative or interpretative (Boland et al., 2017). Whilst integrative approaches collate already existing data, interpretative approaches generate new codes and themes from the original data, allowing for creation of new meaning (Thomas & Harden, 2008). Thematic synthesis is used to analyse and synthesis findings of qualitative research and can be positioned between an integrative and interpretative approach (Boland et al., 2017). It is led by the richness of the data available and focuses on exploring questions relating to people’s experiences and perspectives, deeming it appropriate to help answer the review question posed.

Thematic synthesis consists of three steps. Firstly, findings are coded line by line. The main researcher (JT) used NVIVO (QSR International Pty Ltd, 2020) to complete this process. The second step involves grouping codes together to form descriptive themes and the final stage is the development of analytical themes. Once the main researcher had completed steps two and three discussions were then held with her supervisor (TM) to explore coding rationale and reduce potential bias (See Appendix A for Coding manual).

Significant variations in reporting are noted across qualitative literature, specifically the extent of the data and results presented within them (Thomas and Harden, 2008). Some papers may report only descriptive themes using transcriptions of participant opinions, whilst others may both report data and further develop analytical themes based on what was recorded. To try and capture sufficient data across multiple papers all text recorded within the “Results” sections of the included papers was considered ‘data’ and used for coding (Thomas & Harden, 2008).

1.3.6 Quality Assessment

Quality assessment was completed by the main researcher (JT) and a second independent reviewer (SA). Any rating discrepancies were discussed between the main researcher and independent reviewer and where required, the main researcher’s supervisors (KNT and TM). The quality assessment process was not used as a method to exclude any papers from the analysis process. Instead, quality assessment was completed to gain an overview of the research studies included. This follows guidance suggested by Noyes et al., (2018) which highlights that domains of quality are not equally weighted and consequently cut-off scores are arbitrary.

A total of seven studies were evaluated using the CASP checklist (CASP, 2018). All papers recorded a score of at least 7/10 on quality assessment, with scores ranging from 7/10 to 10/10 (See Table 3 for full quality assessment). Five of the included studies failed to adequately address researcher reflexivity and consider the impact of researcher participant interactions within study methodology. This is despite this being deemed an important consideration for qualitative research to ensure rigorous qualitative methodologies (Teh & Lek, 2018; Dodgson, 2019). A focus on the inclusion of such in future research is required and some caution should be taking when considering this review’s findings in light of this. Within two of the seven studies ethical considerations were not adequately addressed with one receiving a “No” response and one receiving a “Can’t tell” score. Insufficient information was provided in one paper regarding the data analyses conducted, making it impossible to ascertain whether analyses were sufficiently rigorous. This paper received a “Can’t tell” quality rating for this item. Finally, all included papers were completed within the Northern Hemisphere making generalising results across geographical location and cultures more difficult.

Table 3

Quality Assessment of included Studies utilising the CASP checklist

First Author	Clear aims of research?	Appropriate Methodology?	Appropriate design for research aims?	Appropriate recruitment strategy for research aims?	Data collection in a way that addressed the research issue?	Relationship between researcher and participants adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Is there a clear statement of findings?	Is research valuable?	Total
Bay	Y	Y	Y	Y	Y	Can't tell	Y	Y	Y	Y	9
Cowan	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Harris	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Islam	Y	Y	Y	Y	Y	Can't tell	Can't tell	Y	Y	Y	8
Jansen et al., (2015)	Y	Y	Y	Y	Y	Can't tell	Y	Y	Y	Y	9
Jansen et al., 2018	Y	Y	Y	Y	Y	Can't tell	Y	Y	Y	Y	9
Lee	Y	Y	Y	Y	Y	Can't tell	N	Can't tell	Y	Y	7

1.3.7 Reflexivity

Reflexivity is considered a vital element of qualitative research to ensure rigor and quality of the work produced. Some researchers argue it is the most important element of qualitative research practise (Dodgson, 2019). Reflexivity allows the researcher to consider their own role within the research and how their experiences may influence the way they conduct the study (Dodgson, 2019).

Each of the researchers and reviewers involved in this review process are healthcare professionals either currently completing or have completed doctoral training in psychology. The main researcher has experience of collecting data from within an EIP setting and was mindful of how this experience could influence their perceptions of the data (McCabe & Holmes, 2009). Similarly, the main researcher's (JT) supervisors (KNT & TM) have both clinical and research experiences working with FEP populations and across EIP services. These experiences may have been influential during the analyses process and were reflected on within supervision to reduce bias. Specifically, supervisions included the review of the lead researcher’s written reflections and discussion of any themes that were being generated from the data, considering prior knowledge. The research team also sought advice from academic colleagues with an expertise in qualitative methodology regarding codes and themes generated to ensure the thematic synthesis process was followed appropriately. With an awareness of potential bias within the research team, where possible it was agreed that second independent reviewers would not hold knowledge or expertise regarding the topic area of this review.

1.4 Results

1.4.1 Study Characteristics

Seven papers were included in this review, identified from an initial reference search of 534. Study characteristics for included papers are shown in Table 4. The information chosen for extraction was in line with previous literature (Boland et al., 2017; Davenport et al., 2019). Six of the papers were journal articles and one was an unpublished thesis. The studies were conducted within a variety of countries including the United Kingdom (two), Denmark (two), Canada (two) and Norway (one). All included studies reported individual experiences of psychosis and were conducted in countries within the Northern Hemisphere. One study explored experiences of international students studying abroad receiving support for FEP, whilst all other papers used participants living within the country where the research was conducted.

A variety of qualitative methodologies were used for data collection. Five studies used semi-structured interviews, one used focus groups and one used a systematic chart review. In relation to data analysis, Thematic Analysis was the most common analytical method (four), with the other three papers using other approaches: Interpretative Phenomenological approach (one), Narrative Analysis (one) and a Descriptive case series (one). The sample sizes reported in papers ranged from five to 24 participants. In terms of gender representation, all studies recruited male and female participants. Gender representation was approximately equal across six studies. The seventh study (Cowan et al., 2020) recruited more male participants (66.67% of the sample) and included two participants who identified as transgender.

Table 4

Study Characteristics

Author (Year), Country & Date	Title	Aims	Participants (age and gender)	Data Collection Method	Data Analyses
Bay et al., 2016, Norway	Obstacles to care in first-episode psychosis patients with a long duration of untreated psychosis	To investigate factors preventing or delaying patients with a long duration of psychosis from accessing services.	*N* = 8 17-44[†] 4 male, 4 female	Semi-structured Interviews	Interpretative phenomenological approach
Cowan et al., 2020, Canada	Engagement in specialised early intervention services for psychosis as an interplay between personal agency and critical structures: A qualitative study	To investigate factors influencing service users' choice to use, remain involved with or leave early intervention services.	*N* = 24 17-34[†] 22.67 [‡] 16 male, 6 female, 2 transgender	Semi-structured Interviews	Thematic analysis
Harris, 2016, United Kingdom	Exploring Young People's Constructions of a First Episode of Psychosis	To explore the culture narratives held by young people accessing EIP and understand the impact of accessing these services.	*N* = 5 18-35[†] 2 male, 3 female	Semi-structured interviews	Narrative analysis
Islam et al., 2015, United Kingdom	Black and Minority Ethnic Groups' Perception and Experience of Early Intervention in Psychosis Services in the United Kingdom	To understand barriers for BAME individuals in accessing mental health services, relating to cultural appropriateness, accessibility, and acceptability.	*N* = 22 22[†] 11 male, 11 female	Focus Groups	Thematic analysis

Author (Year), Country & Date	Title	Aims	Participants (age and gender)	Data Collection Method	Data Analyses
Jansen et al., 2015, Denmark	Service User Perspectives on the Experience of Illness and Pathway to Care in First-Episode Psychosis: A Qualitative Study Within the TOP Project	To understand perspectives on helpful and unhelpful pathways to care for individuals in FEP & gain further knowledge of the barriers to early detection and treatment of psychosis.	*N* = 11 15-24† 6 male, 5 female	Semi-structured Interviews	Thematic analysis
Jansen et al., 2018, Denmark	Important first encounter: Service user experience of pathways to care and early detection in first-episode psychosis	To explore service user experiences of early detection & transition to specialised psychosis treatment services, including pathways to care, illness understanding and barriers to adequate care and treatment.	*N* = 10 18-27† 5 male, 5 female	Semi-structured Interviews	Thematic analysis
Lee et al., 2015, Canada	Challenges in and recommendations for working with international students with first-episode psychosis: descriptive case series	To identify and describe challenges for international students accessing EIP services for FEP.	*N* = 7 14-35† Males = 4, Females = 3	Chart reviews	Descriptive case series approach

† Range, ‡Mean

1.4.2 Themes

Across the seven studies three themes were generated relating to the barriers and facilitators that influence access to EIP services. The themes identified were Knowledge, Stigma and Relationships. Table 5 provides a summary of the themes and illustrative quotes from participants and authors.

1.4.2.1 Knowledge

The first theme ‘Knowledge’ describes individuals' experiences where the amount of knowledge held by the individual and their wider support system (inclusive of families and mental health professionals) had a critical impact on whether they were able to access EIP services. All papers referenced difficulties relating to a lack of knowledge being a barrier to access. Participants in Jansen and colleagues’ study (2015) discussed how a lack of knowledge about psychosis meant they misattributed symptoms to other causes such as depression, drug use or normal experiences of adolescence. Across three studies, participants did not seek access or support as they did not recognise their need for help nor feel their symptoms warranted treatment. This suggests a lack of knowledge for individuals regarding psychosis, its symptomology, trajectory, and treatment requirements resulted in reduced help-seeking. Reasons for this lack of knowledge were discussed in two papers (Islam et al., 2015 & Bay et al., 2016). These papers highlighted a lack of education as a limiting factor in understanding mental health and a barrier to service access in psychosis. The papers discuss the impact of cultural differences on mental health knowledge and how earlier education within settings such as schools may improve understanding of the nature and treatment of psychosis and why seeking help early is important.

A lack of familial and health care professionals’ awareness of psychosis and mental illness was also discussed as a barrier and resulted in symptoms remaining unrecognised. Consequently, individuals did not gain support from early intervention services in a timely manner. Three studies noted this knowledge gap, particularly for health care professionals such as General Practitioners (GPs) who were employed to help. The papers discussed how GPs misattributed symptoms to anxiety or depression due to a lack of knowledge regarding psychosis (Bay et al., 2016; Islam et al., 2015).

A key barrier to accessing EIP services for individuals relates to the limited knowledge they themselves and their wider support hold about psychosis. A lack of vital knowledge regarding symptomology, potential illness trajectory and treatment options become a barrier to help-seeking.

In contrast the presence of knowledge regarding psychosis, mental health and mental health services was discussed as important for enabling individuals to contact services. Four papers discussed how holding knowledge about psychosis, mental health and mental health services helped to improve understanding and reduce anxieties about accessing EIP services for ongoing treatment and support (Bay et al., 2016; Cowan et al., Harris, 2016 & Jansen et al., 2015).

Two studies identified that seeking additional information about experiences of psychosis helped participants to build their own meaning and understanding about the experiences they were having (Jansen et al., 2015; Harris, 2016). Participants in one paper described how their own experiences of psychosis increased their awareness of the disorder and resulted in increasing knowledge of appropriate support services. Therefore, the presence of knowledge via personal experience was crucial in facilitating the development of knowledge about psychosis and individual’s subsequently presenting to services for appropriate support and treatment.

1.4.2.2 Stigma

An individual’s preconceived ideas of mental health and mental health illness was considered a barrier to accessing EIP services. All studies identified difficulties for individuals accessing EIP related to stigma. This included barriers resultant from held beliefs regarding what it means to have mental illness, due to fears about the perceptions of others as well as due to dominant societal discourses influencing help-seeking. Six studies (Bay et al.,2016, Cowan et al.,2020; Harris, 2016; Jansen et al., 2015; Jansen et al., 2018 & Lee et al., 2016) discussed self-perception beliefs held by participants following onset of symptoms which reduced the likelihood they would seek appropriate help and support. Participants described how a diagnosis of a psychotic illness negatively influenced their own self-identity, increased their anxieties about seeking support and led to avoidance behaviours. This suggests the presence of self-stigma is a barrier to accessing EIP services for FEP.

Two studies (Harris, 2016 & Jansen et al., 2018) identified participant fears about being returned to hospital. This suggests whether individuals ask for help and support depends on their understanding of whether accessing support would result in being detained. Four papers (Bay et al., 2016; Cowan et al., 2020; Harris, 2016 & Jansen et al., 2018) discussed individuals’ reluctance to share their experiences with family and friends due to worries about their reactions and subsequently hide their symptoms.

In addition to worries about familial views of mental illness influencing service access, one paper discussed dominant societal discourses relating to gender as important for individual’s feeling unable to seek help and support (Harris, 2016). Perceived stigma resulting from differences in cultural beliefs between professionals, service users and their families created an additional layer of complexity surrounding access to services. Differing beliefs regarding the nature and cause of the experiences of psychosis were discussed within two papers. One paper highlights opposing cultural views of participants, with some viewing their experiences within a spiritual framework as positive, whilst others reported their experiences as resulting from ‘black magic’. Cultural and religious beliefs regarding appropriate treatments were also discussed (Harris, 2016; Islam et al., 2015).

Participants trying to access support from services also raised concerns about how cultural expectations of mental health are viewed. Harris’s study discussed participant experiences where their native cultures may struggle to understand and accept them if they experience mental illness. Another study (Islam et al., 2015) discussed how anxieties about religious beliefs relating to experiences similar to psychosis (e.g., hearing voices as divine intervention) may be perceived by those with westernised views of mental illness and subsequently impact treatment. Concerns were expressed that misinterpretation of symptoms due to stigma and stereotypical ideas of expected experiences may differ and impact the care received.

1.4.2.3 Relationships

The presence of consistent emotional and practical support, giving individuals the space to share experiences and helping to support with day-to-day occurrences seemed to serve as a facilitator for accessing EIP services across six studies. The role of parents was identified in two studies as a catalyst for intervention and treatment (Jansen et al., 2015 & Jansen et al., 2018). Participants described a level of apprehension towards telling parents about their experiences due to feelings of guilt and shame. Although, when difficulties were shared studies reported familial support as helpful (Jansen et al., 2015).

In contrast, lack of supportive familial and friend relationships was identified as a barrier to accessing EIP (Harris, 2016 & Lee et al., 2016). Some of the studies suggested that disbelief about the individual’s experiences in the family system and amongst professionals created barriers. Four studies (Cowan et al., 2020; Harris, 2016; Islam et al., 2015; Jansen et al., 2018) discussed the importance of relationships and the inclusive nature of services, providing individuals’ opportunities to make their own choices about the care and treatment they receive. This involved having shared goals, providing consistent care, and allowing the individual a choice over which parts of their care or treatment to prioritise. Two studies recognised the importance of a collaborative approach between individuals and their care and treatment team for them to feel empowered, increasing their likelihood to collaborate with their treatment team and access services (Harris, 2016 & Cowan et al., 2020). Studies discussed the importance of participants having the opportunity to feel heard and their opinions valued in relation to their own care and treatment experiences. The importance of providing consistent support, shared goals, staff genuineness, skillset and knowledge were all identified as key factors in facilitating and maintaining early engagement with services (Cowan et al., 2020; Harris, 2016; Islam et al., 2015; Jansen et al., 2015).

Experiences where services made it easy for participants to access and reassess use of the service in line with their own needs was discussed as a facilitator (Cowan et al., 2020). For example, the degree to which participants were allowed to engage at their own pace was important for increasing their sense of autonomy, control and overall power. This subsequently facilitated an increased desire to access and gain support from EIP services. One paper focused on understanding the experiences of international students accessing EIP services identified difficulties in maintaining visa status and having adequate financial support and health insurance to receive appropriate medical care outside of their home country (Lee et al., 2016). A lack of a supportive network to help individuals manage these practical requirements was noted and would impact early service access. This suggests that these are key practical barriers to remaining engaged with services at a time where support is critical for successful outcomes.

Table 5

Themes and illustrative quotes from participants and authors

Themes	Papers evidencing themes	Quotes from papers
Knowledge	1, 2, 3, 4, 5, 6, 7	*6. ‘I thought it was only a sad period, ‘just let things pass as they normally do’, until I’d gotten my head under control again’.* *5.’I think I kept it to myself because I thought it was normal’* *1.“Others did not consider themselves as belonging to the TIPS target group mainly due to feeling insufficiently unwell (i.e. not sick enough) for TIPS” (A)* *1. At times, they received treatment from GPs, psychologists, psychiatrists and school nurses for symptoms of anxiety and depression, but health-care professionals failed to correctly detect and diagnose psychosis.* (A) *3. Joseph emphasised his open-mindedness to multiple explanations of his experiences… However, it is possible that Joseph was not entirely satisfied with the range of explanations provided, since he described seeking sources of additional information in his search for meaning. (A)* *3.Joseph explained how the support provided by the EIP service and his personal research had facilitated self-reflection and knowledge. (A)*

Themes	Papers evidencing themes	Quotes from papers
Stigma	1, 2, 3, 4, 5, 6, 7	*5.“Six participants discussed that shame and fear of stigma in relation to mental illness and how this made them less inclined to disclose symptoms and seek appropriate treatment”. (A)* *6.’What I was most nervous about . . . to be labelled as crazy, afraid of being locked up, and not being let out again. It took a lot of courage to tell my general practitioner’.* 7. *‘She presented with a long history of untreated psychosis and reported not seeking help earlier as mental illness was considered a taboo back home’ (A)* *6. ‘I still find it difficult to accept that I have it, more because I’m worried that when I tell people about it, they label me crazy’.* *5. ‘… so you’re just kind of afraid of being stigmatised by other people … you just know there are prejudices about all these things’* *3. Frank talked about accessing the EIP service in a way that suggested this posed a threat to his previous sense of self, one strongly associated with dominant narratives of masculinity and the non-expression of emotion (A)* 4. *‘I think for Asian people it’s quite difficult having a mental health problem . . . Asian people aren’t as accepting if you have a mental health problem and treat you very differently’.*
Relationships	2, 3, 4, 5, 6, 7	*3. …facing numerous barriers to receiving support as she was dismissed by health care professionals and her family (A)* 3. *[216-219] ‘But the more time that they don’t give up on you (1) if that makes any sense, the more times that they stay there and when you do your stupidness they kind of don’t react to it, it kind of makes you realise that you do need a service’.* 2. *‘Even when I haven’t come for like months on end, they always end up taking me back, when I feel like they’re going to think I’m using them but they’re always like, ‘This is what we’re here for’, so I really appreciate that. And they’re –they’re good, they’re flexible and they’re understanding’.* *3...'I told my family members (1) my sister but they, they didn’t believe me at first, they said it might be nothing'.* *5. Parents also assisted in finding, motivating for and visiting appropriate services (A)* *7. Despite reporting loneliness, she had one supportive friend in Montreal (also from her country) whom she considered to be like a sister. This friend occasionally accompanied her to appointments. Ms E was involved in a church that offered her emotional and instrumental (e.g. clothing) support (A)*

Note. 1 = Bay et al., (2016); 2 = Cowan et al., (2020); 3 = Harris (2016); 4 = Islam et al., (2015); 5 = Jansen et al., (2015); 6 = Jansen et al., (2018); 7 = Lee et al., (2016); (A) = Author quotes

1.5 Discussion

This review aimed to elucidate the barriers and facilitators that can impact individuals' likelihood of accessing EIP services. The review found seven qualitative studies which met criteria and were deemed suitable to answer the review question. The focus of this project was to gain a novel understanding from service users' perspectives of the barriers and facilitators to accessing EIP services. Previous reviews have identified barriers and facilitators to implementing early intervention services for FEP (O'Connell et al., 2022). The current review found three key interpersonal processes which served as barriers and facilitators for individuals in their journey to accessing EIP services. These three themes were Knowledge, Stigma, and Relationships.

The presence of knowledge regarding psychosis, mental health and mental health services was found to facilitate access to services, whilst limited knowledge served as a barrier. This finding is in line with current literature which suggests lack of information and knowledge regarding mental health hinders access to mental health support for those with psychosis (Anderson et al., 2013; Lal et al., 2015). It also highlights the importance of being informed as a way of improving the likelihood of individual's seeking support, reducing the likelihood of DUP and improving outcomes. Additional training and education for professionals and the general population would aid the development of understanding and knowledge of psychosis, increase access to EIP services and improve outcomes. Important topics for further education include identification of symptoms, pathways to care and addressing myths to reduce stigma regarding psychosis.

The findings from this review highlight difficulties with recognition of psychosis symptomology and fear of stigmatising responses as barriers for accessing support and treatment from early intervention services. This is in line with other current literature by McGonagale et al. (2021). They identified fear of stigma and difficulties in recognition of psychosis experiences lessened help-seeking behaviours and subsequent engagement in early intervention services. Dominant societal discourses regarding mental health, stigma, and help-seeking as to how they may influence access to services was only explored within one paper in this review (Harris, 2016). Harris' work discussed how one participant's experiences as a male negatively influenced intentions to help seek as dominant societal beliefs deem it less appropriate for males to receive emotional support. Other research supports this influence and acknowledges the role of gender in reduced help-seeking (Chatmon, 2020). Careful consideration of whether societal discourses and expectations of factors such as gender needs to be considered further. This is of particular importance within psychosis populations, given the incidence of psychosis is higher in males (Aleman et al., 2003; McGrath, 2006).

The presence or absence of supportive relationships was identified as a key theme. This finding supports current research which identifies the vital role of care givers in initially seeking and gaining support for an individual experiencing FEP (Upthegrove et al., 2013). One of the included papers (Lee et al., 2016) completed a descriptive case series of the experiences of international students accessing Early Intervention services. This paper identified some of the unique barriers for international students when trying to access services for emerging psychosis symptomology whilst studying abroad. Further research to investigate this within other countries would be beneficial as methodological deficits were found within this paper, impacting its quality.

1.5.1 Strengths and Limitations

This is the first review of qualitative studies examining experiences of individuals with psychosis and the barriers and facilitators experienced when accessing EIP services. It provides a novel insight into individual's experiences of accessing EIP services for FEP. This review synthesizes current theoretical understanding of how knowledge, stigma and relationships influence access to EIP services at a crucial time for individuals experiencing FEP. This review was completed utilising the recommended PRISMA guidelines for Systematic Reviews (Moher et al., 2009), improving the transparency, quality, and replicability of the research. The quality of this review was enhanced through utilising the CASP checklist, a commonly used tool for appraisal qualitative methodology across healthcare (Long et al., 2020).

Papers not written in the English language were excluded and the impact of this regarding the generalisability of findings to other cultures is noted. Completing research including individuals who identify as Black or minority ethnic populations is particularly important as the rate of psychoses diagnoses is disproportionately high within these populations (Morgan et al., 2004). Finally, due to time constraints it was not possible for coding to be completed by a second independent reviewer. The potential for bias at point of coding was reduced through discussion between the main researcher (JT) and one of her supervisors (TM).

1.5.2 Clinical Implications and Future Research

The recognition that the presence or absence of knowledge of psychosis and mental health services, stigma and supportive relationships can influence an individual's access to EIP services is critical for understanding the barriers impacting access to services found across the literature.

Services should prioritise further education regarding psychosis for individuals, their families and the wider population to ensure absence of knowledge is not a barrier to service access. Investigation of how best to disseminate information to improve knowledge of psychosis is required. Clinicians involved in primary care, such as GPs, would benefit from additional training to identify early onset, or prodromal, psychosis symptomology. Improving mental health literacy and psychosis specific knowledge across the general population needs to be prioritised as higher prevalence of negative attitudes and social distance are noted in comparison to other mental health presentations (Svensson & Hansson, 2016).

Stigma of mental health conditions has been identified as a major concern worldwide (Mak et al., 2007) and is described by many as worse than the mental health condition itself (Thornicroft et al., 2022). Mental health stigma has a detrimental impact on individual's social, psychological and physical functioning, subsequently increasing treatment delays and the likelihood of reduced help-seeking (Sickel et al., 2014). Those who experience psychosis are one of the most stigmatised minority groups across society (Wood et al., 2014a) and this stigma negatively impacts quality of life (Degnan et al., 2021). To negate this, dominant societal discourses regarding mental health and mental health stigma should be more readily considered as part of clinical practice within services. This could be achieved through curiously exploring this with individuals in the initial assessment processes as well as routine discussions as part of clinician reflective practice and case discussions. Consideration of these factors would help understanding of the patterns of service access across cultures and how stigma may be hindering help-seeking and engagement. Finally, consideration of the presence or absence of supportive relationships for an individual experiencing FEP should become part of routine clinical practice to help inform professionals' understanding of what may be reducing an individual's likelihood to present to services. Alternative or additional signposting to befriending or peer support services for individuals without supportive relationships should be considered as part of routine practice.

Future research and reviews should consider the experiences of individuals from a wider range of cultural backgrounds, focused on investigating how spiritual and cultural experiences of mental health may be influencing time and point of access for FEP. Consideration of these factors as part of routine clinical assessment and intervention should also be considered (Islam et al., 2015).

The number of primary studies found within the initial searches for this study highlights limited research considering the barriers and facilitators for individuals in accessing EIP services. It is therefore suggested that further qualitative research is completed within this area with a particular emphasis on gathering participants from wider geographical areas both within the UK and abroad.

Future qualitative research should also routinely consider the role of research reflexivity and include this as part of the methodological rationale and explanations within published studies. This will improve the transparency and rigour of published qualitative research (Dodgson, 2019).

The results from this review build upon the previous review by O'Connell and colleagues (2022) which focused upon barriers and facilitators to accessing EIP at a service implementation level. This review adds additional insight regarding the barriers and facilitators at an individual level. Together, these results provide compelling evidence and a comprehensive insight into the importance of services targeting the identified barriers to EIP access. Important next steps would include involving experts by experience in the process of service design and implementation to inform understanding of how barriers have been or can be overcome to improve recovery outcomes for psychosis populations. A focus on providing comprehensive training and education for clinicians, individuals and their wider support systems will be important for enhancing knowledge about psychosis and subsequently reduce mental health stigma. Finally, consideration of building peer support networks for individuals experiencing FEP is crucial for early intervention.

1.5.3 Conclusions

This review highlights the barriers and facilitators to accessing EIP for individuals with experiences of psychosis. The importance of understanding and eliminating barriers to accessing EIP services cannot be overstated as improving knowledge, reducing stigma, and facilitating supportive relationships for services users will help to reduce the devastating impact of DUP for individuals and their families. Increasing knowledge about psychosis, reducing mental health stigma and ascertaining the presence or absence of supportive relationships should be a focus for all EIP services as early recognition of barriers will facilitate better longer-term outcomes. Further research is warranted to understand individuals' perceptions about how barriers to EIP have been overcome and how best services can support individuals to do this.

Chapter 2 The role of attachment on emotional regulation, help-seeking, service engagement and recovery in psychosis

The following paper has been prepared in line with the ‘Psychology and Psychotherapy: Theory, Research and Practice’ journal author guidelines.

2.1 Abstract

Objectives: Untreated psychosis has detrimental impacts for individuals and wider society. Further understanding of the intra-personal factors affecting recovery in psychosis is required. This study aimed to ascertain whether differences in attachment style influence emotional regulation, help-seeking, service engagement, and clinical and recovery outcomes in a sample of individuals with psychosis.

Design: A cross-sectional study was utilised, with trait attachment style as the predictor variable. Trait measures investigating use of emotional regulation strategies, tendency to help-seek, service engagement, and clinical and recovery outcomes were the dependent variables.

Methods: Sixty-five participants were recruited from across two recruitment pathways (Community and NHS Early Intervention services). All participants reported current or previous experiences of psychosis. A battery of standardised questionnaire measures was completed by participants online at a single timepoint.

Results: Regression analyses showed that insecure attachment (anxious and avoidant) was associated with higher use of dysfunctional emotional regulation strategies, reduced help-seeking and service engagement, and poorer clinical and recovery outcomes. Medium to large effect sizes were found across this study.

Conclusions: Attachment style appears to be associated with the way in which individuals respond to distress (emotional regulation and help-seeking strategies) and clinical and recovery outcomes. Next steps would be to investigate the impact of routine assessment of attachment for those with psychosis at initial contact with services and tailoring interventions offered accordingly to determine if this facilitates help-seeking, ongoing engagement, and thus clinical and recovery outcomes.

Keywords: Attachment; Emotional Regulation; Help-seeking; Service Engagement; Clinical Outcomes; Recovery; Psychosis

Practitioner Points

- Insecure attachment predicts responses to distress in people with psychosis
- Anxious and avoidant attachment predicts emotion regulation, help-seeking, service engagement and clinical and recovery outcomes
- Attachment style should be assessed routinely in early intervention services and interventions should be adapted to account for attachment style
- Clinicians working with people with psychosis should be trained in the implications of attachment for managing psychosis

2.2 Background

Psychosis is a significant mental health presentation characterised by marked changes in an individual's thoughts, affect, perceptions and behaviour (National Collaborating Centre for Mental Health [NCCMH], 2014). Individuals may experience various symptomology including hallucinations, delusions, and disorganised speech (British Psychological Society [BPS], 2017). Individuals with psychosis can experience difficulties in their interpersonal relationships and meeting their vocational and self-care needs (Penn et al., 2004; Read et al., 2005). Early intervention during First episode Psychosis (FEP) is essential for negating the impact of symptoms and increasing the chance of recovery (Killackey & Yung, 2007). Research shows duration of untreated psychosis (DUP; the time between symptom onset and contact with services) for FEP negatively impacts 'illness' trajectory and recovery success (Kular et al., 2018; Fridgen et al., 2013). Reducing the detrimental impact of DUP has become a global focus (World Health Organisation, 2001). Understanding factors which influence help-seeking and service engagement for individuals with psychosis is crucial. Furthering clinician and service knowledge of the factors which may hinder or help help-seeking and engagement is key for developing interventions which will best support this population throughout the course of the illness. One influential intra-personal factor is attachment style.

Many people with psychosis have an 'insecure attachment style'. Strong evidence exists to suggest attachment styles influence an individual's ability to manage distressing experiences in psychosis, both internally (emotional regulation strategies) and externally (influencing help-seeking) (Lecomte et al., 2008; Mikulincer & Shaver, 2007; O'Driscoll et al., 2014; Sood et al., 2022). Consequently, impacting clinical and recovery outcomes (Read et al., 2005; Gumley et al., 2014; Quijada et al., 2015).

2.2.1 Attachment

Attachment theory is a developmental theory which suggests early experiences with primary caregivers critically impacts the way individuals experience themselves, others, and the world. This affects interpersonal relationships in adulthood through the development of 'Internal Working Models' (Bowlby, 1969). Internal working models are beliefs about the self and others which guide individuals' interpretation of interpersonal experiences, influencing emotional regulation and interpersonal behaviours (Cobb & Davila, 2009). Caregiver sensitivity is crucial for determining the development of internal working models and infant attachment style. Attachment style is presumed to develop in childhood and remain relatively stable (Scharfe & Bartholomew, 1994).

Individuals with a responsive caregiver in tune with their distress will exhibit a secure attachment style, resulting in adults who develop a positive sense of self, regulate their affect, cope with distress, and appropriately help-seek. Insecure attachment occurs when caregivers are inconsistent, unresponsive, or insensitive to an infant's needs. An insecure, anxiously attached infant increases their distress to try and elicit a caring response. In adulthood this individual would experience high levels of affect and be sensitive to rejection, resulting in ambivalence when help-seeking, both seeking and shying away from support (Gumley et al., 2014). An insecure avoidant infant will disengage from their caregiver resulting in low affect and avoidance of close relationships during adulthood (Shaver & Mikulincer, 2002). Avoidant individuals are less likely to help-seek, more likely to minimise and avoid supportive relationships (Gumley et al., 2014).

More recent research has suggested the presence of an additional attachment style. Disorganised attachment is believed to develop when infants experience inconsistent, contradictory caregiver responses (Main & Soloman, 1986). Caregivers represent a place of safety, and a source of fear as infant needs are not addressed as needed or expected (Main & Soloman, 1986). Disorganised attachment in adulthood presents as simultaneously wanting to seek and avoid close relationships for fear of rejection (Bartholomew, 1994).

Attachment style can influence both onset and trajectory of an individual's psychotic experiences (Lawlor et al., 2020). Insecure attachment styles are more prevalent in psychosis populations in comparison to non-clinical samples and other mental health populations (Berry et al., 2007; Ponizovsky et al., 2007; Gumley et al., 2014; Lavin et al., 2020). de With et al. (2023) compared insecure attachment styles and social functioning between patients with non-affective psychotic disorders, their siblings, and healthy controls across a two-month period. They identified elevated levels of insecure attachments in the patient population compared to the sibling and control samples. Carr et al. (2018) found evidence to support increased prevalence of disorganised attachment in psychosis populations. MacBeth and colleagues (2011) found almost 30% of FEP participants exhibited a disorganised attachment style.

2.2.2 Emotional Regulation

Emotional regulation is defined as the processes through which emotions are recognised and managed (Gross, 1999), including awareness, understanding and acceptance of emotions and strategies to manage them (Gratz & Roemer, 2004). One factor which impacts emotional regulation efficacy is attachment style. Individuals with insecure anxious attachment styles are more likely to exhibit hyperactivating (e.g., rumination and catastrophising) emotional regulation strategies, whilst those with insecure avoidant attachment styles are more likely to utilise deactivating (e.g., lower emotional expression and suppression) emotional regulation systems, as ways of managing difficult emotional experiences (Mikulincer & Shaver, 2007). These internalised emotional regulation strategies are associated with increased psychosis symptomology (Dozier & Lee, 1995) and are important to consider when understanding the development, maintenance, and trajectory of psychosis (Livingstone et al., 2009). Additional research has corroborated this link. Lincoln et al. (2018) found those at clinically high risk for psychosis who were exposed to a social exclusion task presented with heightened paranoia. This was explained through higher levels of dysfunctional emotional regulation strategies (e.g., catastrophising) and lower functional emotional regulation strategies (e.g., acceptance). O’Driscoll et al. (2014) completed a review and meta-analyses investigating emotional regulation strategies, alexithymia and dissociation in people with schizophrenia. They found those with schizophrenia utilised more maladaptive and less adaptive emotional regulation strategies compared to healthy controls.

2.2.3 Help-seeking and Service Engagement

In addition to emotional regulation deficits, attachment style also explains individual differences in help-seeking and engagement. Individuals with psychosis who exhibit insecure attachment styles find it difficult to meaningfully seek help and engage with mental health services (Lecomte et al., 2008). Tait et al. (2002) highlight engagement difficulties for individuals with psychosis. A systematic review by Sood et al. (2022) collated further evidence that attachment style influences help-seeking in psychosis populations. Their review identified individuals with insecure attachment styles developed more unhelpful emotional regulation and help-seeking strategies compared to those with secure attachments who successfully engaged with services. MacBeth et al. (2011) also found insecure attachment style resulted in poorer service engagement when compared to secure attachment styles. Utilising an FEP population this research provides valuable insight into the barriers around engagement for those who have yet to receive help and support for their psychosis. A review by McGonagle et al. (2021) investigating associations between adult attachment style and engagement with services found similar results. They found attachment avoidance predicted difficulties in therapeutic alliance, although two longitudinal studies reviewed did not find this association. Only one study found anxious attachment to be associated with therapeutic alliance, suggesting a stronger association between avoidant attachment and quality of alliance. The review discusses numerous reasons for difficulties in help-seeking and engagement for individuals with psychosis including stigma and difficulties recognising psychosis symptoms.

Conversely, Degnan et al. (2022) investigated associations between attachment style, therapeutic alliance, and service engagement. They found avoidant attachment influenced therapeutic alliance but neither insecure attachment style influenced service engagement. McGonagle et al. (2021) suggest caution during interpretation due to recognised inconsistencies across the methodology utilised to investigate attachment style and therapeutic alliance in psychosis populations.

2.2.4 Clinical and Recovery outcomes

Associations between attachment style, development of emotional regulation strategies and help-seeking tendencies are well documented for those experiencing psychosis. Routine clinical and recovery outcomes for this population are considered poor. Recovery has been defined as a ‘dynamic’ and ‘personal process’ within psychosis (Slade & Haywood, 2007; Pitt et al., 2007), although there is consensus that changes in clinical and function outcomes (e.g. symptom remission, ability to maintain employment) should be considered as indicative of recovery (Albert et al., 2011). Poor recovery outcomes found within FEP may be due to prolonged DUP.

Outcomes for individuals experiencing psychosis are negatively impacted by DUP and poorer baseline functioning. Wunderink and colleagues (2009) followed a FEP sample for the final 9 months of a 2-year follow-up. Only half met criteria for symptomatic remission, a quarter for functional remission and only a fifth recovered overall (Wunderick et al., 2009). A systematic review by Norman et al. (2005) found DUP independently predicted treatment outcome, specifically remission of positive symptoms over the first year of treatment. Pentilla et al. (2014) identified DUP as associated with more severe symptomology, poorer social and global outcomes, and a reduced likelihood of remission. Concerning recovery, van Bussel et al. (2023) investigated the role of attachment style on recovery outcomes for a psychosis population and found both insecure attachment styles had negative associations with recovery. In contrast, Craig et al., (2000) found no associations between DUP, illness course or clinical outcomes at 24 month follow up for individuals experiencing psychosis. However, this paper recognised difficulties in retrospective DUP reporting.

Taken together, the research to date suggests attachment style influences emotional regulation, help-seeking, and service engagement. These factors are likely to influence DUP and ongoing engagement with services, impacting outcomes. To our knowledge these factors have not yet been studied collectively following a set of theoretically integrated hypotheses.

2.2.5 Current study

As discussed, the role of attachment on emotional regulation, help-seeking, service engagement and recovery outcomes is well documented. To date, these factors have been studied in isolation.

To address this gap, this study tested a set of theoretically derived and integrated hypotheses regarding the likely impact of attachment on people's ability to manage distress internally (emotion regulation) and interpersonally (help-seeking, and service engagement). Participants were recruited via two recruitment pathways, in line with previous research (Pilton et al., 2016; Partridge et al., 2022).

This study aims to investigate the following hypotheses:

(1) Insecure avoidant attachment (measured by Psychosis Attachment Measure – Revised [PAM-R], Pollard et al., 2020) will predict higher levels of emotional suppression (measured by Emotional Regulation Questionnaire [ERQ], Gross & John, 2003) and lower levels of emotional expression (measured by the Brief Experiential Avoidance Questionnaire [BEAQ]; Gamez et al., 2014).

(2) Insecure anxious attachment (measured by PAM-R) will predict higher levels of emotional expression (as measured by the BEAQ), catastrophisation and rumination (measured on the Cognitive Emotional Regulation Questionnaire [CERQ], Garnefski et al., 2001).

(3) Insecure avoidant attachment (measured by PAM-R) will predict lower levels of service engagement (measured by the Inpatient-Treatment Alliance Scale adapted [I-TAS], Blais, 2004) and help-seeking behaviours (measured by Help-Seeking Measure [HSM-T, Sood et al., 2021]).

(4) Both insecure attachment styles (measured by PAM-R) will predict poorer recovery (measured on the Hope Agency Opportunity Scale [HAO]; Newman-Taylor et al., 2017) and

clinical outcomes (measured by Revised-Green's Paranoia Thought Scale [R-GPTS], Freeman et al., 2019).

2.3 Method and Materials

2.3.1 Design

In line with previous literature a cross-sectional design was utilised. Data collection occurred between January-March 2023 (Lecomte et al., 2008; Owens et al., 2013; Partridge et al., 2022)[1]. Attachment was the predictor variable. The Psychosis Attachment Measure-Revised (PAM-R) has found attachment is relatively consistent across psychosis populations (Berry et al., 2008). Emotional regulation, help-seeking, service engagement and clinical and recovery outcomes were dependent variables. A G*Power analysis identified that 69 participants would be required at the .05 alpha error probability to obtain .80 power and a medium effect size (.15) (Tabacknik & Fidell, 2013). Medium effect sizes were predicted based on previous empirical literature findings (Correll et al., 2018; Sood et al., 2022) and to allow for sufficient power for explanatory and practical application of findings (Funder & Ozer, 2019).

2.3.2 Participants

Participants were recruited across community and NHS pathways as per previous research investigating attachment in psychosis (Darrell-Berry et al., 2017; Partridge et al., 2022). Community participants were identified from a pre-existing list of individuals on the online recruitment platform Prolific, who self-reported experiences of psychosis (current or historic). NHS participants were receiving support from an Early Intervention for Psychosis (EIP) team. Study inclusion criteria were as follows; participants ≥16 years (after their 16th birthday), able to consent, fluent in English (questionnaires were written and standardised in English) and experiencing psychosis symptoms at commencement of study (NHS pathway only).

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[1] This research is embedded within a plan to complete longitudinal research investigating the role of attachment on emotional regulation, help-seeking, service engagement, and clinical and recovery outcomes.

2.3.3 Procedure

The study protocol was pre-registered in December 2022 on OSF registries (https://osf.io/vru83) and run with a EIP service in Southern England. Key clinicians within the service reviewed their caseloads to identify eligible participants and approached them for initial consent. The lead researcher then contacted potential participants to discuss the study. The study was advertised and completed according to NHS and Trust guidelines (See Appendix B and C). Participants could complete the study via telephone, in person or through video conferencing (Microsoft Teams). The community sample received the study via an online survey link on Prolific.

Participants were presented with an information sheet (See Appendices D & E) and asked to provide consent (See Appendices F & G). Measures were presented as follows: demographic questionnaire, PAM-R, CERQ, BEAQ, ERQ, I-TAS, HSM-T, HAO, R-GPTS. The Clinical Outcomes in Routine Evaluation-10 (CORE-10; Barkham et al., 2013) and The Psychotic Symptom Rating Scale (PSYRATS; Haddock et al., 1999) were collated for sample descriptive purposes. Upon completion participants were debriefed (See Appendices H & I). This research aimed to collate staff measures of participant engagement (NHS pathway), but this proved unfeasible due to staff workload. Community participants were paid £4.50 (in line with Prolific payment guidelines). NHS pathway participants were paid £10 for their participation and any incurred travel expenses.

2.3.4 Measures

2.3.4.1 Demographic Questionnaire

A self-report measure collected demographic sample information on; age, gender, ethnicity, nationality, time since onset of psychosis and any formal mental health diagnoses received. Length of time accessing EIP services was collected for NHS pathway participants.

2.3.4.2 Attachment

The Psychosis Attachment Measure-Revised (PAM-R; Pollard et al., 2020) is a 26-item questionnaire measuring trait attachment style on three subscales: avoidant, anxious and disorganised. A 4-point Likert Scale from 0 (*Not at all*) to 3 (*Very much*) is used. Averages for each subscale are created. Higher scores indicate greater attachment anxiety, attachment avoidance and disorganised attachment. The measure has good internal consistency for anxiety (α=0.87) and disorganised attachment (α=0.89) and acceptable internal consistency for avoidance (α=0.79) within a psychosis population (Pollard et al., 2020). Internal consistency for the current sample was excellent (α=.92).

2.3.4.3 Emotional Regulation

The Cognitive Emotional Regulation Questionnaire (CERQ; Garnefski et al., 2001) is a 36-item questionnaire measuring use of emotional regulation strategies including cognitive focused reactions in response to stressful events. Two subscales were used for this study (Rumination and Catastrophisation) and average subscales scores were calculated. The CERQ has good reliability and validity (Cronbach alpha range α=.75 -.87; Garnefski & Kraaik, 2007). Higher scores indicate greater use of the specific emotional regulation strategy. Internal consistency for the current sample was good for the catastrophisation subscale (α=.86) and acceptable for the rumination subscales (α=.75).

The Brief Experiential Avoidance Questionnaire (BEAQ; Gamez et al., 2014) is a 15-item questionnaire measuring experiential avoidance on a 6-point Likert scale from 1(*Strongly Disagree*) to 6(*Strongly Agree*). Item 6 is reverse scored. The BEAQ has acceptable levels of convergent and discriminant validity and high levels of internal reliability and consistency (Gamez et al., 2014; Schaeuffele et al., 2022). Higher total scores suggest higher experiential avoidance. Internal consistency for the current sample was excellent (α=.90).

The Emotional Regulation Questionnaire (ERQ; Gross & John, 2003) is a 10-item questionnaire measuring cognitive reappraisal and expressive suppression on a 7-point scale from 1(*Strongly Disagree*) to 7(*Strongly Agree*). This study used the 4-item suppression subscale. An average score was calculated for analyses. This subscale has acceptable internal consistency (α =0.73; Gross and John, 2003). Higher scores indicate greater use of suppression. Internal consistency for the current sample was good (α=.89).

2.3.4.4 Engagement

The Inpatient-Treatment Alliance Scale adapted (I-TAS; Blais, 2004) is a 10-item questionnaire measuring patient alliance with their care. Items are scored on a 7-point Likert scale, 0 (*False*) to 6 (*Completely true*). The scale was adapted with permission to capture experiences of care in community samples. The ITAS has excellent internal consistency(α=.94). Higher total scores indicate greater alliance and were used for analysis. Internal consistency for the current sample was excellent(α=.96).

2.3.4.5 Help-seeking

The Help Seeking Measure – adapted for trait (HSM-T; Sood et al., 2021) is a 3-item measure assessing help-seeking behaviour. Items are rated on a 5-point scale from 1(*Not at all*) to 5(*Extremely*). Higher total scores indicate increased likelihood of help-seeking. The state version of the measure has good to excellent internal consistency (α=0.89-0.93; Sood et al., 2021). Internal consistency for the current sample was excellent (α=.91).

2.3.4.6 Recovery and Clinical Outcomes

The Hope Agency Opportunity Questionnaire (HAO; Newman-Taylor et al., 2017) is a 4-item questionnaire assessing personal recovery inclusive of hope, agency, and opportunity. A 5-point scale from 0(*None of the time*) to 4(*All the time*) is used and a total score calculated. Higher scores suggest better recovery. The measure has acceptable internal consistency given the small number of items (α=0.69). Internal consistency for the current sample was good (α=.89).

The Revised-Green et al's Paranoia Thought Scale (R-GPTS; Freeman et al., 2019) measures paranoia levels on a 5-point Likert scale from 0(*Not at all*) to 4(*Totally*). The 18-items measure ideas of social reference (8 items) and persecutory ideation (10 items). Scores are summed to create two subscale total scores. Higher scores indicate higher levels of paranoia. The R-GPTS has excellent reliability (α>.90; Freeman et al., 2019) and very high internal consistency (Latteur et al., 2022). Internal consistency for this sample was excellent (α=.96).

The Clinical Outcomes in Routine Evaluation-10 (CORE-10; Barkham, et al., 2013) is a 10-item measure assessing overall wellbeing over the last week. Items are rated on a 5-point scale from 0(*Not at all*) to 4(*Most or all the time*) and show excellent internal consistency (α=.94 clinical sample, α=.92 non-clinical sample; Barkham et al., 2013). This sample has acceptable internal consistency (α=.76) Higher scores suggest higher psychological distress. Scores >10 are considered in the clinical range.

The Psychotic Symptom Rating Scale (PSYRATS; Haddock et al., 1999) is a 17-item questionnaire measuring severity of delusions (six items) and auditory hallucinations (11 items) in psychosis. Items are scored on a 4-point scale, 0 (*No problem*) to 4 (*Maximum Severity*). This study used one item relating to the amount of distress caused by voices. The PSYRATS has shown to be reliability and valid (Drake et al., 2007).

2.3.5 Ethical Considerations

Ethical approval was granted by the University of Southampton Ethics committee (ERGO:72393), the Health Research Authority/Social Care REC (IRAS:314111) and the local NHS Trust Research and Development Department (see Appendix J). Standardised measures used within routine clinical practice were included and no known adverse effects were noted. Short version questionnaires were used where possible. During consent and debrief participants were informed that questionnaires may ask about topics of a sensitive nature (e.g., relationships with others) and they were directed to sources of support if needed.

2.3.6 Statistical Analyses

Simple linear regression analyses were completed for each hypothesis proposed. Following Berry (personal communication), 23 of the 26 items included in Pollard et al.'s (2020) original article were included in the present analyses, given the original factor analysis.

2.4 Results

Microsoft Excel and SPSS 28 were used for data cleaning and analyses purposes (Statistics, I.S., 2021). Thirty-six missing data points were identified. Eighteen corresponded to the PSYRATS questionnaire. Upon review “Not Applicable” ratings were assigned as it was deemed likely that an absence of an answer was likely explained by an absence of voices, deeming the question irrelevant. The other 18 missing data points belonged to nine participants on the CORE-10 questionnaire. Imputation of the mean for each participant across the subscale was completed (Tabachnick & Fidell, 2013; Bannon, 2015). Due to data entry error, the CERQ rumination subscale short form (items one and two) was used for analyses (Garnefski & Kraaij, 2006).

2.4.1 Sample Characteristics and Intercorrelations

Sixty-five participants completed this study; 55 participants were recruited from the community pathway (Prolific) and 10 participants were recruited from the clinical pathway (NHS EIP settings). Table 6 presents sample demographic data; Table 7 shows overall sample scores for the included measures. Of the total sample, 37 participants scored above clinical cut off for paranoia, suggesting this subsample were experiencing paranoia at comparable levels with previous studies recruiting clinical samples (Freeman et al., 2019). Appendix K shows comparative statistics across the recruitment pathways.

Table 6

Demographic data and descriptive statistics

Variable	Descriptive statistic Current Sample
Gender: *n*(%)	64† (98.46)
Female	34 (52.31)
Male	26 (40.00)
Other (no gender, non-binary)	4 (6.15)
Age of participant in years: *n* (%)	
20-29	32 (49.23)
30-39	20 (30.77)
40-49	9 (13.85)
50-59	4 (6.15)
Ethnicity: *n* (%)	
White	54 (83.08)†
Black Caribbean & White	3 (4.76)
Mixed	3 (4.76)
All other ethnicities: Black, Bangladeshi, Indian Caribbean, African, Asian	5 (7.93)
Nationality: *n* (%)	
British; Scottish, Welsh, English	61 (93.85)†
British American	1 (1.54)
Hong Kong	1 (1.54)
Nigerian British	1 (1.54)
Polish	1 (1.54)
Formal Mental Health Diagnoses	
Yes	59 (90.77)
No	6 (9.23)
Formal Mental Health Diagnoses: *n* (%)	
Psychosis	25 (38.46)
Anxiety	23 (36.50)
Depression	21 (33.33)
Bipolar	11 (17.46)
Emotionally Unstable Personality Disorder	11 (17.46)
Post-traumatic stress disorder	7 (11.11)
Autism	5 (7.93)
Schizoaffective Disorder	5 (7.93)
Attention Deficit Hyperactivity Disorder	3 (1.89)
Obsessive Compulsive Disorder	3 (1.89)
Dissociative Identity Disorder	2 (1.26)
Eating Disorders	2 (1.26)

Variable	Descriptive statistic Current Sample
Insomnia	1 (0.63)
Social Phobia	1 (0.63)
Panic Disorder	1 (0.63)
Mixed Personality Disorder	1 (0.63)
Time since onset of psychosis in months (*M, SD)*	114.71 (94.08)
Time since commenced treatment in EIP service (*M, SD)*	14.90 (11.94)

[†] Ethnicity and Nationality data was self-defined by participants.

Note. N = 65, *n* may not equal total N due to missing demographic data

Table 7

Descriptive statistics for included measures

Measures	Descriptive statistic Current Sample	Comparison Statistic
Attachment Avoidance – PAM-R (*M, SD)*	1.84 (0.67)	2.85 (0.49)[‡]
Attachment Anxiety – PAM-R (*M,SD)*	1.7 (0.74)	1.95 (0.75)[‡]
Attachment Disorganised – PAM-R (*M, SD)*	1.55 (0.76)	1.49 (0.79)[‡]
Paranoia – Social Reference R-GPTS (*M, SD)*	13.58 (9.10)	15.8 (7.42)[†]
Paranoia – Persecution R-GPTS (*M, SD)*	14.63 (12.30)	13.7 (13.0)[†]
Emotional Regulation – ERQ (*M, SD)*	3.97 (1.07)	
Emotional Regulation – BEAQ (*M, SD)*	57.26 (14,54)	
Emotional Regulation – CERQ Rumination *(M, SD)*	3.75 (0.94)	
Emotional Regulation – CERQ Catastrophisation(*M, SD)*	2.92 (1.05)	
Engagement – ITAS	33.95 (15.84)	
Help-seeking – HSM-T	8.02 (3.01)	
Recovery Outcomes - HAO	7.52 (4.05)	
Clinical Outcomes – CORE 10	23.98 (6.20)[§]	
Clinical Outcomes - PSYRATS	2.92 (1.66) [¶]	

[†]1804 adults recruited from clinical settings identified as having psychotic disorder (Freeman et al., 2019). R-GPTS score ranges for Persecution: Average (0-5), Elevated (6-10), Moderately Severe(11-17), Severe(18-27), Very Severe(28+). R-GPTS score ranges for Social Reference: Average (0-9), Elevated (10-15), Moderately Severe (16-20), Severe (21-24), Very Severe (25+).

[‡] 51 patients with non-affective psychotic disorder (Varela et al., 2021); 242 participants who self-report experiences of psychosis or have received support for psychosis previously (Humphreys et al.,2022).

[§]The average score on the CORE-10 for symptoms of psychological distress fell within the moderately severe range, suggesting participants may benefit from clinical intervention.

[¶] Average score on PSYRATS across the sample. For those who experience voices the results suggest the minority were distressing.

2.4.2 Regression Analyses

Inspection of histograms revealed all variables were normally distributed. All analyses assumptions were met, and planned analyses completed. Bonferroni adjustments (Emerson, 2020; 0.5/13 = 0.00385, Critical *a*) were used for regression analyses to reduce the likelihood of Type I error. Table 8 shows intercorrelations between measures.

Table 8

Descriptive Statistics and Intercorrelations

Measure		Mean (*SD*)	1	2	3	4	5	6	7	8	9	10	11	12	13
PAM-R	1.Avoidant Attachment	1.84 (0.67)													
	2.Anxious Attachment	1.7 (0.74)	.37**	-											
	3.Disorganised Attachment	1.55 (0.76)	.69**	.59**	-										
CERQ	4.Rumination Subscale	3.75 (0.94)	.25*	.37**	.33**	-									
	5.Catastrophisation Subscale	2.92 (1.05)	.11	.25*	.18	.37**	-								
BEAQ	6. Experiential Avoidance	57.26 (14.55)	.60**	.49**	.63**	.29*	.40**	-							
ERQ	7. Suppression Subscale	4.06 (1.70)	.50**	.09	.45**	.02	.18	.48**	-						
ITAS	8. Treatment Alliance	33.95 (15.84)	-.31*	-.27*	-.30*	-.19	.02	-.26*	-.13	-					
HSM-T	9. Help-Seeking	8.02 (3.01)	-.73**	-.20	-.44**	-.24	-.22	-.54**	-.43**	.36**	-				
HAO	10. Recovery	7.52 (4.05)	-.52**	-.36**	-.41**	-.22	-.24	-.45**	-.23	.51**	.57**	-			
CORE-10	11. Clinical Outcomes – Wellbeing	23.98 (6.20)	.34**	.45**	.45**	.48**	.32**	.47**	.12	-.26*	-.38**	-.43**	-		
RGPTS	12. Social Reference (R-GPTS)	13.58 (9.11)	.39**	.55**	.53**	.36**	.36**	.50**	.25*	-.13	-.36**	-.34**	.52**	-	
	13. Persecution (R-GPTS)	14.63 (12.30)	.35	.39**	.43**	.35**	.37**	.57**	.28*	0.05	-.29*	-.35**	.47**	.81**	-
PSYRATS	14. Clinical outcomes - Voices	2.92 (1.66)	.06	.04	-.13	.11	.10	-.02	.08	.20	-.09	.10	-.02	.03	.09

*p <.05

**p <.004 (Bonferroni Correction - Adjusted *p* value is 0.00385)

PAM-R – Psychosis Attachment Measure – Revised; Cognitive Emotion Regulation Questionnaire (CERQ); Brief Experiential Avoidance Questionnaire (BEAQ); Emotional Regulation Questionnaire (ERQ); Inpatient-treatment Alliance Scale (ITAS; adapted with permission for community sample); *HSM-T* Help-Seeking Measure (HSM-T; trait version); Hope, Agency, Opportunity Questionnaire (HAO); Clinical Outcomes in Routine Evaluation (CORE-10); Revised-Green et al., Paranoia Thoughts Scale (R-GPTS); The Psychotic Symptom Rating Scale (PSYRATS)

Does attachment style predict emotional regulation?

Table 8 shows both insecure attachment styles were associated with lower levels of emotional expression. Attachment avoidance was also associated with higher levels of emotional suppression. Attachment anxiety was associated with heightened levels of rumination.

Table 9 highlights that attachment avoidance predicted higher levels of suppression as a method of emotional regulation (R^2=.25,F(1,63)=21.48,p<.001). Attachment avoidance also predicted lower levels of emotional expression (R^2=.35,F(1,63)=34.48,p<.001). Attachment anxiety also predicted lower levels of emotional expression (R^2=.24,F(1,63)=19.59,p<.001). This is contrary to the proposed hypothesis. Further, attachment anxiety was found to predict levels of rumination (R^2=.13,F(1,63)=9.72,p<.003).

Does attachment style predict help-seeking and engagement?

Table 8 highlights a moderate negative association between attachment avoidance and tendency to help-seek and a strong negative association between attachment avoidance and sense of treatment alliance. Table 9 shows attachment avoidance was associated with levels of help-seeking (R^2=.54,F(1,63)=72.35,p<.001).

Does attachment style predict recovery and clinical outcomes?

Table 8 shows both insecure attachment styles were negatively correlated with recovery outcomes (HAO). Attachment avoidance and attachment anxiety were also shown to positively correlate with heightened experiences of paranoia.

Table 8 shows attachment avoidance was more strongly correlated with poorer recovery compared to attachment anxiety. Table 9 shows avoidant attachment (R^2=.27,F(1,63)=23.27,p<.001) and anxious attachment (R^2=.13, F(1,63)=9.17,p<.004) predicted poorer recovery outcomes. Attachment avoidance predicted heightened levels of social reference (R^2=.15,F(1,63)=11.04,p<.001). Attachment anxiety predicted elevated levels of social reference (R^2=.30,F(1,63)=26.78,p<.001) and persecution (R^2=.15,F(1,63)=11.03,p<.001).

Table 9

Regression Analyses

		Model			Regression coefficient			
Predictor(s)	**Dependent**	***F*(1,63)**	***p***	***R^2***	***β***	***t (63)***	***p***	***sr^2***
Avoidant attachment (PAM-R)	Suppression (ERQ)	21.48	<.001	.25**	.50	4.64	<.001	.25
	Experiential Avoidance - (BEAQ)	34.48	<.001	.35***	.60	5.87	<.001	.35
	Treatment Alliance – (ITAS – adapted)	6.78	<.01	.10	-.31	-2.60	.01	-
	Help-Seeking (HSM-T)	72.35	<.001	.54***	-.73	-8.51	<.001	.53
	Recovery (HAO)	23.27	<.001	.27***	-.52	-4.82	<.001	.27
	Social Reference (R-GPTS)	11.04	<.001	.15**	.39	3.32	.001	0.15
	Persecution (R-GPTS)	8.97	.004	.13**	.35	3.00	.004	-
Predictor(s)	**Dependent**	***F*(1,63)**	***P***	***R^2***	***β***	**t (63)**	***p***	***sr^2***
Anxious attachment (PAM-R)	Experiential Avoidance (BEAQ)	19.59	<.001	.24**	.49	4.43	<.001	.24
	Catastrophisation (CERQ)	4.04	<.05	.06	.25	2.01	.049	-
	Rumination (CERQ)	9.72	<.003	.13**	.37	3.12	.003	.13
	Recovery - (HAO)	9.17	<.004	.13**	-.36	-3.03	.004	.13
	Social Reference –Symptomology (R-GPTS)	26.78	<.001	.30***	.55	5.18	<.001	0.30
	Persecution Symptomology (R-GPTS)	11.03	<.001	.15**	.39	3.32	.001	0.15

Note. Psychosis Attachment Measure – Revised (PAM-R); Cognitive Emotion Regulation Questionnaire (CERQ); Brief Experiential Avoidance Questionnaire (BEAQ); Emotional Regulation Questionnaire (ERQ); Inpatient-treatment Alliance Scale (I-TAS; adapted with permission for community sample); Help-Seeking Measure (HSM-T; trait version); Hope, Agency, Opportunity Questionnaire (HAO); Clinical Outcomes in Routine Evaluation (CORE-10); Revised-Green et al., Paranoia Thoughts Scale (R-GPTS); The Psychotic Symptom Rating Scale (PSYRATS).

*Small effect,** medium effect,*** large effect

β=standardized regression coefficient.

sr^2=squared semipartial regression coefficient

2.5 Discussion

This study aimed to determine whether attachment style predicts emotional regulation, help-seeking, service engagement, and clinical and recovery outcomes across community and clinical recruitment pathways for individuals experiencing psychosis.

As hypothesised attachment avoidance predicted the use of dysfunctional emotional regulation strategies including higher levels of emotional suppression and lower emotional expression as well as help-seeking, consistent with previous studies (Lecomte et al., 2008; Mikulincer & Shaver, 2019). Attachment anxiety predicted greater use of dysfunctional emotional regulation strategies, and greater use of rumination. Use of catastrophisation was identified as a trend within the data for those with attachment anxiety. This was unexpected, as other research has found higher levels of catastrophisation in individuals at clinically high-risk for psychosis (Lincoln et al., 2018).

As predicted, attachment avoidance predicted higher levels of experiential avoidance (measured by the BEAQ), indicating lower levels of emotional expression. This supports previous literature that those with an avoidant attachment style are less likely to express distress (Shaver & Mikulincer, 2002). Interestingly, attachment anxiety was also associated with higher scores of experiential avoidance (measured by the BEAQ), suggesting less emotional expression. This contrasts with the hypotheses and existing literature which suggests that anxiously attached individuals seek help and support and show their distress to elicit a care response (Shaver & Mikulincer, 2002). This finding should be interpreted cautiously as it could be the BEAQ does not have the sensitivity required to measure emotional expression.

In line with predicted hypotheses, attachment avoidance and attachment anxiety were associated with poorer recovery outcomes. This supports existing research which indicates that insecure attachment has a detrimental impact on recovery in psychosis (van Bussel et al., 2023). Attachment avoidance was negatively associated with recovery to a stronger extent than attachment anxiety. This corroborates current theory which would predict that individuals with attachment avoidance would be less likely to help-seek and engage with services due to an avoidance of care and therefore poorer psychosis recovery outcomes would be expected (Tait et al., 2002; Sood et al., 2022). Clinically this could increase longer DUP and negatively impact illness trajectory and prognosis.

Attachment avoidance and attachment anxiety were associated with poorer clinical outcomes relating to psychosis symptomology. Attachment avoidance predicted higher levels of social reference. Attachment anxiety was shown to predict both elevated levels of social reference and persecution. This confirms previous findings which suggest insecure attachment style negatively impacts symptomology, and personal and social recovery outcomes for individuals with psychosis (van Bussel et al., 2021).

2.5.1 Strengths and Limitations

These findings add to the existing literature regarding the impact of attachment on emotional regulation, help-seeking, engagement, and clinical and recovery outcomes. Recruiting across two pathways (NHS and community) enhances the generalisability of the findings and the sample size was sufficiently powered (Tabacknik & Fidell, 2013). The findings suggested similar levels of paranoia (R-GPTS) across this sample when compared to other literature (Freeman et al., 2019). Additionally, overall wellbeing scores (CORE-10) for the sample fell within the 'moderately severe' range, suggesting clinical intervention may be beneficial. These high outcome scores suggest this sample are comparable to other clinical populations studied and support previous research regarding poorer outcomes for psychosis populations (Gumley et al., 2014; Quijada et al., 2015). A good balance of age ranges and genders were recruited across the sample, however most participants identified as British (93.85%), impacting the generalisability of findings.

The sample size was sufficiently powered, however recruiting individuals who are currently receiving support from across clinical services is limited (Gumley et al., 2014; Korver-Nieberg et al., 2014). Recruiting additional participants from the NHS pathway would be beneficial. Study inclusion criteria for psychosis symptomology differed between sample groups, with the clinical recruitment pathway requiring current psychosis symptomology and the community recruitment pathway requiring current or historic psychotic symptomology. This is noted as a potential limitation of this study, although recruiting those with active psychosis symptomology in the clinical sample reflects NHS service criteria and recruiting from different recruitment pathways is in line with previous research in the field (Darrell-Berry et al., 2017; Partridge et al., 2021). Descriptive data for this sample highlights comparable levels of symptomology across the two recruitment pathways. Additionally, use of a cross-sectional design limits the ability to establish causality of associations between variables. Although, it is argued attachment style is established in infancy and remains fairly consistent, whilst psychosis emerges in adolescence providing support for the temporal order of variables. Longitudinal research is required to establish causal links between attachment style and the dependent variables of interest. The role of disorganised attachment was not considered, although research on this attachment style in psychosis populations is growing. Further research should consider how this might influence help-seeking, treatment engagement and overall recovery in psychosis.

This study utilised the BEAQ to measure emotional expression. However, the BEAQ primarily measures experiential avoidance. Thus, queries regarding the appropriateness and sensitivity of the BEAQ to capture the interested variable were noted. The current findings relating to anxious attachment and its impact on emotional expression should be interpreted cautiously. Further research should ensure measures used to assess emotional expression are specific to expression, rather than a general measure of experiential avoidance. Before commencing additional research calculation of psychometric properties and factor loadings of each item on the BEAQ relating to emotional expression is required to determine the appropriateness of this questionnaire in measuring the variable of interest, emotional expression.

2.5.2 Clinical Implications and Future Research

This research provides further support for the existing link between attachment style and the variables of interest (emotional regulation, help-seeking and engagement) in psychosis. Further research needs to examine the impact of attachment assessment across clinical services as part of routine practice, to determine causality between the variables and understand how interventions could be adapted for attachment style. The need for this research is acknowledged by McGonagle and colleagues (2021) who suggest routine assessment of attachment (e.g., PAM-R) in psychosis would be beneficial at point of service access and during formulation (Pollard et al., 2020). This would help promote ongoing engagement for individuals' who have contacted services but who are at increased risk of drop out. Ensuring individuals remain engaged with services is crucial for enhancing the benefits of early intervention, decreasing DUP and improving overall outcomes.

Additional training, supervision and reflective practice for staff would enhance understanding of the practicalities of working with different attachment styles. McGonagle et al. (2021) highlight the importance of a secure base for professionals and clients, to create a sense of safety and security through which to work and build collaborative relationships. Newman-Taylor et al. (2022) investigated the implementation of attachment-based CBT models within acute settings for psychosis. Furthering patient, staff, and familial understanding of the importance of interpersonal relationships and attachment style guided more effective staff-patient interactions, improving recovery outcomes. Further research across clinical services is required to enhance understanding for the role of attachment style on meaningful engagement and help-seeking across psychosis populations. Additional research would allow us to understand the impact of attachment, thus adapting interventions accordingly to suit individual patient need, enhancing the efficacy of intervention, treatment and outcomes. Where possible, consideration of proportional cultural and ethnicity representation is required during recruitment to enhance generalisability of outcomes for individuals from Black and minority ethnic communities, as they experience disproportionately high rates of psychosis, more adverse pathways to care and poorer outcomes (Singh et al., 2013; Islam et al., 2015).

Additional longitudinal research to map the impact of attachment style over time on help-seeking, engagement, and clinical and recovery outcomes for those accessing EIP services is currently underway by the research team. This will allow clinicians to understand and predict the differences in help-seeking and engagement across insecure attachment styles in psychosis more readily, increasing their ability to adapt interventions to individual need (Tyrell,.1999). For example, assertively engaging those with an avoidant attachment style, whilst those with an anxious attachment style could be taught ways to manage hyperactivating emotional regulation systems to then able them to engage better with treatment.

2.5.3 Conclusions

Insecure attachment style predicts difficulties with emotional regulation, help-seeking, engagement, and recovery in psychosis. This research supports the central role of attachment in influencing an individual with psychosis’ ability to seek help and remain engaged with services which is likely to affect clinical and recovery outcomes over time (Read et al., 2005; Gumley et al., 2014; Quijada et al., 2015).

This study provides clear recommendations for the routine assessment of attachment across clinical practice. Further, this study highlights that professionals working with individuals with psychosis should be trained to understand the importance of attachment with regards to ongoing help-seeking, engagement and treatment alliance which influences outcomes across this population. Longitudinal research with clinical samples is now required to further understanding of the impact of attachment on psychosis trajectory, duration of DUP and subsequent barriers to remaining engaged.

Consideration of attachment style is crucial for individuals' accessing services for support with psychosis as the presence of insecure attachment creates barriers to meaningful engagement. Routine consideration of this key intra-personal process is required to address the subsequent barriers to engagement, reduce DUP and impact on overall illness recovery.

Appendix A Coding Manual

Descriptions of analytical and descriptive themes and corresponding codes

Analytical Theme & Description	Descriptive Themes	Codes
Knowledge: Experiences of individuals which encompass how the presence or absence of knowledge regarding psychosis serves as a barrier or facilitator to accessing service.	*Individual Knowledge*: Examples where the individual discusses their own level of knowledge relating to psychosis, mental health, and mental health services and how the presence (or absence) of this impacted their interpretation of their experiences and whether they chose to seek help or support.	·Accessing information to improve understanding ·Higher symptom frequency, higher relevance and awareness ·Being informed decreases worries about receiving support ·Avoidance of difficulties ·Use of substances to cope ·Psychotic symptoms increase isolation ·Not feeling unwell enough for treatment ·Belief that no intervention is required ·Normal adolescent experience ·Failure to recognise help is needed ·Managing expectations ·Lack of language to describe experience ·Thoughts of being too unwell for treatment ·Sense of relief ·Managing expectations
	Family and support systems: Examples where barriers and facilitators to an individual accessing EIP are discussed in the context of the presence or absence of care giver and support system knowledge regarding psychosis, mental health, and mental health support.	·Unsure how to access support ·Not recognising need for help until crisis ·Perceived mental health difficulties other than psychosis ·Misattributing symptoms ·Lack of education about mental health & mental health support

Appendix A

Analytical Theme & Description	Descriptive Themes	Codes
	Professionals: Experiences which discusses the impact of level of knowledge held by mental health and primary care professionals and how this can impact access to services.	·Lack of knowledge about mental health and services ·Lack of knowledge about psychosis symptoms ·Failure by professionals to correct mental health condition ·Concerns not addressed adequately by mental health professionals ·Services not feeling helpful ·Lack of staff consistency impacts wellbeing
Stigma: This theme describes the role of stigma and how self-stigma, societal narratives, and fears of stigma from others how stigma relating to mental health and psychosis can influence access to EIP services.	*Self-Stigma*: Examples that highlight the impact of an individual's own negative attitudes or beliefs about their mental health experiences which subsequently impacts their access to services.	·Not disclosing need for help due to guilt ·Wanting to appear normal ·Mental illness influencing self-identity ·Fear of loss of freedom ·Thoughts of being too unwell for treatment ·Negative self-perceptions due to mental health difficulties ·Fear of misunderstanding of religious beliefs will influence treatment
	Societal Stigma: Examples where wider societal narratives are shown to interplay with an individual's experiences of psychosis and how this might impact their ability or want to access early intervention for psychosis services.	·Negative attitudes to mental health ·Dominant gender discourse reducing help-seeking ·Different cultural expectations influencing perceptions of mental health
	Stigma from others: Examples which describe individual's concerns about how others will perceive their experiences and how this might impact their care and treatment, including differences in cultural beliefs and expectations and how this impacts access to EIP services.	·Negative perceptions of mental health settings and services ·Not wanting others to know •Lack of cultural views decrease sharing of experiences
Relationships: This theme highlights the importance of the presence or absence of relationships and the elements of the relationship that help or hinder individuals accessing EIP services, with emphasis on emotional and practical support and choice.	*Emotional Support*: Examples where participants discuss the role of their wider support system and how the presence or absence of emotional support impacts their wellbeing and likelihood of accessing support.	·Supportive relationships ·Positive experiences of team & services ·Adapting for patient need ·Staff genuineness ·Shared goals

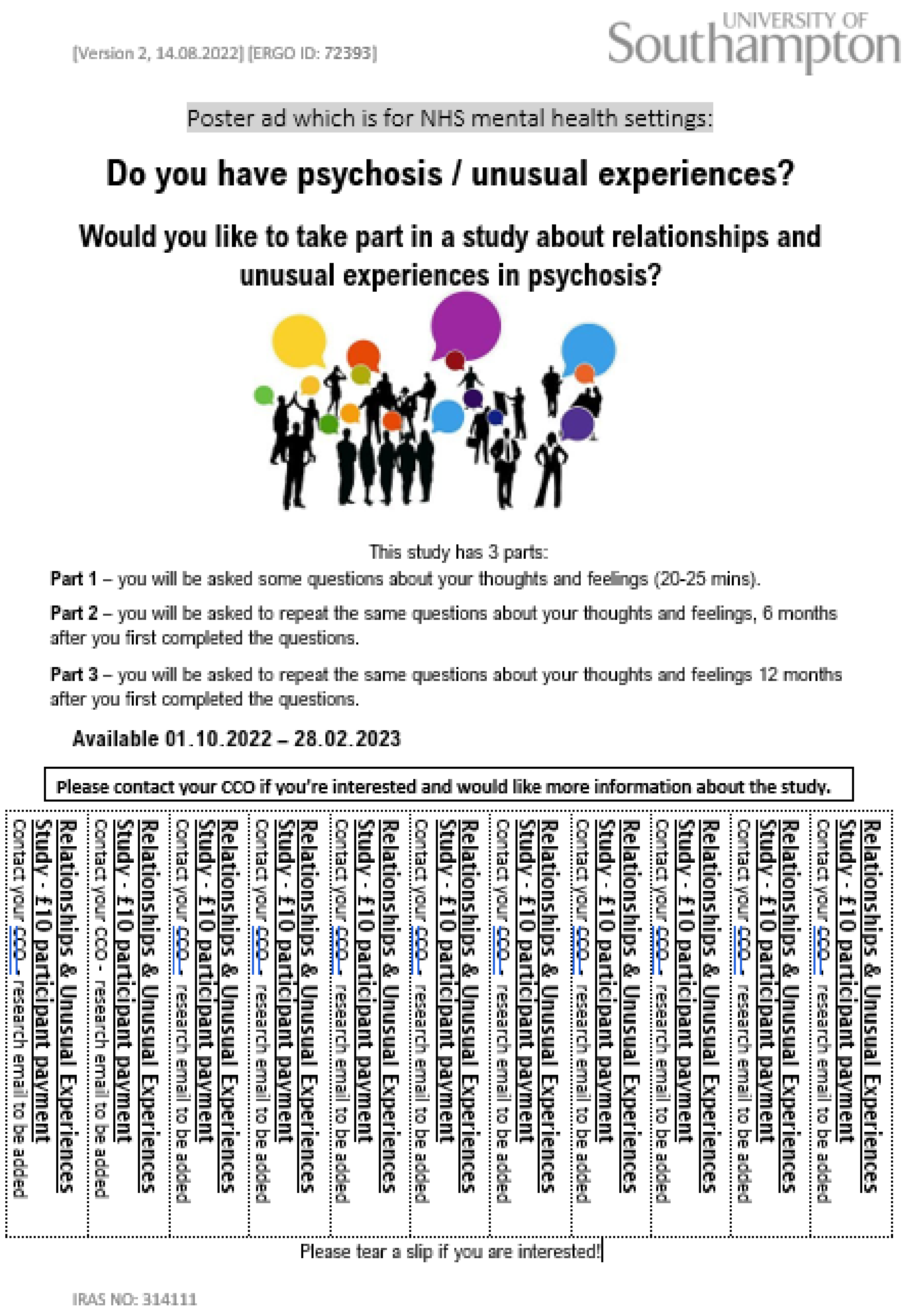
Appendix A

Analytical Theme & Description	Descriptive Themes	Codes
		·Sense of relief ·Continued support ·Consistent & Understanding team ·Professional skillset & knowledge provides support & guidance ·Friends as confidants ·Sharing similar experiences ·Lack of familial support ·Lack of familial support locally ·Loss of strong service user and staff relationships due to staff turnover ·Reiterating prior mental health experiences negatively affecting wellbeing
	Practical Support: Examples which discuss the role of an individual's family or support network and their role in providing practical support during the initial onset of psychosis and accessing of services.	·Offering practical support ·Family & friends notice change first ·Proactive family system ·Family supporting engagement ·Parents as catalysts for help-seeking ·Maintenance of visa status ·Financial requirements of healthcare ·Ease of Access
	Choice & Power: Discussions of how choice and power can be influential in whether an individual initially accesses support and remains engaged with EIP services. Any actions or discussions which highlight the factors that can impact whether an individual feels care is collaborative.	·Empowerment ·Disempowerment ·Competing priorities influence access ·Opportunity for patient voice to be heard ·Opportunity to tell their story ·Different patient and professional perspectives ·Not being heard ·Patient integrity questioned ·Opportunity to develop own understanding of difficulties

Appendix A

Note. 1 = Bay et al., 2016; 2 = Cowan et al., (2020); 3 = Harris (2016); 4 = Islam et al., 2015; 5 = Jansen et al., 2015; 6 = Jansen et al., (2018); 7 = Lee et al., (2016); (A) = Author quote

Appendix B Study Advert - NHS Recruitment pathway



[Version 2, 14.08.2022] [ERGO ID: 72393]

UNIVERSITY OF Southampton

Poster ad which is for NHS mental health settings:

Do you have psychosis / unusual experiences?

Would you like to take part in a study about relationships and unusual experiences in psychosis?

This study has 3 parts:

Part 1 – you will be asked some questions about your thoughts and feelings (20-25 mins).

Part 2 – you will be asked to repeat the same questions about your thoughts and feelings, 6 months after you first completed the questions.

Part 3 – you will be asked to repeat the same questions about your thoughts and feelings 12 months after you first completed the questions.

Available 01.10.2022 – 28.02.2023

Please contact your CCO if you're interested and would like more information about the study.

Relationships & Unusual Experiences
Study - £10 participant payment
Contact your CCO - research email to be added

Relationships & Unusual Experiences
Study - £10 participant payment
Contact your CCO - research email to be added

Relationships & Unusual Experiences
Study - £10 participant payment
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Study - £10 participant payment
Contact your CCO - research email to be added

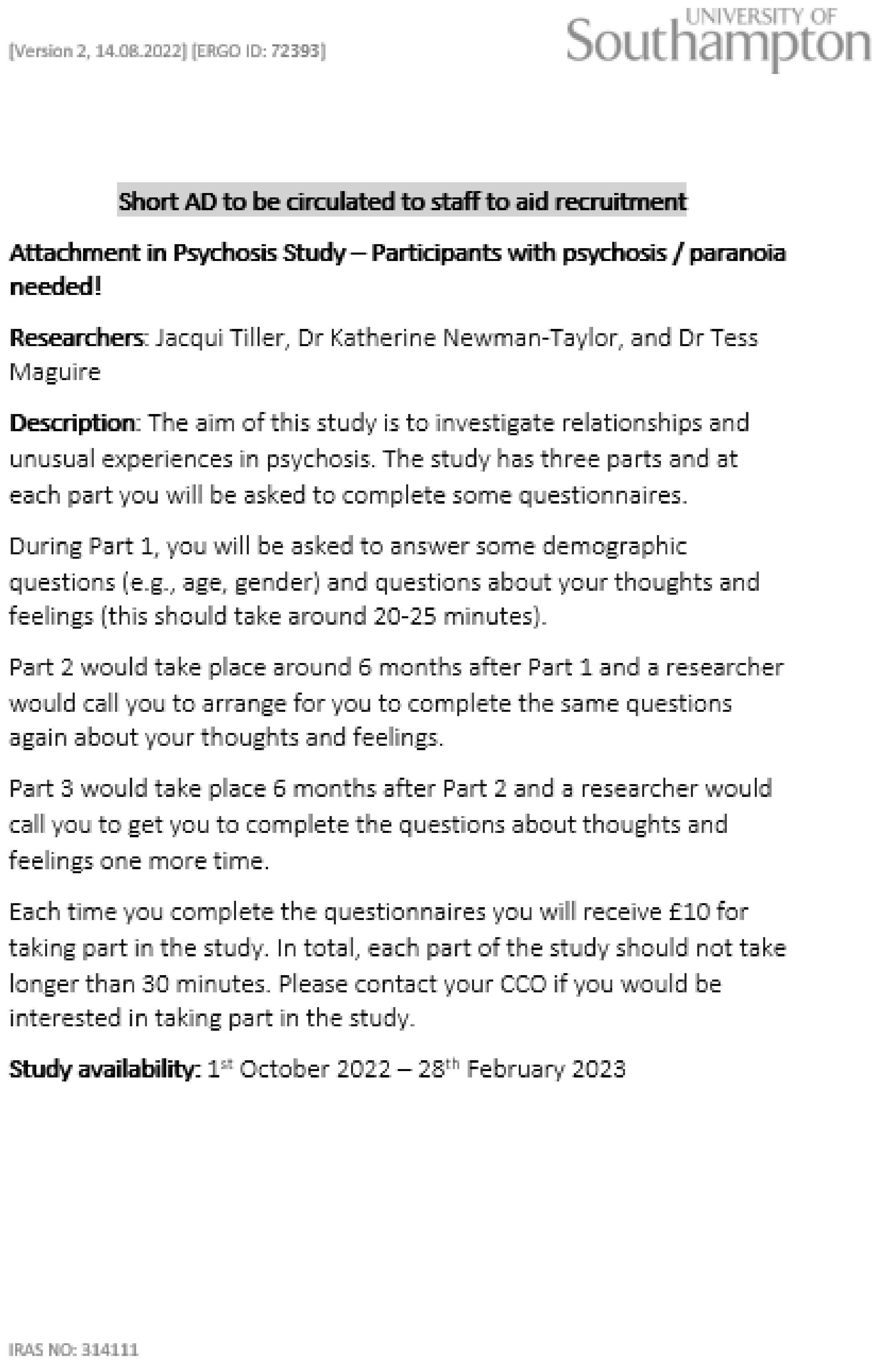
Relationships & Unusual Experiences
Study - £10 participant payment
Contact your CCO - research email to be added

Relationships & Unusual Experiences
Study - £10 participant payment
Contact your CCO - research email to be added

Please tear a slip if you are interested!

IRAS NO: 314111

Appendix B



[Version 2, 14.08.2022] [ERGO ID: 72393]

UNIVERSITY OF Southampton

Short AD to be circulated to staff to aid recruitment

Attachment in Psychosis Study – Participants with psychosis / paranoia needed!

Researchers: Jacqui Tiller, Dr Katherine Newman-Taylor, and Dr Tess Maguire

Description: The aim of this study is to investigate relationships and unusual experiences in psychosis. The study has three parts and at each part you will be asked to complete some questionnaires.

During Part 1, you will be asked to answer some demographic questions (e.g., age, gender) and questions about your thoughts and feelings (this should take around 20-25 minutes).

Part 2 would take place around 6 months after Part 1 and a researcher would call you to arrange for you to complete the same questions again about your thoughts and feelings.

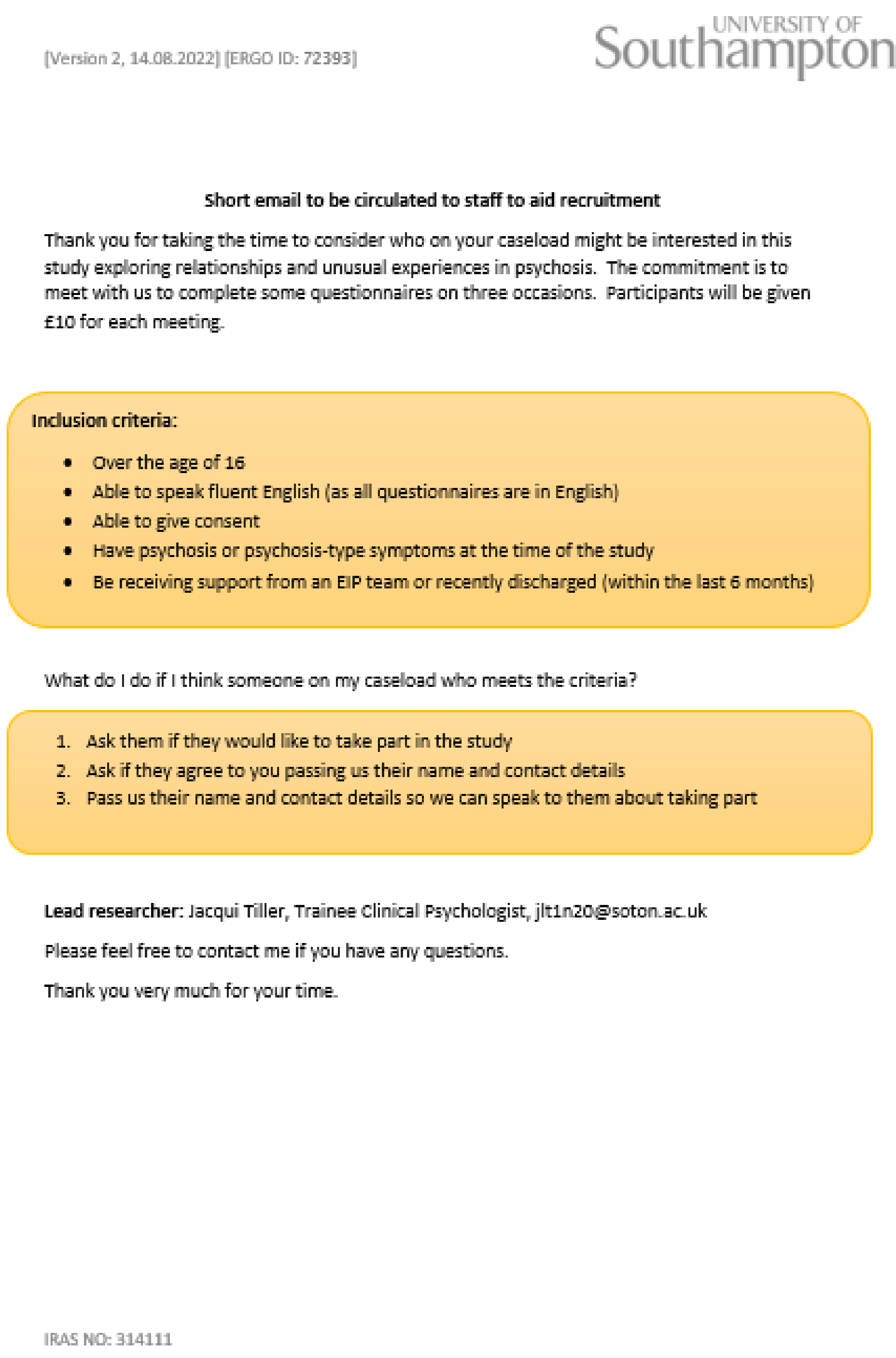
Part 3 would take place 6 months after Part 2 and a researcher would call you to get you to complete the questions about thoughts and feelings one more time.

Each time you complete the questionnaires you will receive £10 for taking part in the study. In total, each part of the study should not take longer than 30 minutes. Please contact your CCO if you would be interested in taking part in the study.

Study availability: 1st October 2022 – 28th February 2023

IRAS NO: 314111

Appendix B



[Version 2, 14.08.2022] [ERGO ID: 72393]

Short email to be circulated to staff to aid recruitment

Thank you for taking the time to consider who on your caseload might be interested in this study exploring relationships and unusual experiences in psychosis. The commitment is to meet with us to complete some questionnaires on three occasions. Participants will be given £10 for each meeting.

Inclusion criteria:

- Over the age of 16
- Able to speak fluent English (as all questionnaires are in English)
- Able to give consent
- Have psychosis or psychosis-type symptoms at the time of the study
- Be receiving support from an EIP team or recently discharged (within the last 6 months)

What do I do if I think someone on my caseload who meets the criteria?

1. Ask them if they would like to take part in the study
2. Ask if they agree to you passing us their name and contact details
3. Pass us their name and contact details so we can speak to them about taking part

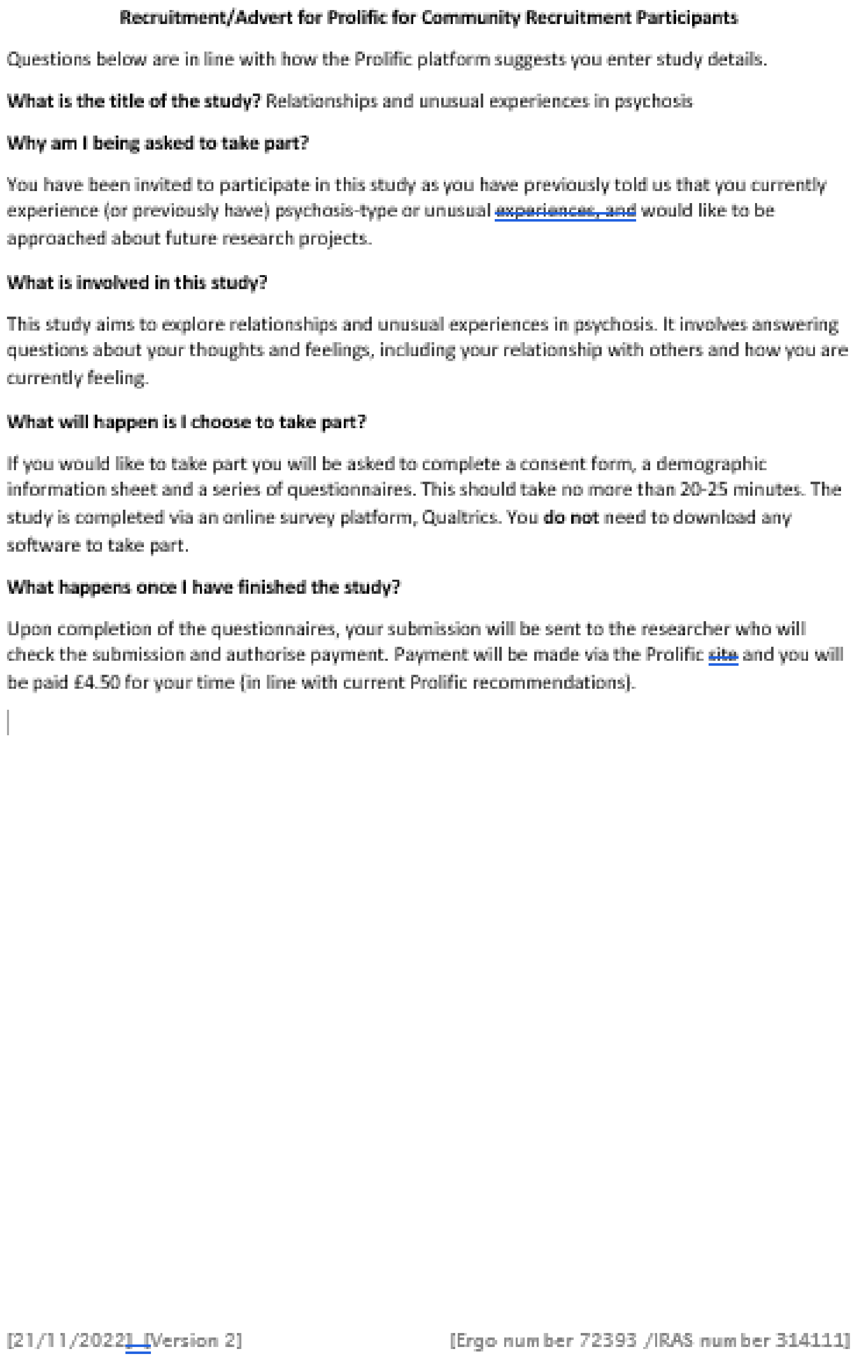
Lead researcher: Jacqui Tiller, Trainee Clinical Psychologist, jlt1n20@soton.ac.uk

Please feel free to contact me if you have any questions.

Thank you very much for your time.

IRAS NO: 314111

Appendix C Study Advert - Community Recruitment pathway



Recruitment/Advert for Prolific for Community Recruitment Participants

Questions below are in line with how the Prolific platform suggests you enter study details.

What is the title of the study? Relationships and unusual experiences in psychosis

Why am I being asked to take part?

You have been invited to participate in this study as you have previously told us that you currently experience (or previously have) psychosis-type or unusual experiences, and would like to be approached about future research projects.

What is involved in this study?

This study aims to explore relationships and unusual experiences in psychosis. It involves answering questions about your thoughts and feelings, including your relationship with others and how you are currently feeling.

What will happen is I choose to take part?

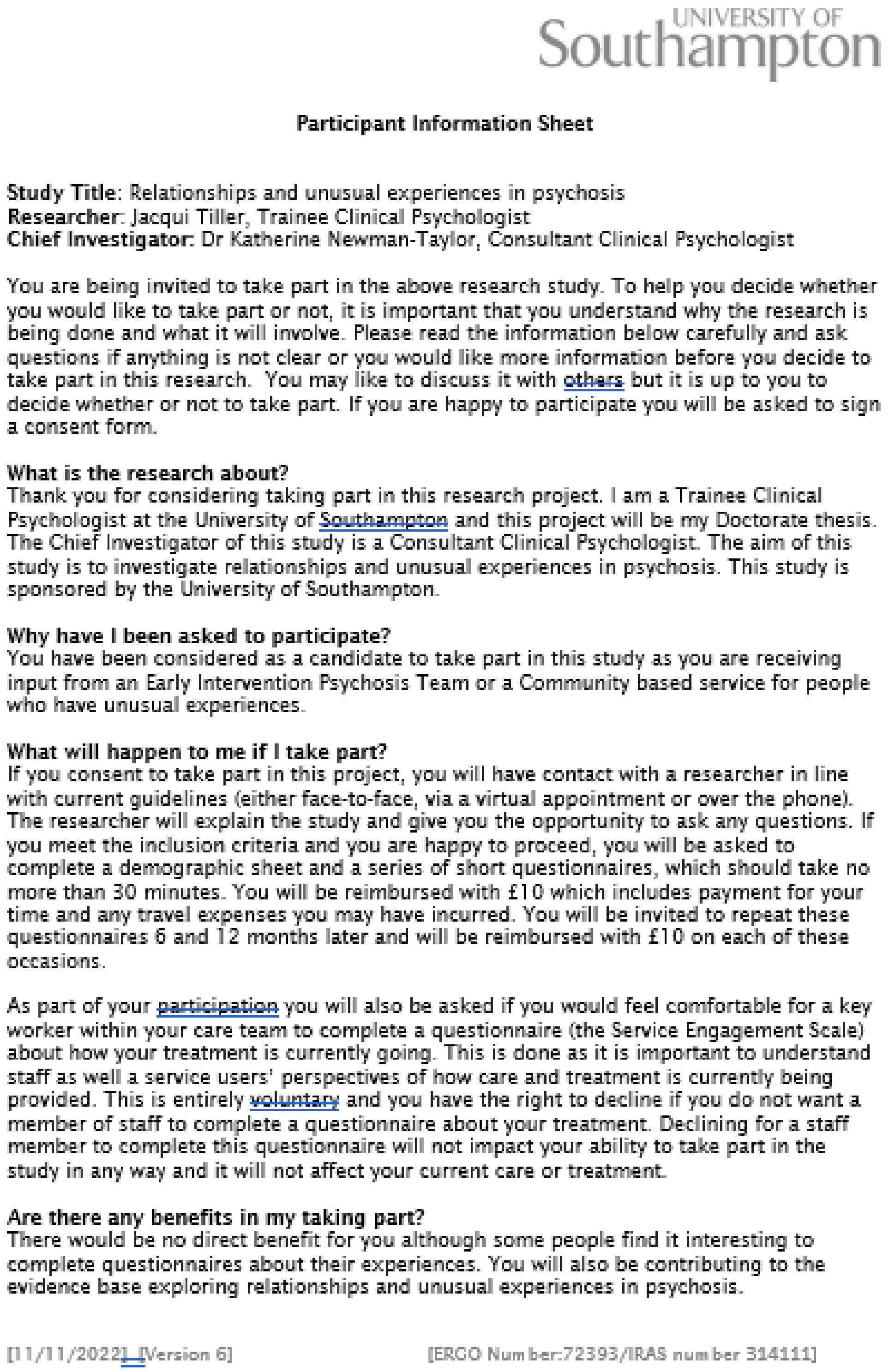
If you would like to take part you will be asked to complete a consent form, a demographic information sheet and a series of questionnaires. This should take no more than 20-25 minutes. The study is completed via an online survey platform, Qualtrics. You **do not** need to download any software to take part.

What happens once I have finished the study?

Upon completion of the questionnaires, your submission will be sent to the researcher who will check the submission and authorise payment. Payment will be made via the Prolific site and you will be paid £4.50 for your time (in line with current Prolific recommendations).

[21/11/2022] [Version 2] [Ergo number 72393 /IRAS number 314111]

Appendix D Information sheet - NHS Recruitment pathway



UNIVERSITY OF Southampton

Participant Information Sheet

Study Title: Relationships and unusual experiences in psychosis
Researcher: Jacqui Tiller, Trainee Clinical Psychologist
Chief Investigator: Dr Katherine Newman-Taylor, Consultant Clinical Psychologist

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?
Thank you for considering taking part in this research project. I am a Trainee Clinical Psychologist at the University of Southampton and this project will be my Doctorate thesis. The Chief Investigator of this study is a Consultant Clinical Psychologist. The aim of this study is to investigate relationships and unusual experiences in psychosis. This study is sponsored by the University of Southampton.

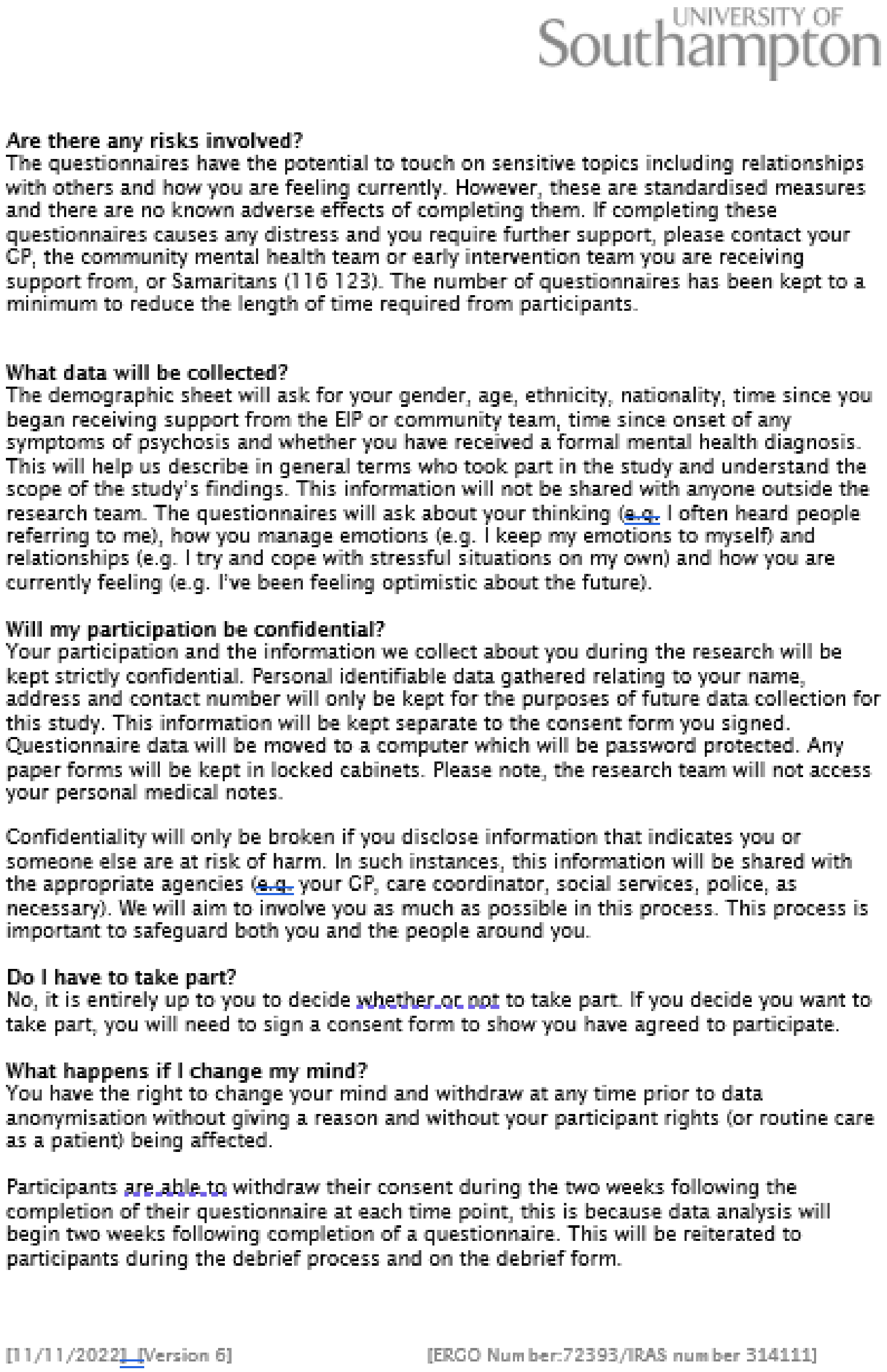
Why have I been asked to participate?
You have been considered as a candidate to take part in this study as you are receiving input from an Early Intervention Psychosis Team or a Community based service for people who have unusual experiences.

What will happen to me if I take part?
If you consent to take part in this project, you will have contact with a researcher in line with current guidelines (either face-to-face, via a virtual appointment or over the phone). The researcher will explain the study and give you the opportunity to ask any questions. If you meet the inclusion criteria and you are happy to proceed, you will be asked to complete a demographic sheet and a series of short questionnaires, which should take no more than 30 minutes. You will be reimbursed with £10 which includes payment for your time and any travel expenses you may have incurred. You will be invited to repeat these questionnaires 6 and 12 months later and will be reimbursed with £10 on each of these occasions.

As part of your participation you will also be asked if you would feel comfortable for a key worker within your care team to complete a questionnaire (the Service Engagement Scale) about how your treatment is currently going. This is done as it is important to understand staff as well a service users' perspectives of how care and treatment is currently being provided. This is entirely voluntary and you have the right to decline if you do not want a member of staff to complete a questionnaire about your treatment. Declining for a staff member to complete this questionnaire will not impact your ability to take part in the study in any way and it will not affect your current care or treatment.

Are there any benefits in my taking part?
There would be no direct benefit for you although some people find it interesting to complete questionnaires about their experiences. You will also be contributing to the evidence base exploring relationships and unusual experiences in psychosis.

[11/11/2022] [Version 6] [ERGO Number:72393/IRAS number 314111]



UNIVERSITY OF Southampton

Are there any risks involved?
The questionnaires have the potential to touch on sensitive topics including relationships with others and how you are feeling currently. However, these are standardised measures and there are no known adverse effects of completing them. If completing these questionnaires causes any distress and you require further support, please contact your GP, the community mental health team or early intervention team you are receiving support from, or Samaritans (116 123). The number of questionnaires has been kept to a minimum to reduce the length of time required from participants.

What data will be collected?
The demographic sheet will ask for your gender, age, ethnicity, nationality, time since you began receiving support from the EIP or community team, time since onset of any symptoms of psychosis and whether you have received a formal mental health diagnosis. This will help us describe in general terms who took part in the study and understand the scope of the study's findings. This information will not be shared with anyone outside the research team. The questionnaires will ask about your thinking (e.g. I often heard people referring to me), how you manage emotions (e.g. I keep my emotions to myself) and relationships (e.g. I try and cope with stressful situations on my own) and how you are currently feeling (e.g. I've been feeling optimistic about the future).

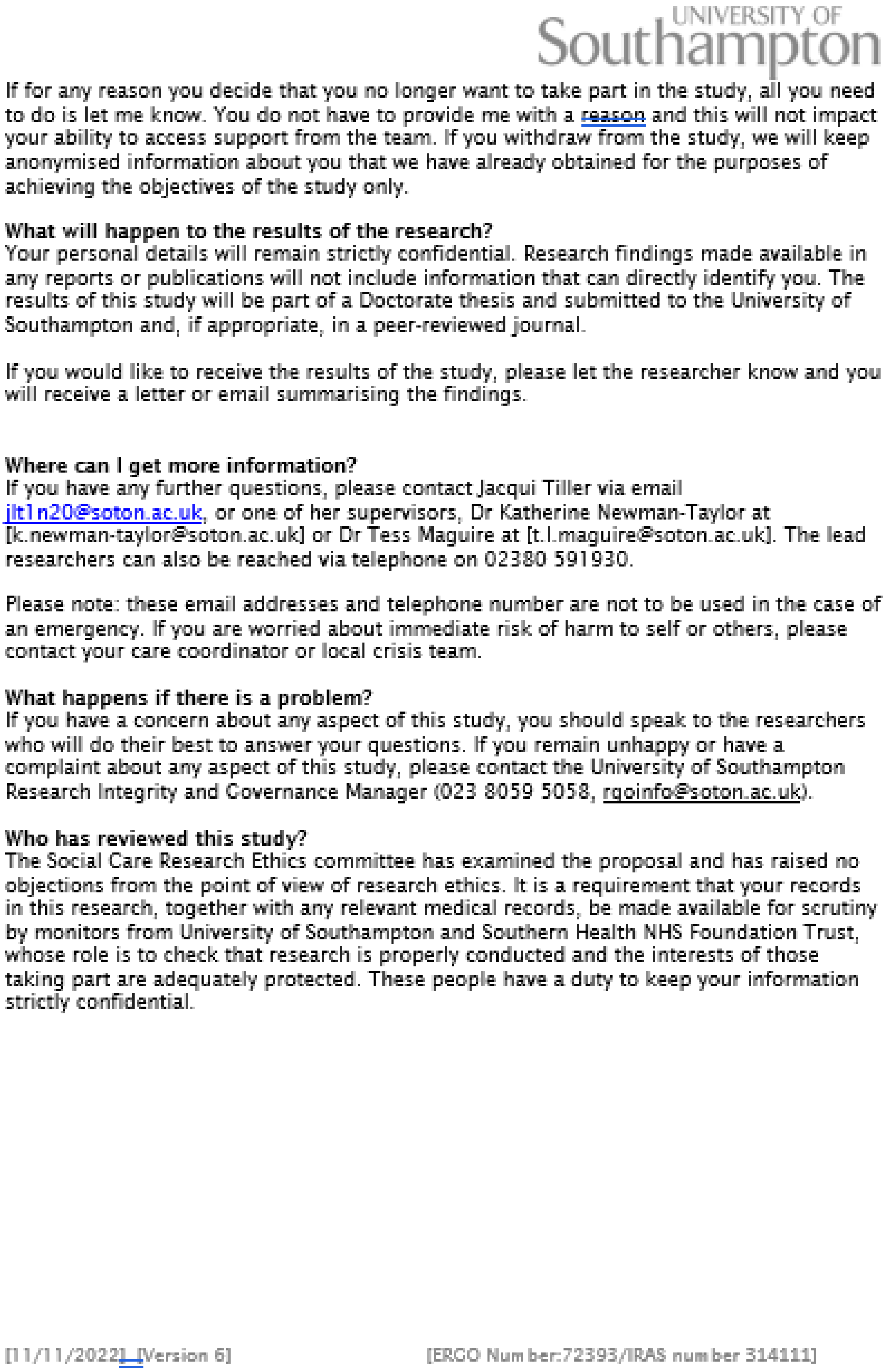
Will my participation be confidential?
Your participation and the information we collect about you during the research will be kept strictly confidential. Personal identifiable data gathered relating to your name, address and contact number will only be kept for the purposes of future data collection for this study. This information will be kept separate to the consent form you signed. Questionnaire data will be moved to a computer which will be password protected. Any paper forms will be kept in locked cabinets. Please note, the research team will not access your personal medical notes.

Confidentiality will only be broken if you disclose information that indicates you or someone else are at risk of harm. In such instances, this information will be shared with the appropriate agencies (e.g. your GP, care coordinator, social services, police, as necessary). We will aim to involve you as much as possible in this process. This process is important to safeguard both you and the people around you.

Do I have to take part?
No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to sign a consent form to show you have agreed to participate.

What happens if I change my mind?
You have the right to change your mind and withdraw at any time prior to data anonymisation without giving a reason and without your participant rights (or routine care as a patient) being affected.

Participants are able to withdraw their consent during the two weeks following the completion of their questionnaire at each time point, this is because data analysis will begin two weeks following completion of a questionnaire. This will be reiterated to participants during the debrief process and on the debrief form.



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If for any reason you decide that you no longer want to take part in the study, all you need to do is let me know. You do not have to provide me with a reason and this will not impact your ability to access support from the team. If you withdraw from the study, we will keep anonymised information about you that we have already obtained for the purposes of achieving the objectives of the study only.

What will happen to the results of the research?
Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you. The results of this study will be part of a Doctorate thesis and submitted to the University of Southampton and, if appropriate, in a peer-reviewed journal.

If you would like to receive the results of the study, please let the researcher know and you will receive a letter or email summarising the findings.

Where can I get more information?
If you have any further questions, please contact Jacqui Tiller via email jlt1n20@soton.ac.uk, or one of her supervisors, Dr Katherine Newman-Taylor at [k.newman-taylor@soton.ac.uk] or Dr Tess Maguire at [t.l.maguire@soton.ac.uk]. The lead researchers can also be reached via telephone on 02380 591930.

Please note: these email addresses and telephone number are not to be used in the case of an emergency. If you are worried about immediate risk of harm to self or others, please contact your care coordinator or local crisis team.

What happens if there is a problem?
If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions. If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Who has reviewed this study?
The Social Care Research Ethics committee has examined the proposal and has raised no objections from the point of view of research ethics. It is a requirement that your records in this research, together with any relevant medical records, be made available for scrutiny by monitors from University of Southampton and Southern Health NHS Foundation Trust, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected. These people have a duty to keep your information strictly confidential.

[11/11/2022] [Version 6] [ERGO Number:72393/IRAS number 314111]

UNIVERSITY OF Southampton

Data Protection Privacy Notice
The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies (Research Data Management Policy & Data Protection Policy) in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

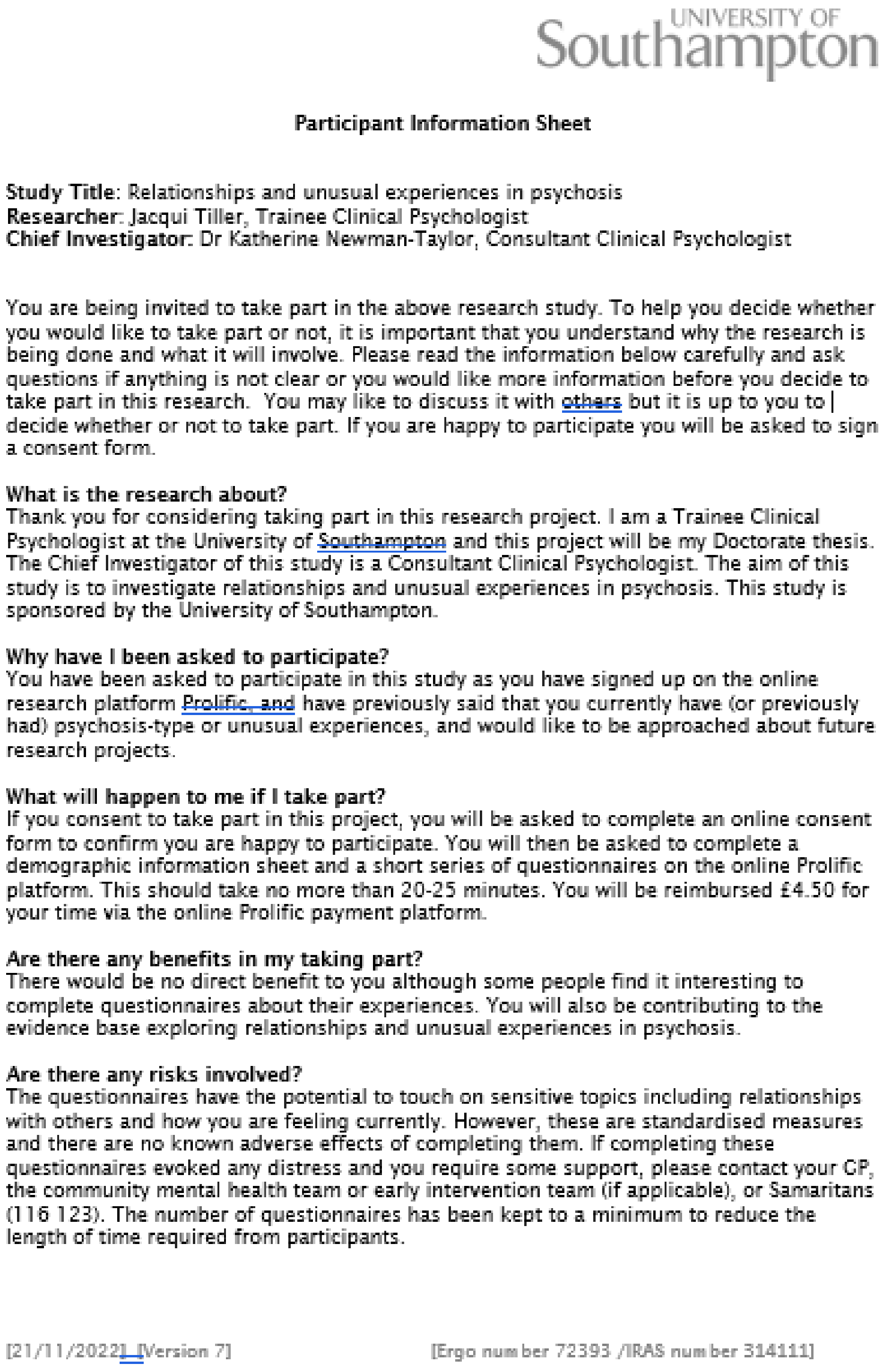
For the purposes of data protection law, the University of Southampton is responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you (consent forms) for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you for taking the time to read the information sheet and considering taking part in the research.

Appendix E Information sheet - Community Recruitment pathway



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Participant Information Sheet

Study Title: Relationships and unusual experiences in psychosis
Researcher: Jacqui Tiller, Trainee Clinical Psychologist
Chief Investigator: Dr Katherine Newman-Taylor, Consultant Clinical Psychologist

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?
Thank you for considering taking part in this research project. I am a Trainee Clinical Psychologist at the University of Southampton and this project will be my Doctorate thesis. The Chief Investigator of this study is a Consultant Clinical Psychologist. The aim of this study is to investigate relationships and unusual experiences in psychosis. This study is sponsored by the University of Southampton.

Why have I been asked to participate?
You have been asked to participate in this study as you have signed up on the online research platform Prolific, and have previously said that you currently have (or previously had) psychosis-type or unusual experiences, and would like to be approached about future research projects.

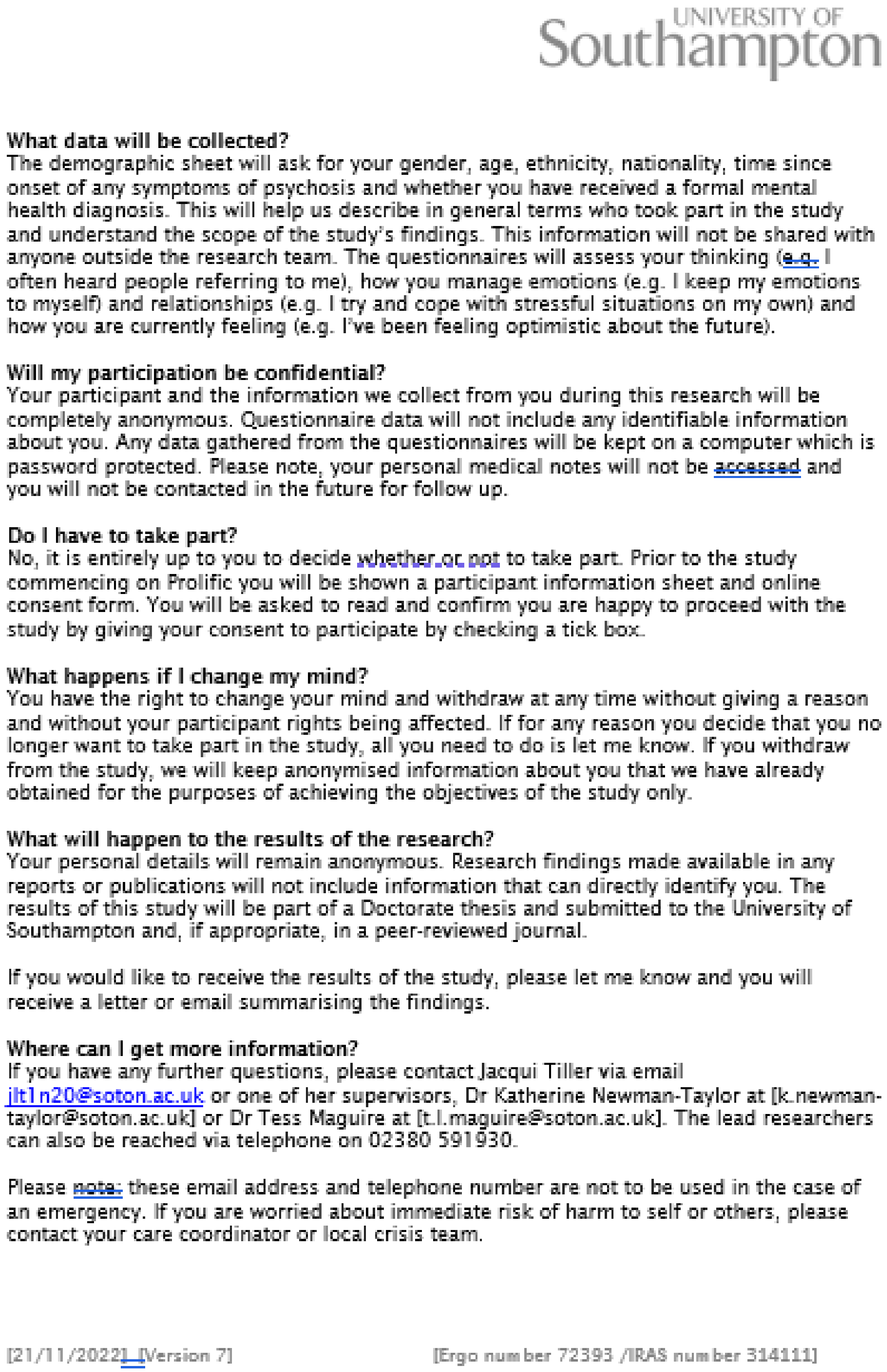
What will happen to me if I take part?
If you consent to take part in this project, you will be asked to complete an online consent form to confirm you are happy to participate. You will then be asked to complete a demographic information sheet and a short series of questionnaires on the online Prolific platform. This should take no more than 20-25 minutes. You will be reimbursed £4.50 for your time via the online Prolific payment platform.

Are there any benefits in my taking part?
There would be no direct benefit to you although some people find it interesting to complete questionnaires about their experiences. You will also be contributing to the evidence base exploring relationships and unusual experiences in psychosis.

Are there any risks involved?
The questionnaires have the potential to touch on sensitive topics including relationships with others and how you are feeling currently. However, these are standardised measures and there are no known adverse effects of completing them. If completing these questionnaires evoked any distress and you require some support, please contact your GP, the community mental health team or early intervention team (if applicable), or Samaritans (116 123). The number of questionnaires has been kept to a minimum to reduce the length of time required from participants.

[21/11/2022] [Version 7] [Ergo number 72393 /IRAS number 314111]

Appendix E



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Southampton

What data will be collected?
The demographic sheet will ask for your gender, age, ethnicity, nationality, time since onset of any symptoms of psychosis and whether you have received a formal mental health diagnosis. This will help us describe in general terms who took part in the study and understand the scope of the study's findings. This information will not be shared with anyone outside the research team. The questionnaires will assess your thinking (e.g. I often heard people referring to me), how you manage emotions (e.g. I keep my emotions to myself) and relationships (e.g. I try and cope with stressful situations on my own) and how you are currently feeling (e.g. I've been feeling optimistic about the future).

Will my participation be confidential?
Your participant and the information we collect from you during this research will be completely anonymous. Questionnaire data will not include any identifiable information about you. Any data gathered from the questionnaires will be kept on a computer which is password protected. Please note, your personal medical notes will not be accessed and you will not be contacted in the future for follow up.

Do I have to take part?
No, it is entirely up to you to decide whether or not to take part. Prior to the study commencing on Prolific you will be shown a participant information sheet and online consent form. You will be asked to read and confirm you are happy to proceed with the study by giving your consent to participate by checking a tick box.

What happens if I change my mind?
You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights being affected. If for any reason you decide that you no longer want to take part in the study, all you need to do is let me know. If you withdraw from the study, we will keep anonymised information about you that we have already obtained for the purposes of achieving the objectives of the study only.

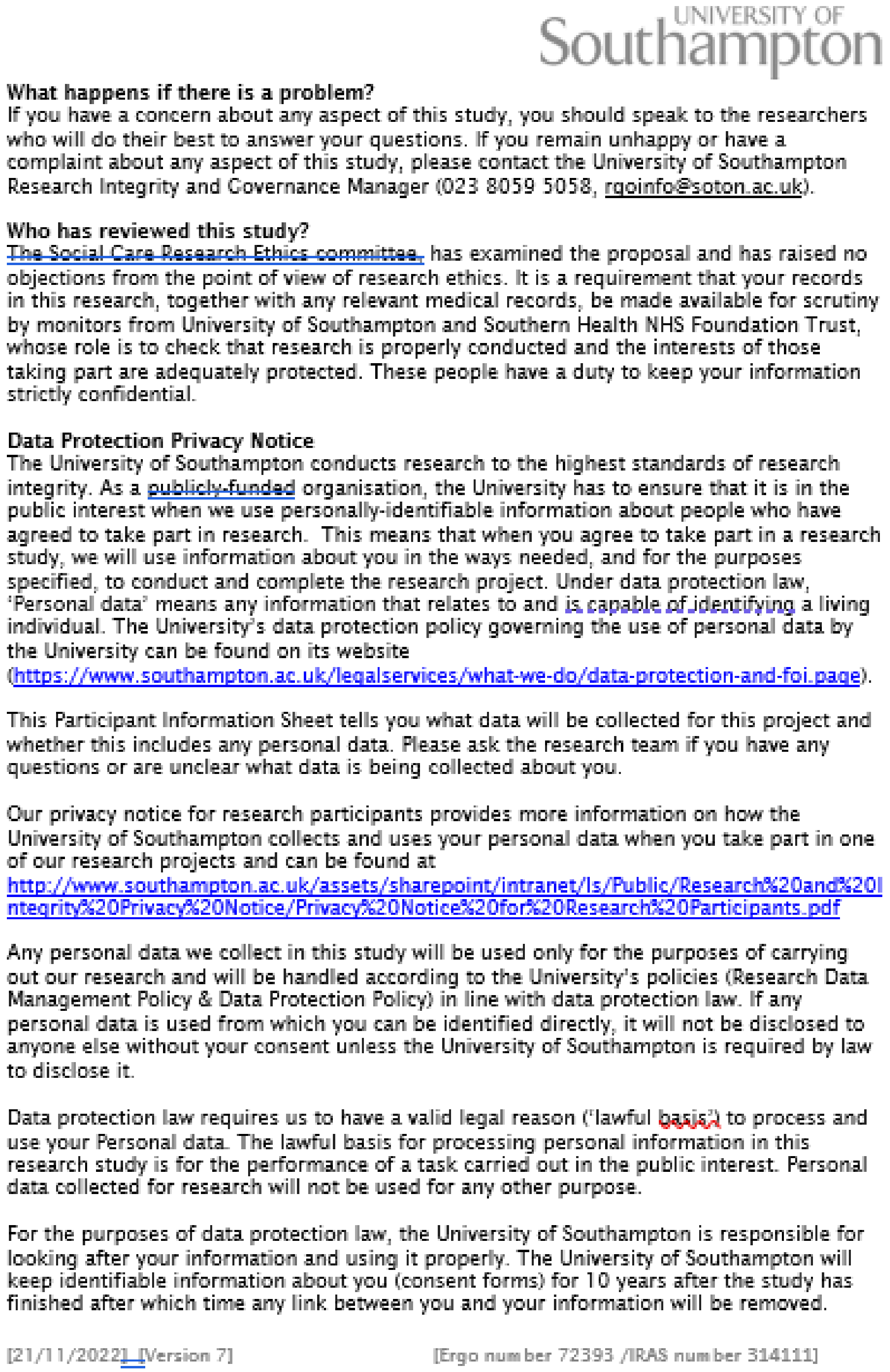
What will happen to the results of the research?
Your personal details will remain anonymous. Research findings made available in any reports or publications will not include information that can directly identify you. The results of this study will be part of a Doctorate thesis and submitted to the University of Southampton and, if appropriate, in a peer-reviewed journal.

If you would like to receive the results of the study, please let me know and you will receive a letter or email summarising the findings.

Where can I get more information?
If you have any further questions, please contact Jacqui Tiller via email jlt1n20@soton.ac.uk or one of her supervisors, Dr Katherine Newman-Taylor at [k.newman-taylor@soton.ac.uk] or Dr Tess Maguire at [t.l.maguire@soton.ac.uk]. The lead researchers can also be reached via telephone on 02380 591930.

Please note: these email address and telephone number are not to be used in the case of an emergency. If you are worried about immediate risk of harm to self or others, please contact your care coordinator or local crisis team.

[21/11/2022] [Version 7] [Ergo number 72393 /IRAS number 314111]



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What happens if there is a problem?
If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions. If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Who has reviewed this study?
~~The Social Care Research Ethics committee,~~ has examined the proposal and has raised no objections from the point of view of research ethics. It is a requirement that your records in this research, together with any relevant medical records, be made available for scrutiny by monitors from University of Southampton and Southern Health NHS Foundation Trust, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected. These people have a duty to keep your information strictly confidential.

Data Protection Privacy Notice
The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

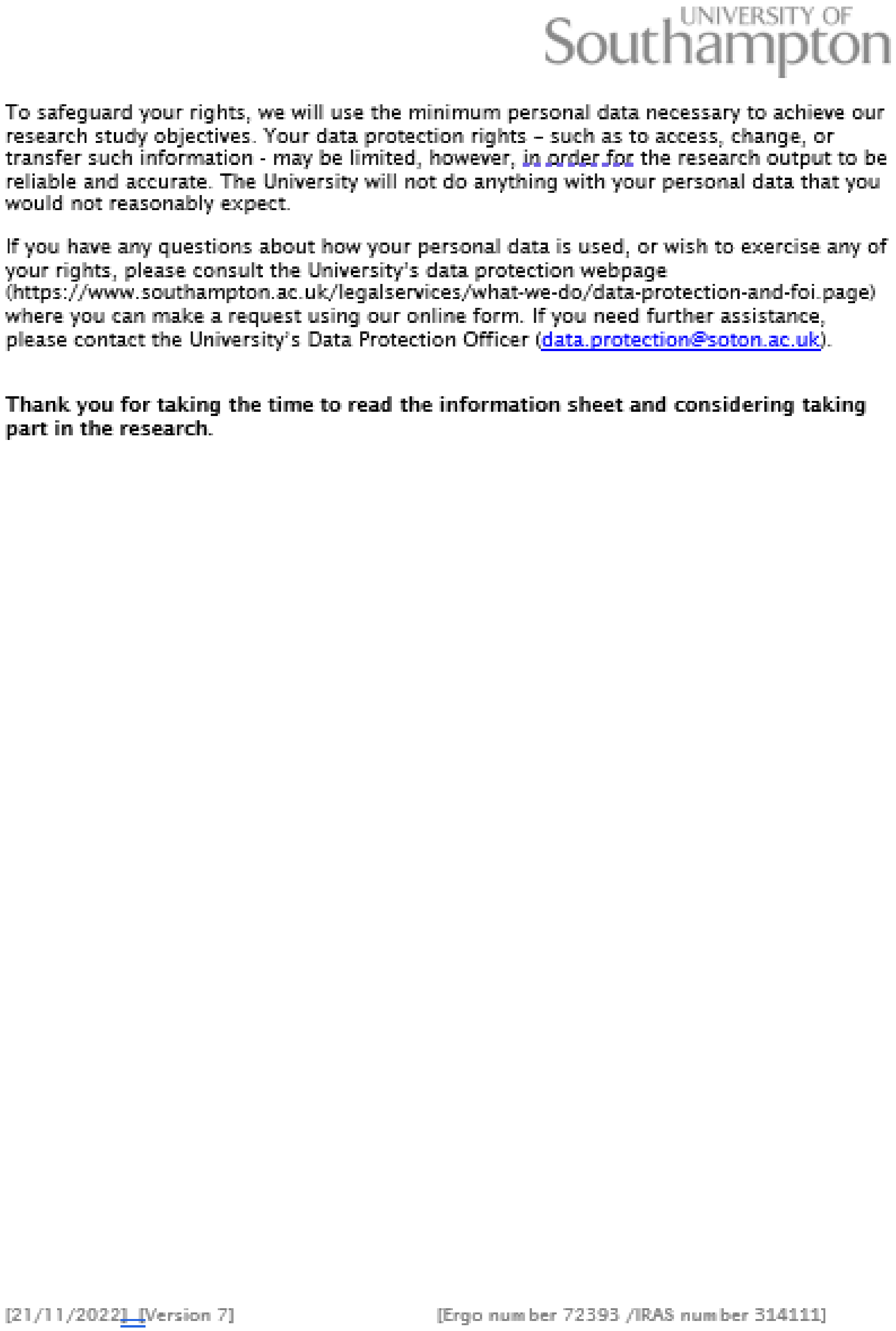
Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies (Research Data Management Policy & Data Protection Policy) in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you (consent forms) for 10 years after the study has finished after which time any link between you and your information will be removed.

[21/11/2022] [Version 7] [Ergo number 72393 /IRAS number 314111]



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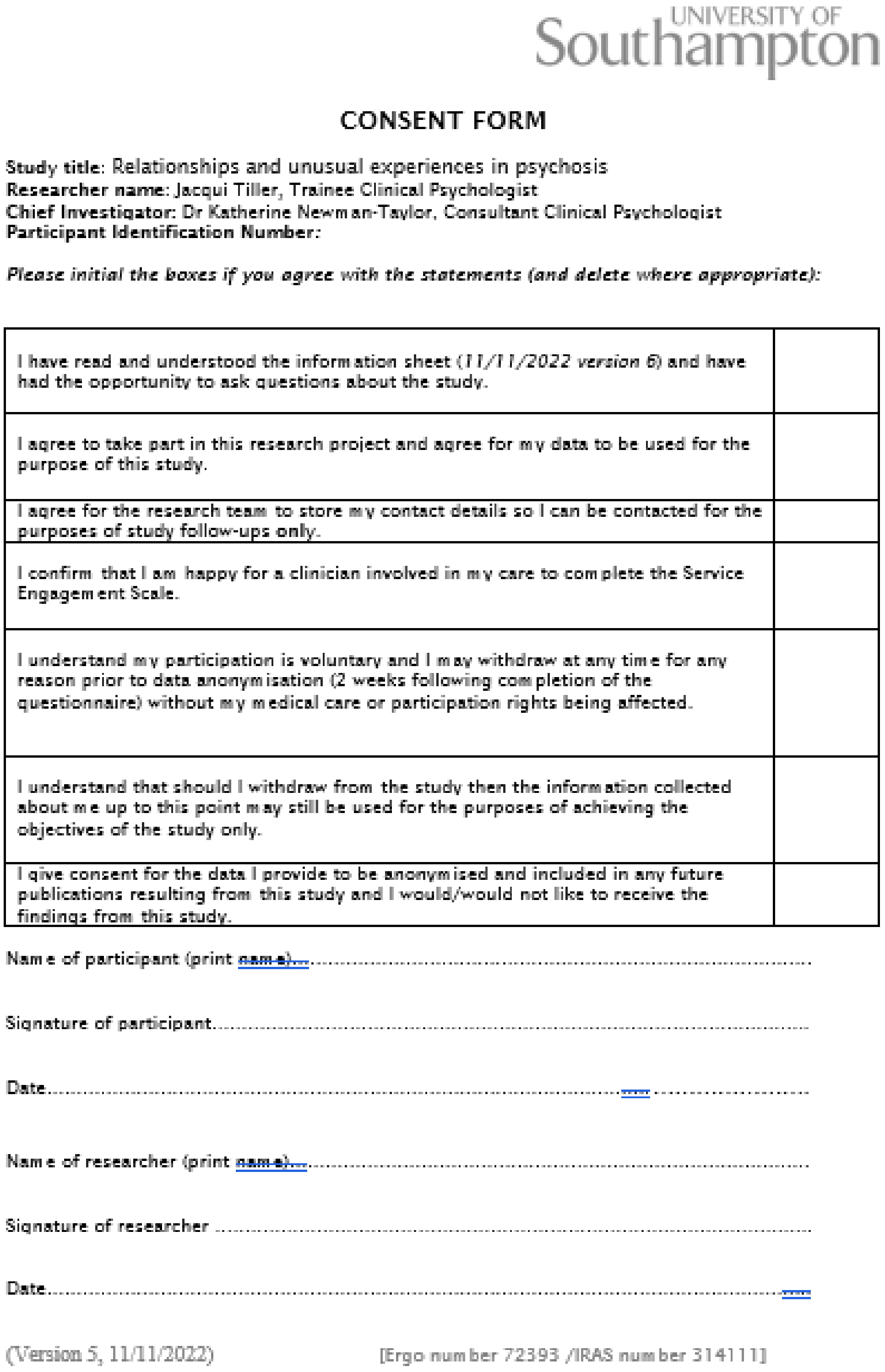
To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you for taking the time to read the information sheet and considering taking part in the research.

Appendix F Consent Form – NHS Recruitment pathway



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CONSENT FORM

Study title: Relationships and unusual experiences in psychosis
Researcher name: Jacqui Tiller, Trainee Clinical Psychologist
Chief Investigator: Dr Katherine Newman-Taylor, Consultant Clinical Psychologist
Participant Identification Number:

Please initial the boxes if you agree with the statements (and delete where appropriate):

I have read and understood the information sheet (*11/11/2022 version 6*) and have had the opportunity to ask questions about the study.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study.	
I agree for the research team to store my contact details so I can be contacted for the purposes of study follow-ups only.	
I confirm that I am happy for a clinician involved in my care to complete the Service Engagement Scale.	
I understand my participation is voluntary and I may withdraw at any time for any reason prior to data anonymisation (2 weeks following completion of the questionnaire) without my medical care or participation rights being affected.	
I understand that should I withdraw from the study then the information collected about me up to this point may still be used for the purposes of achieving the objectives of the study only.	
I give consent for the data I provide to be anonymised and included in any future publications resulting from this study and I would/would not like to receive the findings from this study.	

Name of participant (print ~~name)~~...

Signature of participant...

Date..

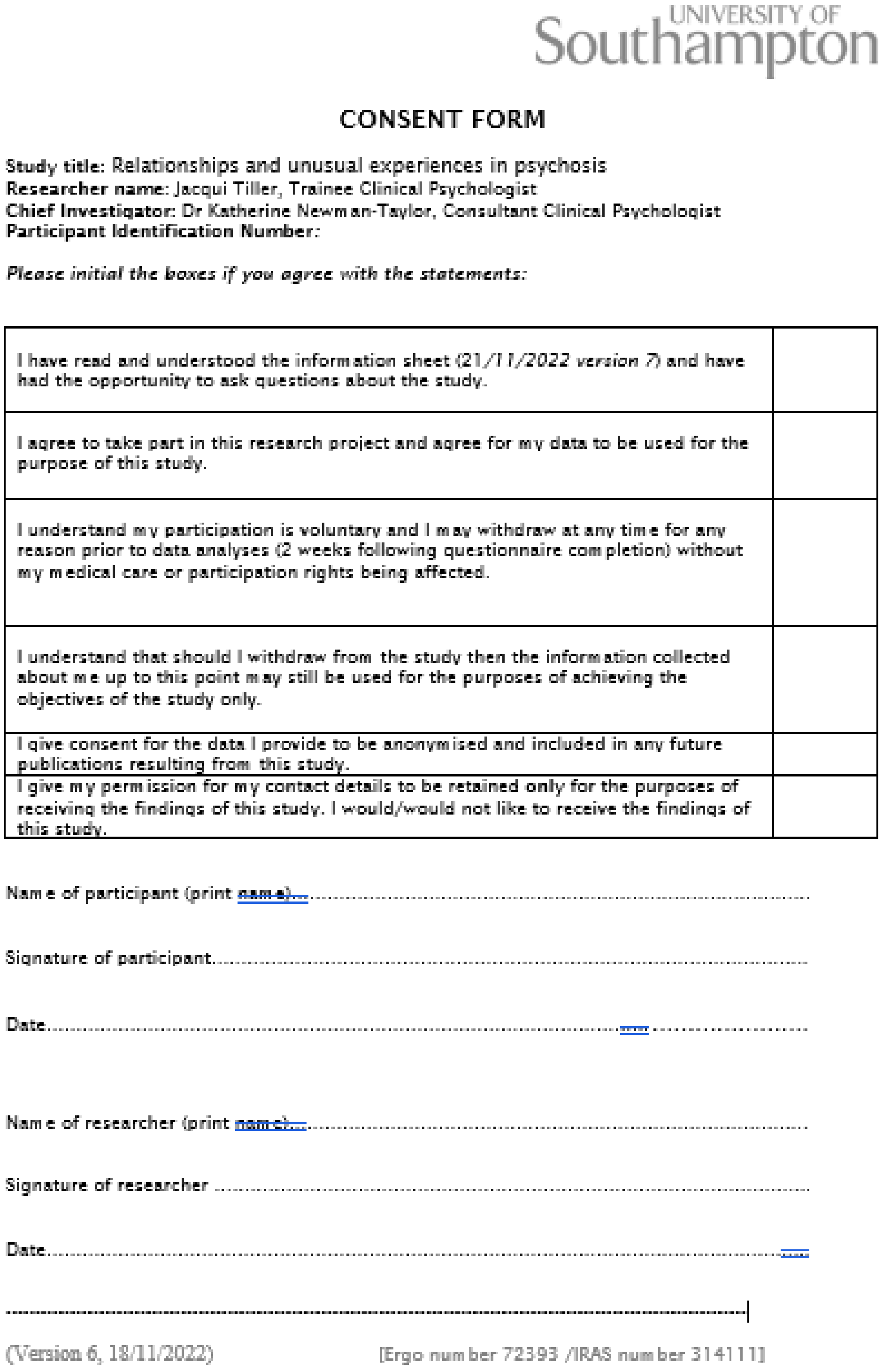
Name of researcher (print ~~name)~~..

Signature of researcher ....

Date..

(Version 5, 11/11/2022) [Ergo number 72393 /IRAS number 314111]

Appendix G Consent Form – Community Recruitment pathway



UNIVERSITY OF Southampton

CONSENT FORM

Study title: Relationships and unusual experiences in psychosis
Researcher name: Jacqui Tiller, Trainee Clinical Psychologist
Chief Investigator: Dr Katherine Newman-Taylor, Consultant Clinical Psychologist
Participant Identification Number:

Please initial the boxes if you agree with the statements:

I have read and understood the information sheet (*21/11/2022 version 7*) and have had the opportunity to ask questions about the study.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study.	
I understand my participation is voluntary and I may withdraw at any time for any reason prior to data analyses (2 weeks following questionnaire completion) without my medical care or participation rights being affected.	
I understand that should I withdraw from the study then the information collected about me up to this point may still be used for the purposes of achieving the objectives of the study only.	
I give consent for the data I provide to be anonymised and included in any future publications resulting from this study.	
I give my permission for my contact details to be retained only for the purposes of receiving the findings of this study. I would/would not like to receive the findings of this study.	

Name of participant (print name)..

Signature of participant...

Date..

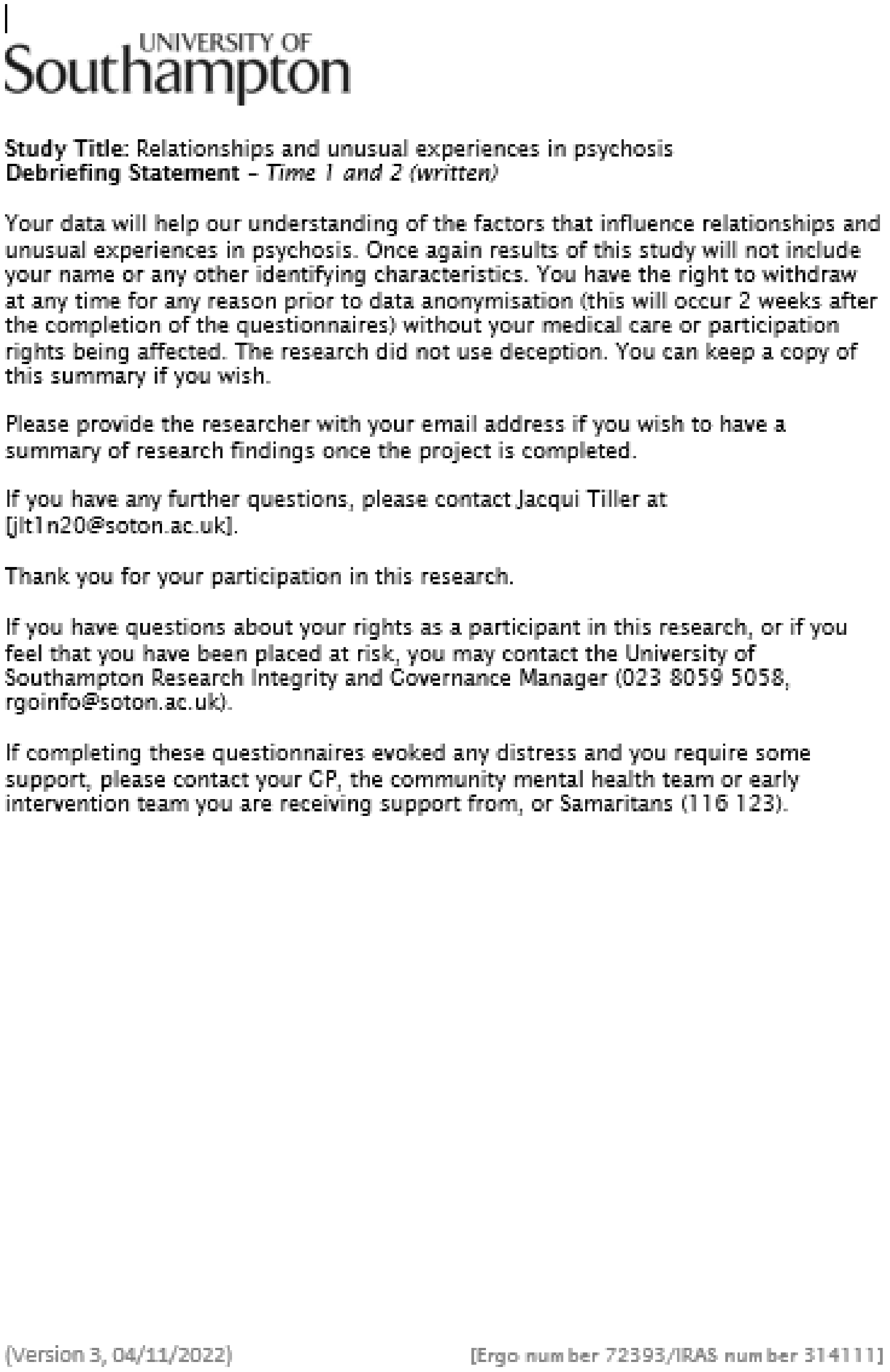
Name of researcher (print name)...

Signature of researcher ....

Date..

(Version 6, 18/11/2022) [Ergo number 72393 /IRAS number 314111]

Appendix H Debrief form - NHS Recruitment pathway



UNIVERSITY OF Southampton

Study Title: Relationships and unusual experiences in psychosis
Debriefing Statement – *Time 1 and 2 (written)*

Your data will help our understanding of the factors that influence relationships and unusual experiences in psychosis. Once again results of this study will not include your name or any other identifying characteristics. You have the right to withdraw at any time for any reason prior to data anonymisation (this will occur 2 weeks after the completion of the questionnaires) without your medical care or participation rights being affected. The research did not use deception. You can keep a copy of this summary if you wish.

Please provide the researcher with your email address if you wish to have a summary of research findings once the project is completed.

If you have any further questions, please contact Jacqui Tiller at [jlt1n20@soton.ac.uk].

Thank you for your participation in this research.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

If completing these questionnaires evoked any distress and you require some support, please contact your GP, the community mental health team or early intervention team you are receiving support from, or Samaritans (116 123).

(Version 3, 04/11/2022) [Ergo number 72393/IRAS number 314111]

Appendix I Debrief Form – Community Recruitment pathway

UNIVERSITY OF Southampton

Study title: Relationships and unusual experiences in psychosis
Debriefing Statement – Time 3 *(written)*

The aim of this research was to explore factors that influence relationships and unusual experiences in psychosis. It is expected that if people struggle in their relationships with others, they may also struggle to ask others or services for help, and this may in turn impact our wellbeing and how well we are feeling.

Your data will help our understanding of the factors that influence thoughts about being wary of others, which may in turn inform treatment options. Once again results of this study will not include your name or any other identifying characteristics. You have the right to withdraw at any time for any reason prior to data anonymisation (this will occur 2 weeks after the completion of the questionnaires) without your medical care or participation rights being affected. This research did not use deception. You can keep a copy of this summary if you wish. Please provide the researcher with your email address if you wish to have a summary of research findings once the project is completed.

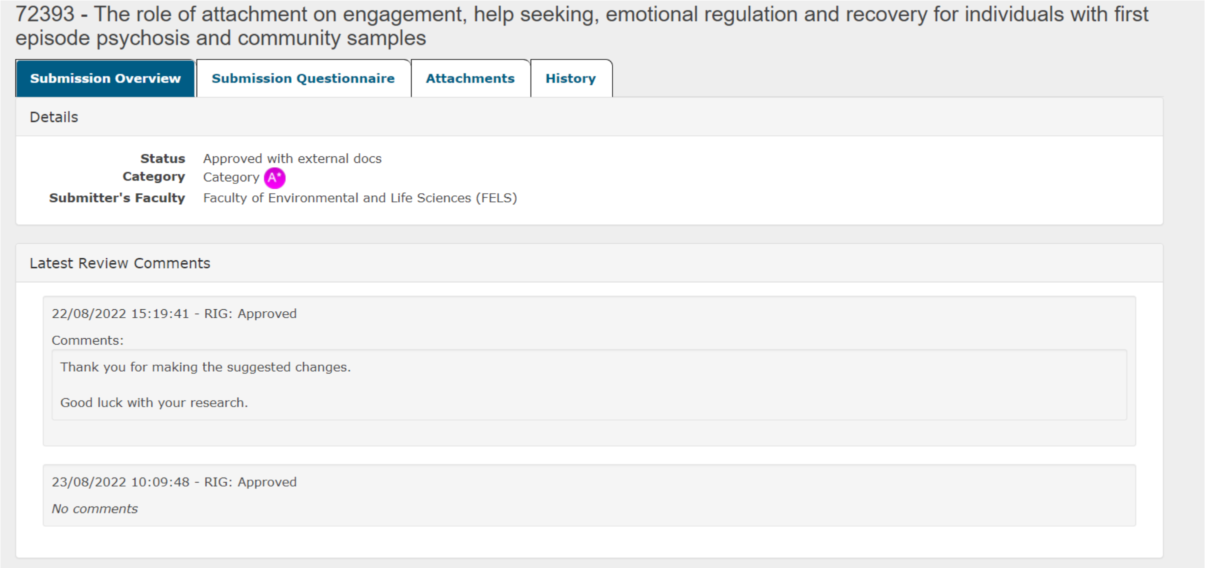
If you have any further questions, please contact Dr Katherine Newman-Taylor at [k.newman-taylor@soton.ac.uk] or Dr Tess Maguire at [t.l.maguire@soton.ac.uk].

Thank you for your participation in this research.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

If completing these questionnaires evoked any distress and you require some support, please contact your GP, the community mental health team or early intervention team you are receiving support from, or Samaritans (116 123).

Appendix J Ethical Approval



72393 - The role of attachment on engagement, help seeking, emotional regulation and recovery for individuals with first episode psychosis and community samples

Details

Status Approved with external docs
Category Category A*
Submitter's Faculty Faculty of Environmental and Life Sciences (FELS)

Latest Review Comments

22/08/2022 15:19:41 - RIG: Approved

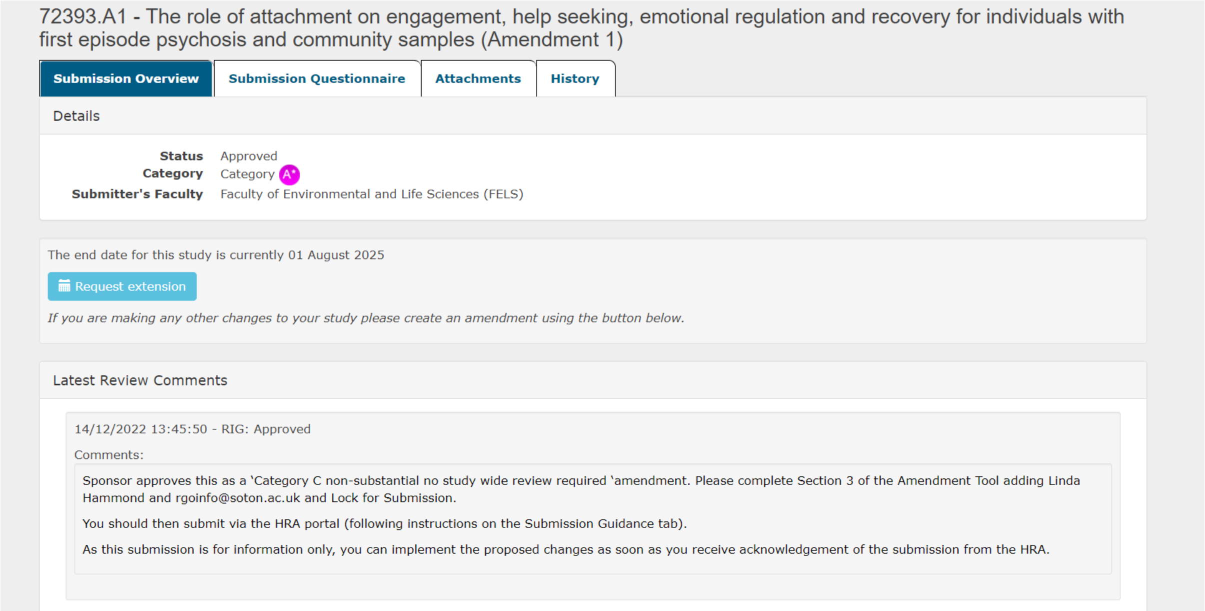
Comments:

Thank you for making the suggested changes.

Good luck with your research.

23/08/2022 10:09:48 - RIG: Approved

No comments



72393.A1 - The role of attachment on engagement, help seeking, emotional regulation and recovery for individuals with first episode psychosis and community samples (Amendment 1)

Details

Status Approved
Category Category A*
Submitter's Faculty Faculty of Environmental and Life Sciences (FELS)

The end date for this study is currently 01 August 2025

If you are making any other changes to your study please create an amendment using the button below.

Latest Review Comments

14/12/2022 13:45:50 - RIG: Approved

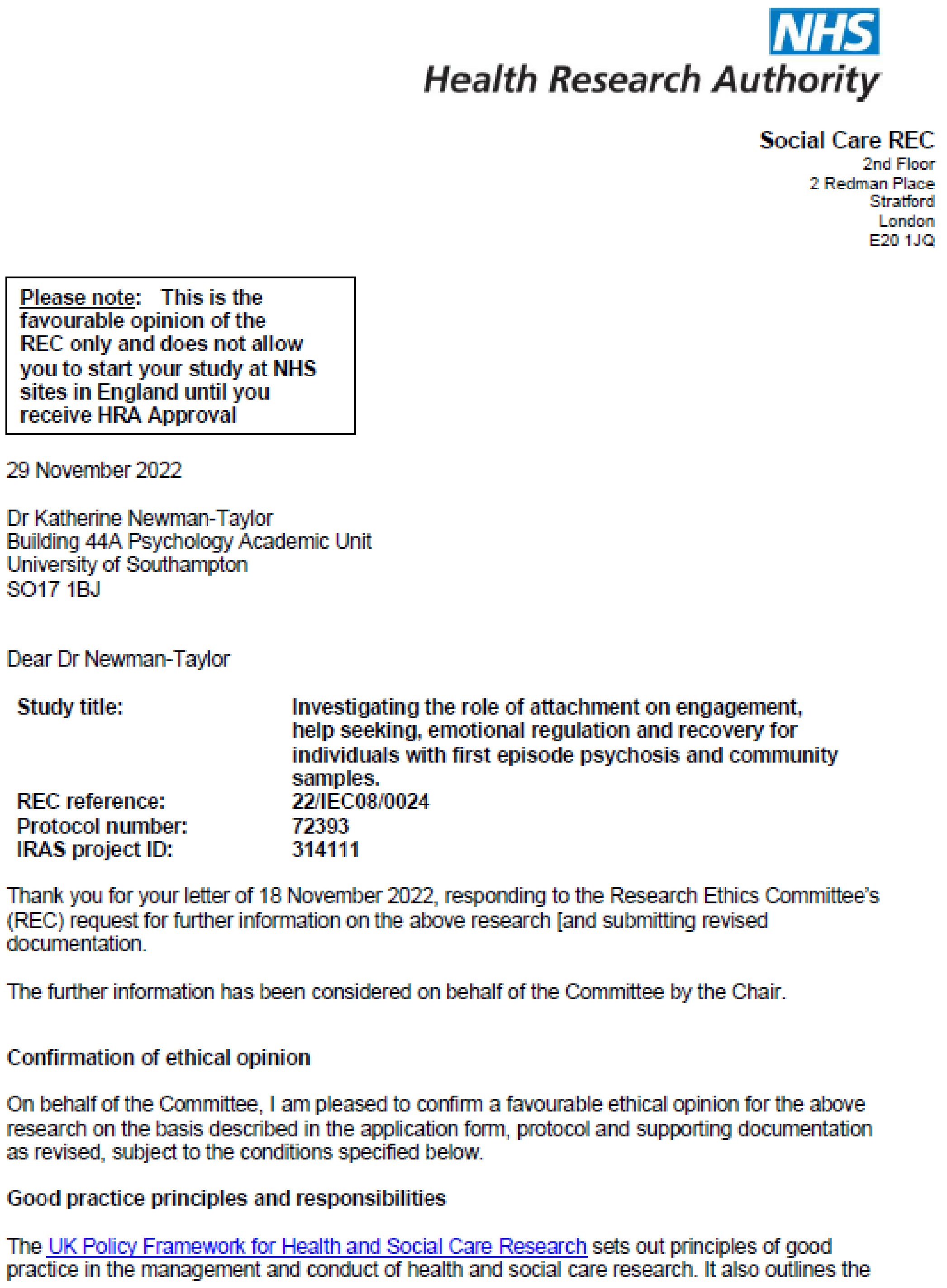
Comments:

Sponsor approves this as a 'Category C non-substantial no study wide review required 'amendment. Please complete Section 3 of the Amendment Tool adding Linda Hammond and rgoinfo@soton.ac.uk and Lock for Submission.

You should then submit via the HRA portal (following instructions on the Submission Guidance tab).

As this submission is for information only, you can implement the proposed changes as soon as you receive acknowledgement of the submission from the HRA.

Appendix J



NHS
Health Research Authority

Social Care REC
2nd Floor
2 Redman Place
Stratford
London
E20 1JQ

<u>Please note</u>: 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

29 November 2022

Dr Katherine Newman-Taylor
Building 44A Psychology Academic Unit
University of Southampton
SO17 1BJ

Dear Dr Newman-Taylor

Study title:	**Investigating the role of attachment on engagement, help seeking, emotional regulation and recovery for individuals with first episode psychosis and community samples.**
REC reference:	**22/IEC08/0024**
Protocol number:	**72393**
IRAS project ID:	**314111**

Thank you for your letter of 18 November 2022, responding to the Research Ethics Committee's (REC) request for further information on the above research [and submitting revised documentation.

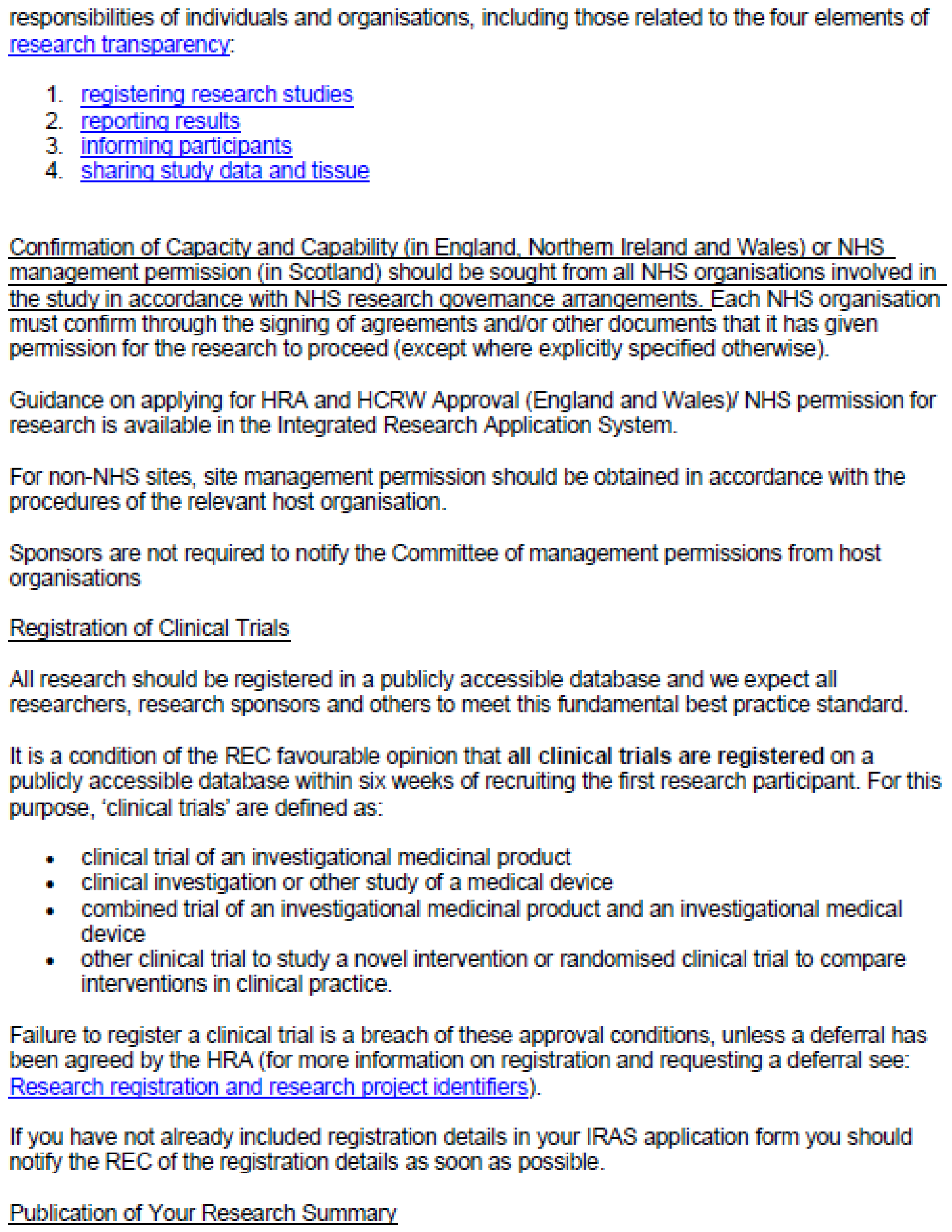
The further information has been considered on behalf of the Committee by the Chair.

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

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 publicly accessible database within six weeks of recruiting the first research participant. 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.

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).

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.

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.
Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

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 https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

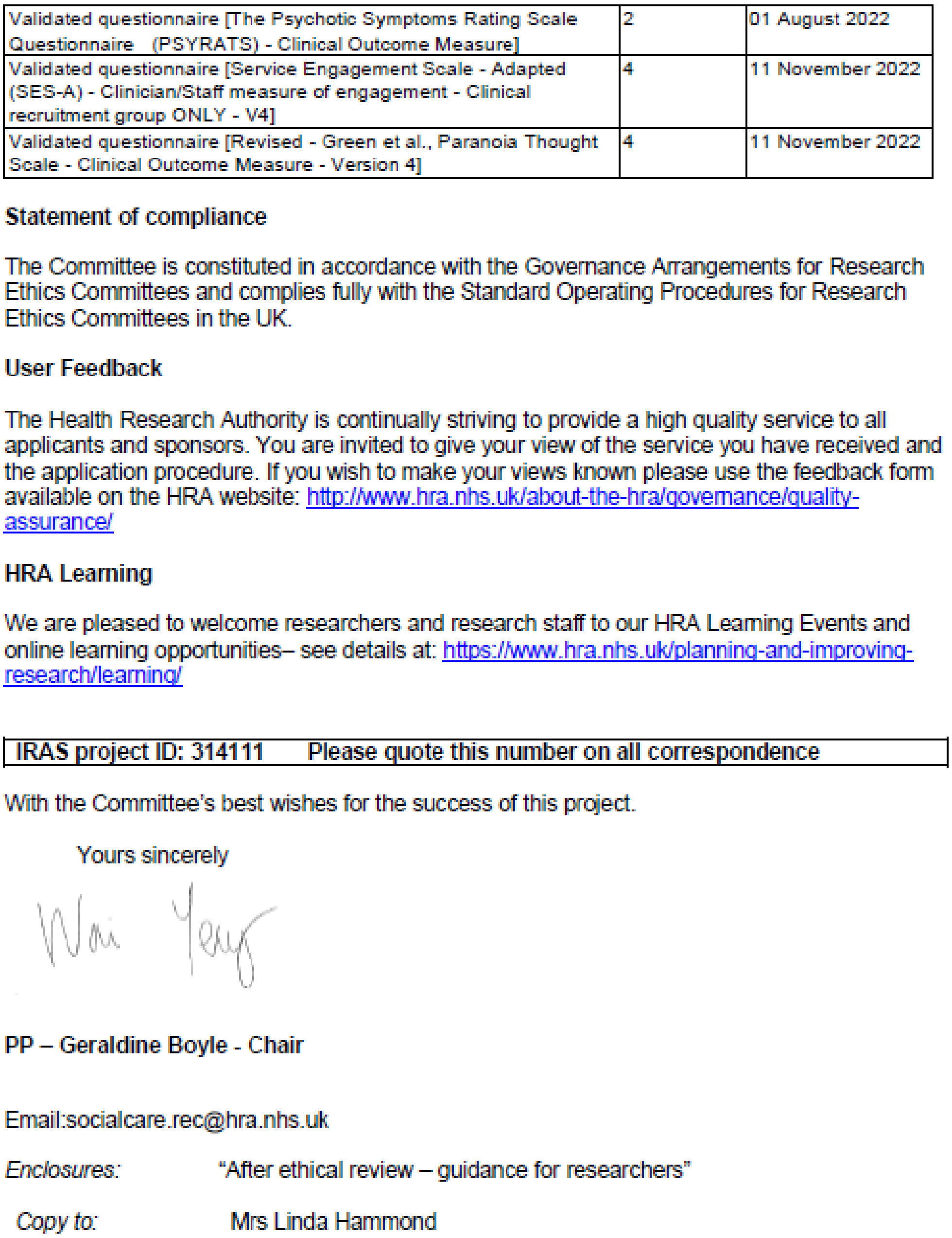
The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions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

Non-NHS/HSC sites

Appendix J

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Study Advert for Staff & Participants_NHS recruitment route]	2	14 August 2022
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of Sponsor Insurance]		01 August 2022
IRAS Application Form [IRAS_Form_31082022]		31 August 2022
Letter from sponsor [Letter from Sponsor]	1	22 August 2022
Non-validated questionnaire [Demographics Questionnaire]	3	12 October 2022
Other [Verification of Insurance Certificate]	1	22 August 2022
Other [Additional Information Requested - Response]	1	07 September 2022
Other [Lone Working Policy_V2]	1	04 November 2022
Other [Email Confirmation - Indemnity Policy Mixed Methods]	1	04 November 2022
Other [Amendments Commentary & Additional Information Required]	1	04 November 2022
Other [IRAS314111_Amendments Outstanding Response_11.11.2022.docx]	1	11 November 2022
Other [IRAS314111 - Outstanding Query Response_18.11.2022]	1	18 November 2022
Participant consent form [Participant Debriefing form - Time1&2]	3	04 November 2022
Participant consent form [Participant Debriefing form - Time3]	4	04 November 2022
Participant consent form [Staff Consent Form_V1]	1	12 October 2022
Participant consent form [Participant Consent Form_Clinical Sample]	5	11 November 2022
Participant information sheet (PIS) [Staff PIS_V1]	1	12 October 2022
Participant information sheet (PIS) [ParticipantInformationSheet_ClinicalSample]	6	11 November 2022
Research protocol or project proposal [Protocol_Document]	7	12 October 2022
Summary CV for Chief Investigator (CI) [KNT Summary CV-Chief Investigator]	1	13 June 2022
Summary CV for student [Summary Student CV]	1	01 April 2022
Summary CV for supervisor (student research) [KNT Summary CV - Academic Supervisor 1/CI]	1	13 June 2022
Summary CV for supervisor (student research) [TM Summary CV - Academic Supervisor 2]	1	12 August 2022
Validated questionnaire [Attachment Measure - PAM-R Questionnaire Measure]	2	01 August 2022
Validated questionnaire [Cognitive Emotional Regulation Questionnaire (CERQ) - Emotional Regulation Measure]	2	01 August 2022
Validated questionnaire [Brief Experiential Avoidance Questionnaire - Emotional Regulation Measure]	2	01 August 2022
Validated questionnaire [Emotional Regulation Questionnaire - Rumination & Catastrophising subscales - Emotional Regulation Measure]	2	01 August 2022
Validated questionnaire [Inpatient Treatment Alliance Scale - Adapted - Participant Measure of Engagement]	2	01 August 2022
Validated questionnaire [Help Seeking Measure (HSM-T).]	2	01 August 2022
Validated questionnaire [Hope Agency Opportunity Questionnaire - Recovery Measure]	2	01 August 2022
Validated questionnaire [CORE-10 - Clinical Outcome Measure - Clinical Outcome measure]	2	01 August 2022

Appendix J



Validated questionnaire [The Psychotic Symptoms Rating Scale Questionnaire (PSYRATS) - Clinical Outcome Measure]	2	01 August 2022
Validated questionnaire [Service Engagement Scale - Adapted (SES-A) - Clinician/Staff measure of engagement - Clinical recruitment group ONLY - V4]	4	11 November 2022
Validated questionnaire [Revised - Green et al., Paranoia Thought Scale - Clinical Outcome Measure - Version 4]	4	11 November 2022

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: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 314111 Please quote this number on all correspondence

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

Yours sincerely

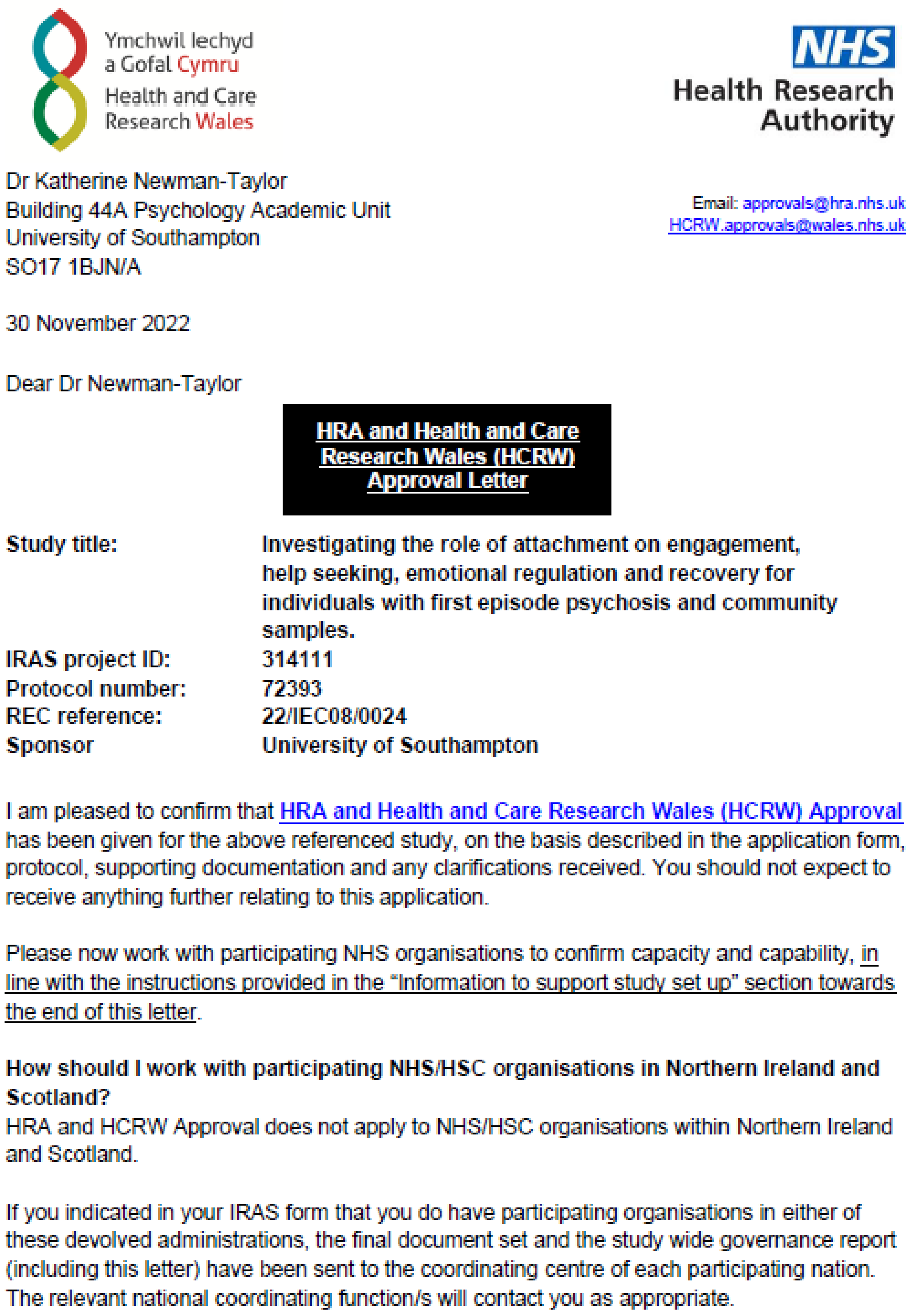
Wai Yeng

PP – Geraldine Boyle - Chair

Email:socialcare.rec@hra.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Mrs Linda Hammond



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Dr Katherine Newman-Taylor
Building 44A Psychology Academic Unit
University of Southampton
SO17 1BJN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

30 November 2022

Dear Dr Newman-Taylor

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

Study title:	**Investigating the role of attachment on engagement, help seeking, emotional regulation and recovery for individuals with first episode psychosis and community samples.**
IRAS project ID:	**314111**
Protocol number:	**72393**
REC reference:	**22/IEC08/0024**
Sponsor	**University of Southampton**

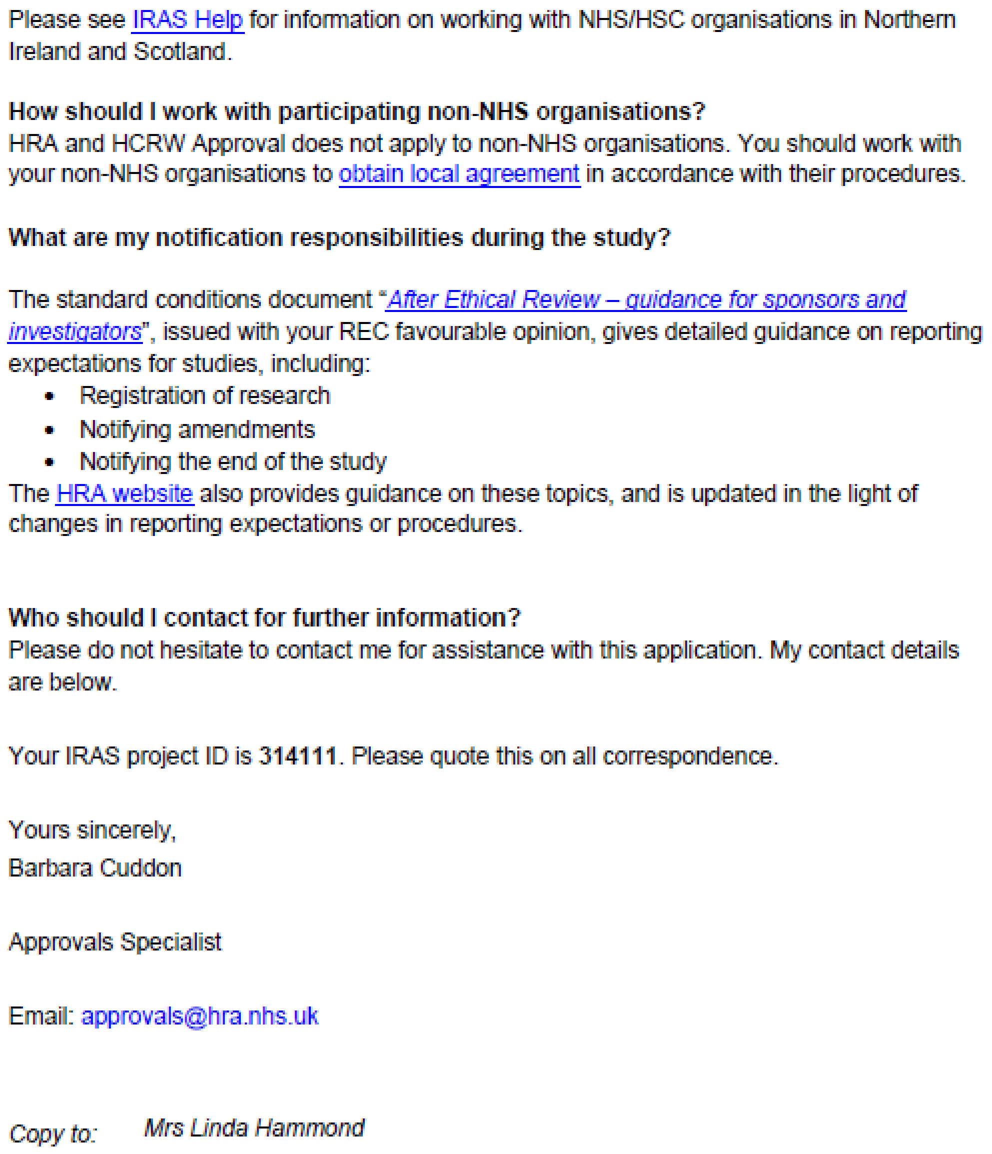
I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating 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 **314111**. Please quote this on all correspondence.

Yours sincerely,
Barbara Cuddon

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Mrs Linda Hammond*

Appendix J

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 [Study Advert for Staff & Participants_NHS recruitment route]	2	14 August 2022
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Participant information sheet (PIS) [ParticipantInformationSheet_ClinicalSample]	6	11 November 2022
Research protocol or project proposal [Protocol_Document]	7	12 October 2022
Schedule of Events or SoECAT [HRA Assessed Version]	1.0	08 September 2022
Summary CV for Chief Investigator (CI) [KNT Summary CV-Chief Investigator]	1	13 June 2022
Summary CV for student [Summary Student CV]	1	01 April 2022
Summary CV for supervisor (student research) [KNT Summary CV - Academic Supervisor 1/CI]	1	13 June 2022
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Validated questionnaire [CORE-10 - Clinical Outcome Measure - Clinical Outcome measure]	2	01 August 2022
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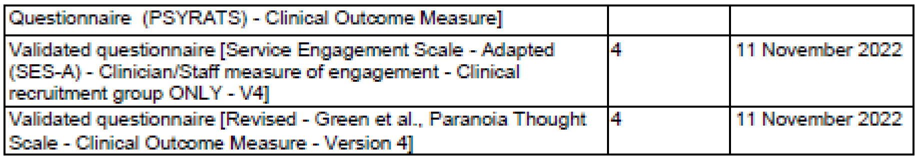
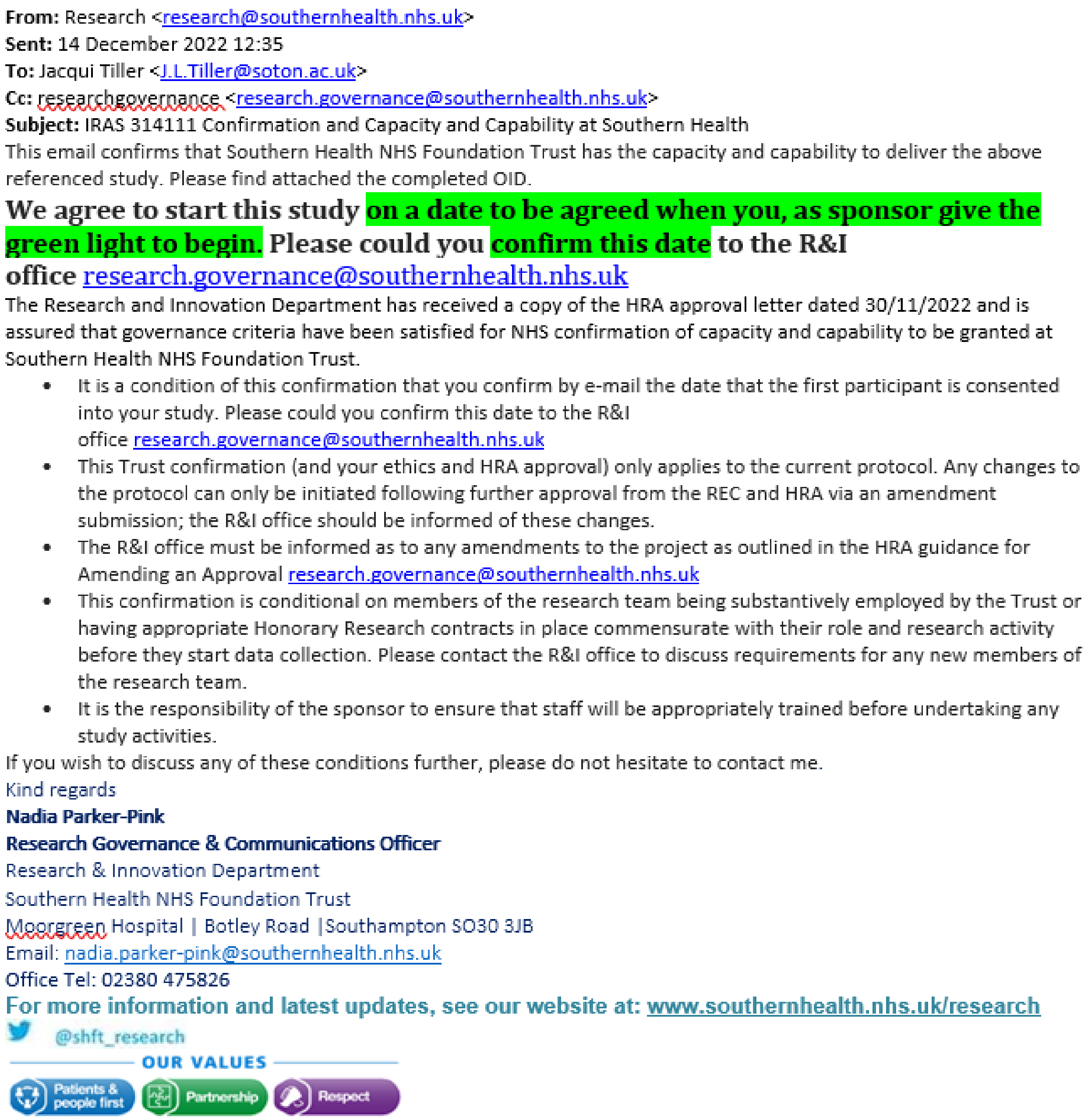
Validated questionnaire [Revised - Green et al., Paranoia Thought Scale - Clinical Outcome Measure - Version 4]	4	11 November 2022



Appendix J



From: Research <research@southernhealth.nhs.uk>
Sent: 14 December 2022 12:35
To: Jacqui Tiller <J.L.Tiller@soton.ac.uk>
Cc: researchgovernance <research.governance@southernhealth.nhs.uk>
Subject: IRAS 314111 Confirmation and Capacity and Capability at Southern Health

This email confirms that Southern Health NHS Foundation Trust has the capacity and capability to deliver the above referenced study. Please find attached the completed OID.

We agree to start this study on a date to be agreed when you, as sponsor give the green light to begin. Please could you confirm this date to the R&I office research.governance@southernhealth.nhs.uk

The Research and Innovation Department has received a copy of the HRA approval letter dated 30/11/2022 and is assured that governance criteria have been satisfied for NHS confirmation of capacity and capability to be granted at Southern Health NHS Foundation Trust.

- It is a condition of this confirmation that you confirm by e-mail the date that the first participant is consented into your study. Please could you confirm this date to the R&I office research.governance@southernhealth.nhs.uk
- This Trust confirmation (and your ethics and HRA approval) only applies to the current protocol. Any changes to the protocol can only be initiated following further approval from the REC and HRA via an amendment submission; the R&I office should be informed of these changes.
- The R&I office must be informed as to any amendments to the project as outlined in the HRA guidance for Amending an Approval research.governance@southernhealth.nhs.uk
- This confirmation is conditional on members of the research team being substantively employed by the Trust or having appropriate Honorary Research contracts in place commensurate with their role and research activity before they start data collection. Please contact the R&I office to discuss requirements for any new members of the research team.
- It is the responsibility of the sponsor to ensure that staff will be appropriately trained before undertaking any study activities.

If you wish to discuss any of these conditions further, please do not hesitate to contact me.

Kind regards
Nadia Parker-Pink
Research Governance & Communications Officer
Research & Innovation Department
Southern Health NHS Foundation Trust
Moorgreen Hospital | Botley Road |Southampton SO30 3JB
Email: nadia.parker-pink@southernhealth.nhs.uk
Office Tel: 02380 475826

For more information and latest updates, see our website at: www.southernhealth.nhs.uk/research

@shft_research

OUR VALUES

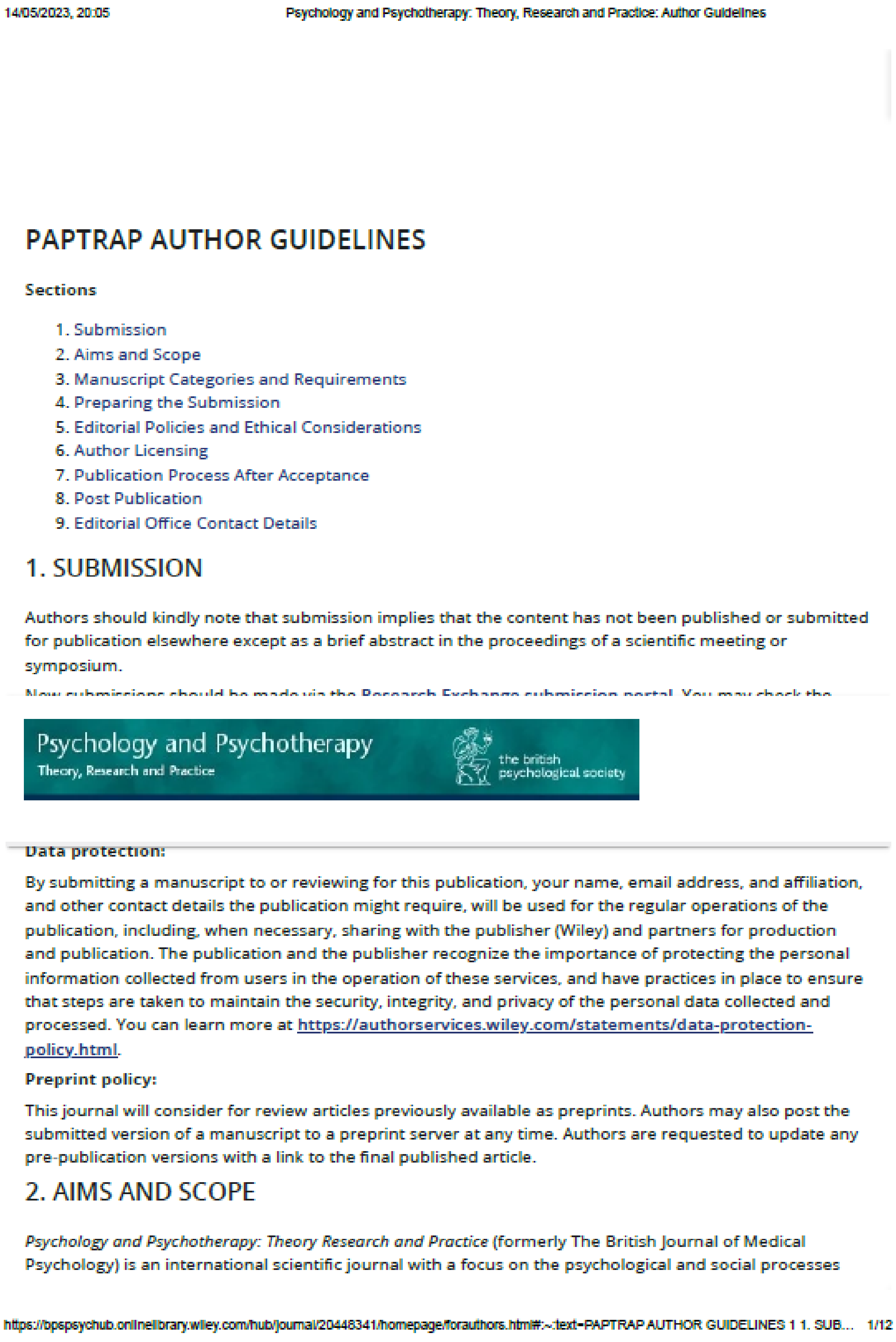
Patients & people first
Partnership
Respect

Appendix K Descriptive Statistics for Clinical and Community participants

Variable	Community (n = 55)	Clinical (n = 10)
Gender: *n*(%)		
Female	28 (50.9)	6 (60)
Male	23 (41.8)	3 (1) †
Other (no gender, non-binary)	4 (7.2)	
Age of participant in years, median *n (*%)		
20-29	26 (47.3)	6 (60)
30-39	17 (30.9)	3 (30)
40-49	9 (16.4)	-
50-59	3 (5.5)	1 (10)
Ethnicity: *n* (%)		
White Caucasian	47 (85.45)	7 (70)
Black Caribbean & White	3 (5.45)	-
Mixed	2 (3.65)	1
All other ethnicities: Black, Bangladeshi, Indian Caribbean, African, Asian	3 (5.45)	2
Nationality: *n* (%)		
White British; Scottish, Welsh, English	52 (94.55)	9 (90)
British American	1 (1.82)	-
Hong Kong	1 (1.82)	-
Nigerian British	1 (1.82)	-
Polish	-	1 (10)
Formal Mental Health Diagnoses		
Yes	51 (92.7)	8 (80)
No	4 (7.3)	2 (20)
Formal Mental Health Diagnoses: *n* (%)		
Psychosis	20 (36.36)	6 (60)
Anxiety	20 (36.36)	2 (20)
Depression	19 (34.55)	1 (10)
Emotionally Unstable Personality Disorder	11 (20)	1 (10)
Bipolar	8 (14.55)	-
Post-traumatic stress disorder	6 (10.91)	-
Autism	5 (9.09)	-
Schizoaffective Disorder	5 (9.09)	-
Attention Deficit Hyperactivity Disorder	3 (5.45)	-
Obsessive Compulsive Disorder	3 (5.45)	-
Dissociative Identity Disorder	2 (3.64)	-
Eating Disorders	2 (3.64)	-
Insomnia	1 (1.82)	-
Social Phobia	1 (1.82)	-
Panic Disorder	1 (1.82)	-
Mixed Personality Disorder	1 (1.82)	-
Time since onset of psychosis in months (*M, SD)*	110.33 (91.81)	138.40 (107.57)

Time since commenced treatment in EIP service in months (*M, SD)*	N/A	14.9 (11.93)
Measures	1.85 (.69)	1.83 (.56)
Attachment Avoidance – PAM-R (*M, SD)*	1.80 (.71)	1.16 (.72)
Attachment Anxiety – PAM-R (*M,SD)*	1.59 (.75)	1.31 (.78)
Attachment Disorganised – PAM-R (*M, SD)*	13.67 (8.96)	13.10 (10.39)
Paranoia – Social Reference R-GPTS (*M, SD)*	13.80 (11.94)	19.20 (13.90)
Paranoia – Persecution R-GPTS R (*M, SD)*	3.95 (1.72)	4.70 (1.57)
Emotional Regulation – ERQ (*M, SD)*	57.35 (14.38)	56.80 (16.25)
Emotional Regulation – BEAQ (*M, SD)*	3.72 (.96)	3.90 (.88)
Emotional Regulation – CERQ Rumination *(M,SD)*	2.91 (1.06)	2.95 (1.00)
Emotional Regulation – CERQ Catastrophisation (*M, SD)*		
Engagement – ITAS *(M,SD)*	30.62 (14.73)	52.30 (5.93)
Help-seeking – HSM-T *(M,SD)*	8.02 (2.97)	8 (3.40)
Recovery Outcomes – HAO *(M,SD)*	7.20 (4.23)	9.30 (2.26)
Clinical Outcomes – CORE 10 *(M,SD)*	24.15 (6.28)	23.10 (6.01)
Clinical Outcomes – PSYRATS *(M,SD)*	2.80 (1.66)	3.60 (1.58)

Appendix L Author Guidelines for PAPTRAP



14/05/2023, 20:05 Psychology and Psychotherapy: Theory, Research and Practice: Author Guidelines

PAPTRAP AUTHOR GUIDELINES

Sections

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

New submissions should be made via the Research Exchange submission portal. You may check the

Data protection:

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that underlie the development and improvement of psychological problems and mental wellbeing, including:

- theoretical and research development in the understanding of cognitive and emotional factors in psychological problems;
- behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological distresses;
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We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds both within the UK and internationally.

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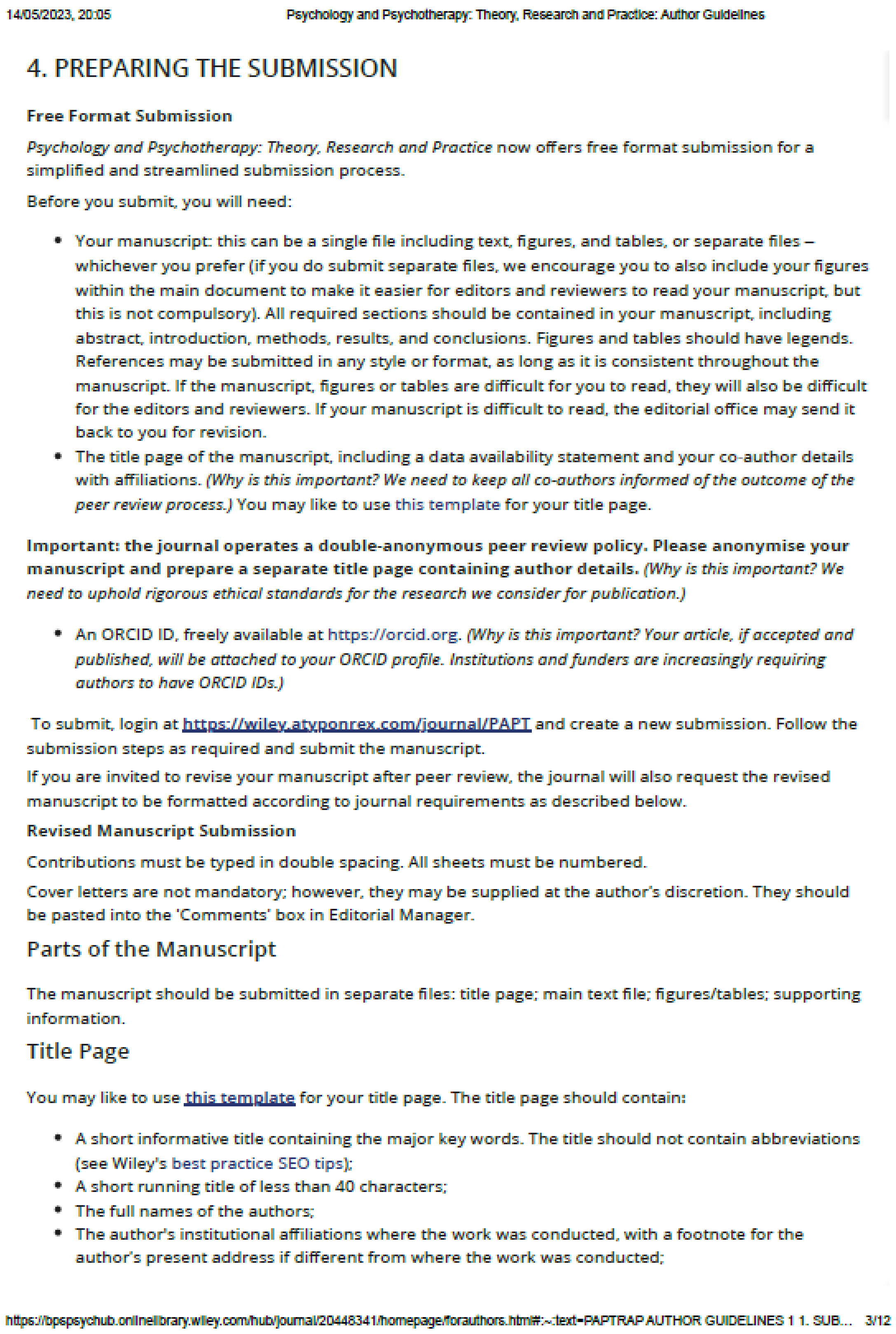

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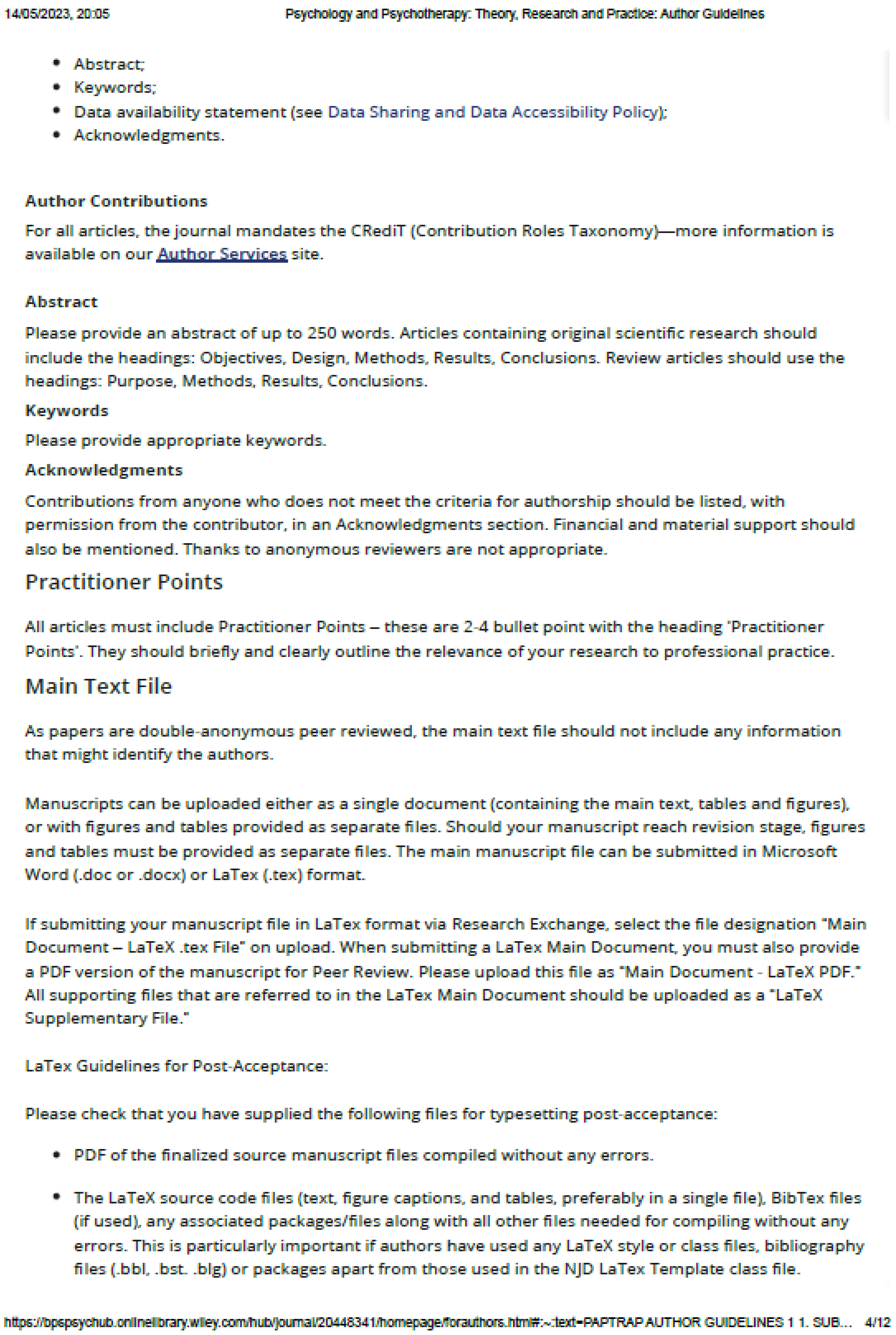

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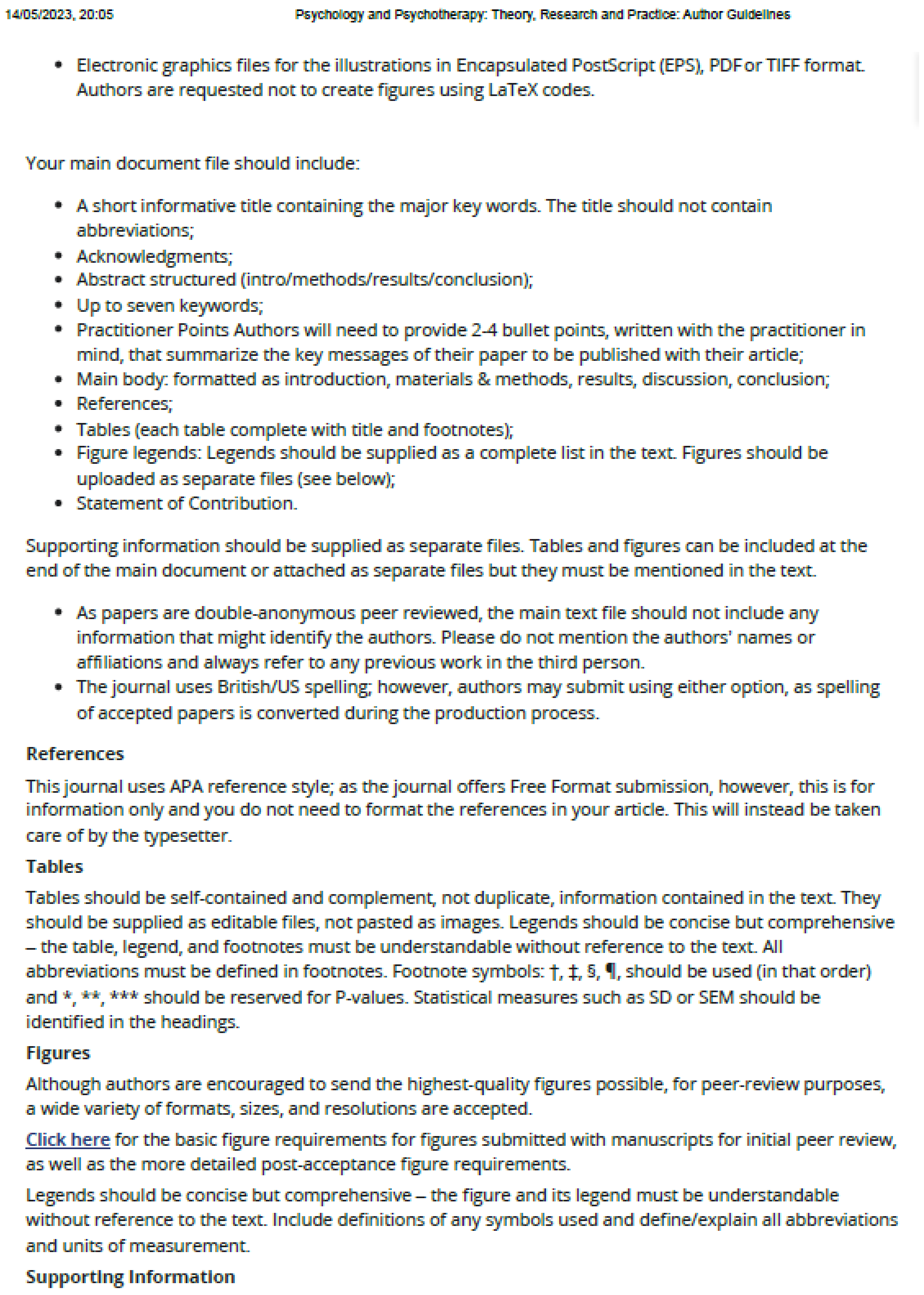

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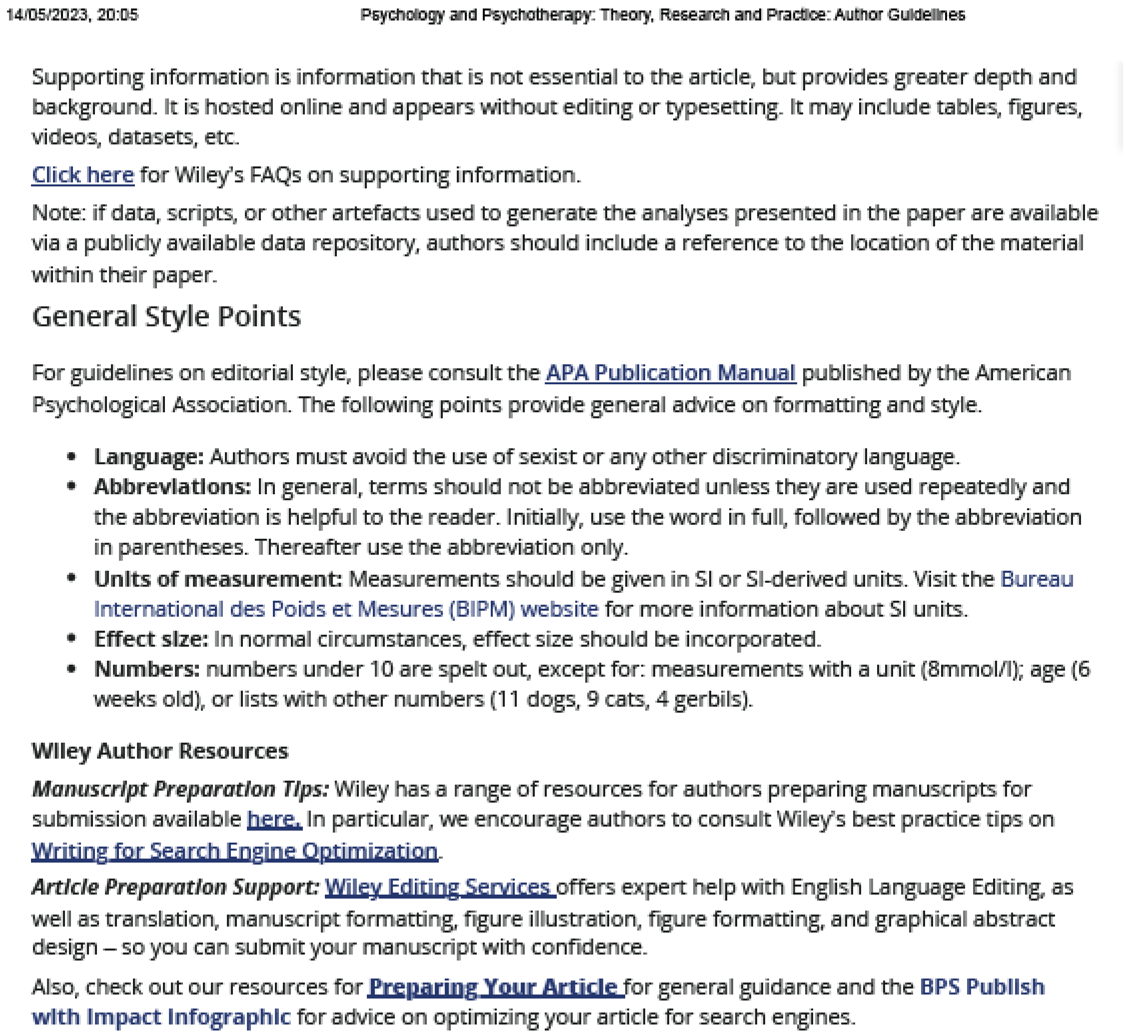

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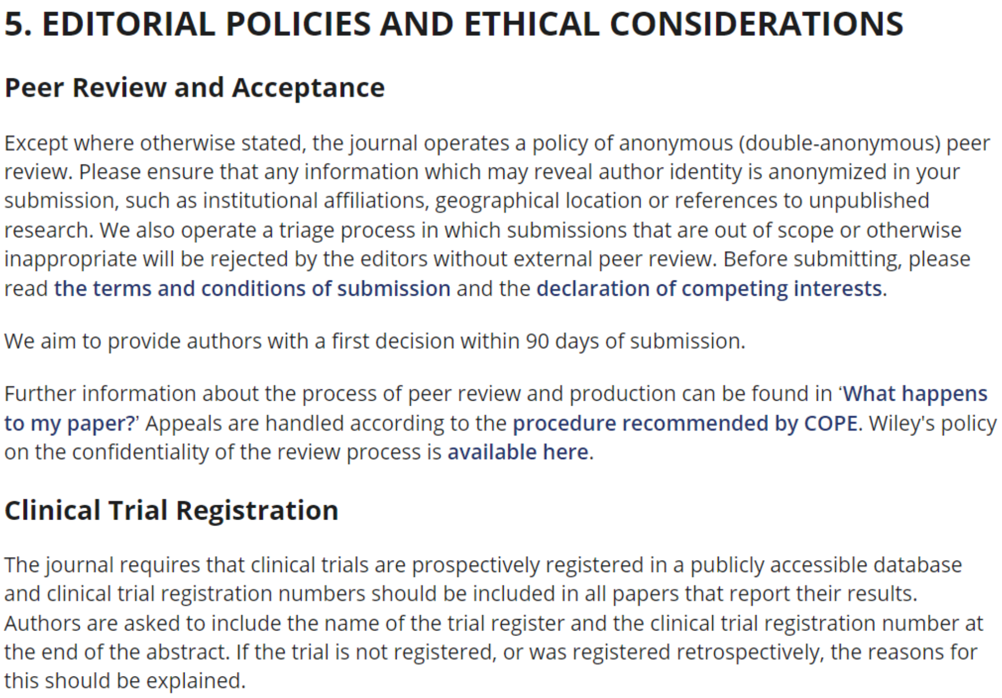

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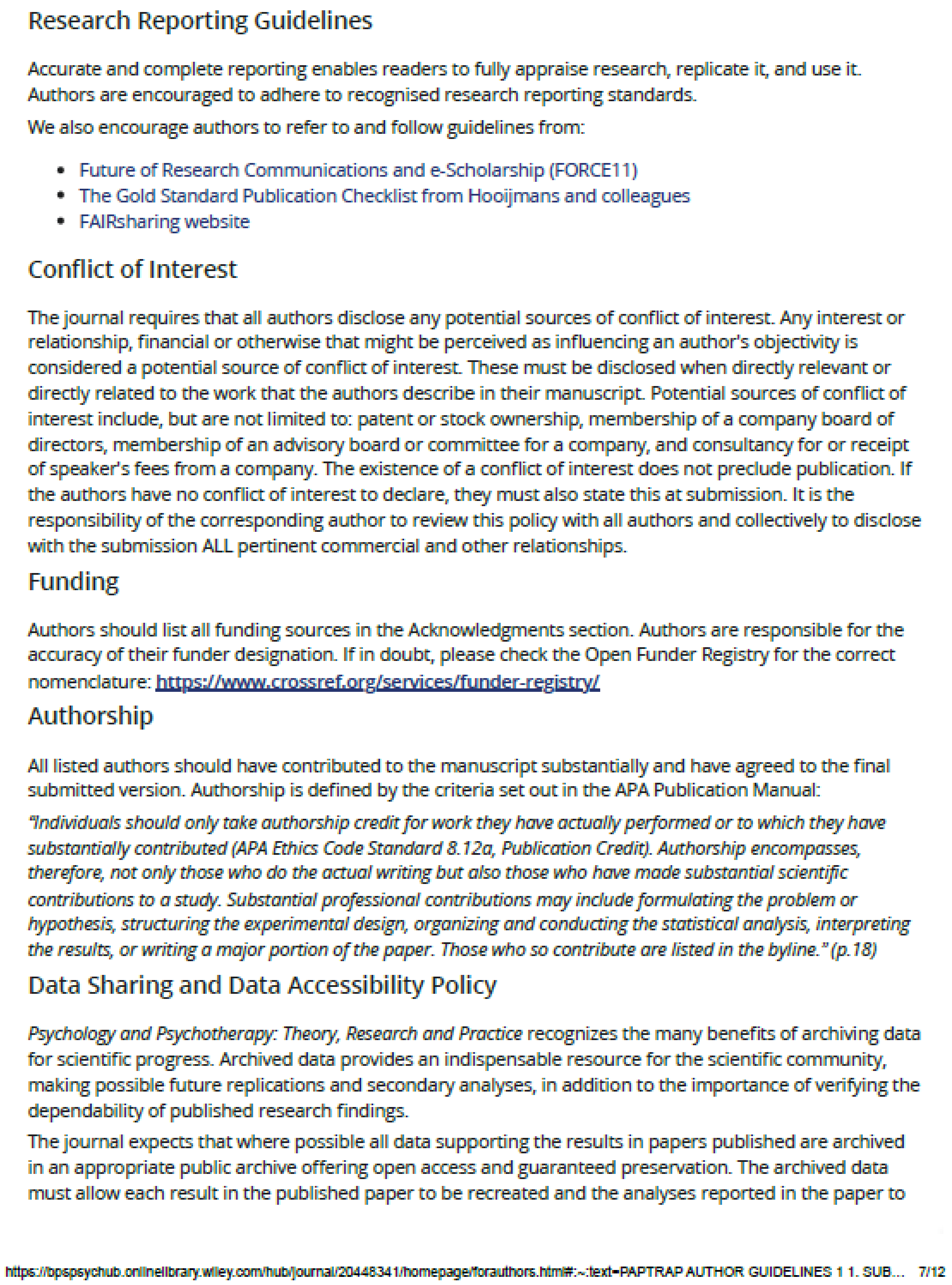

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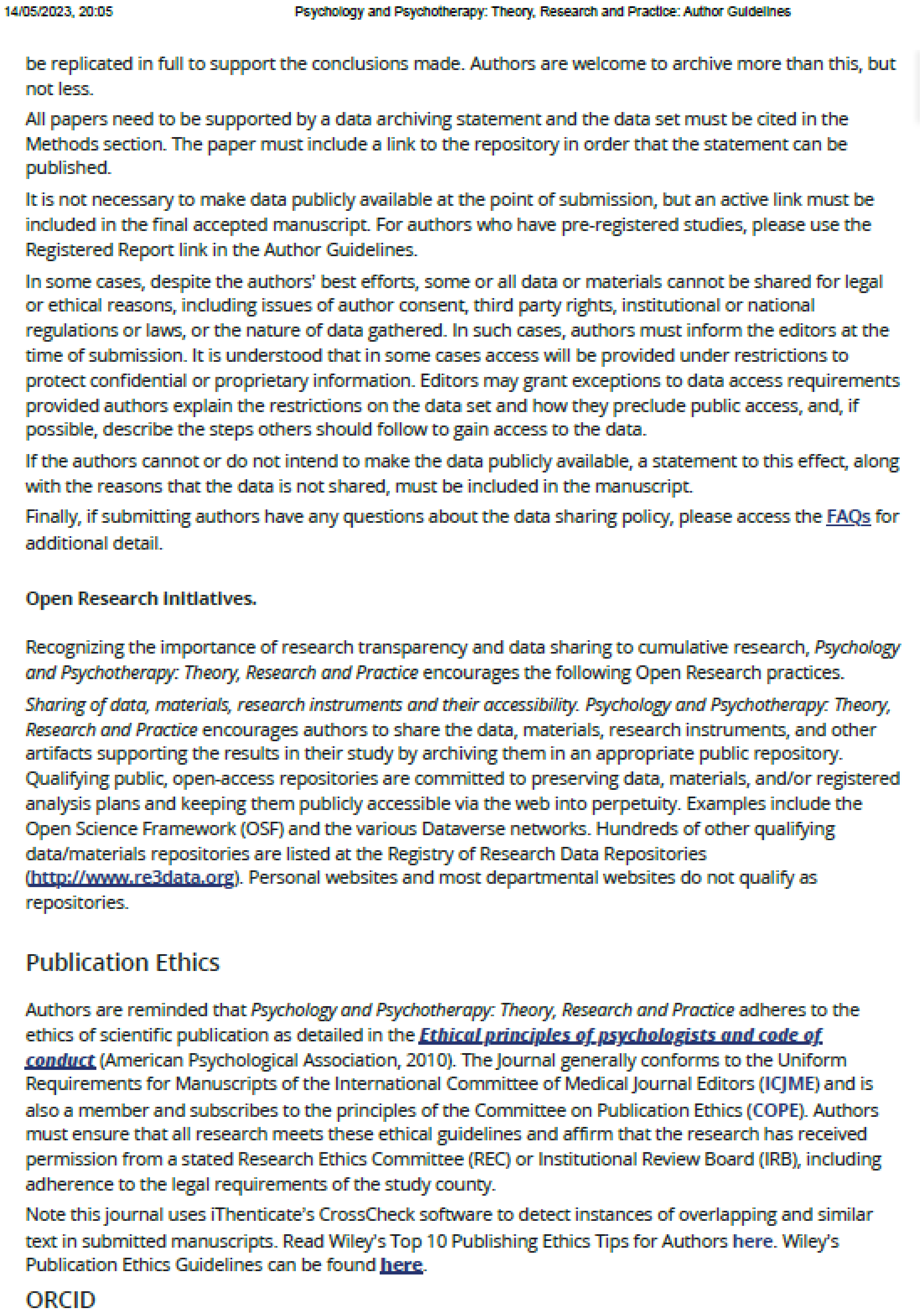

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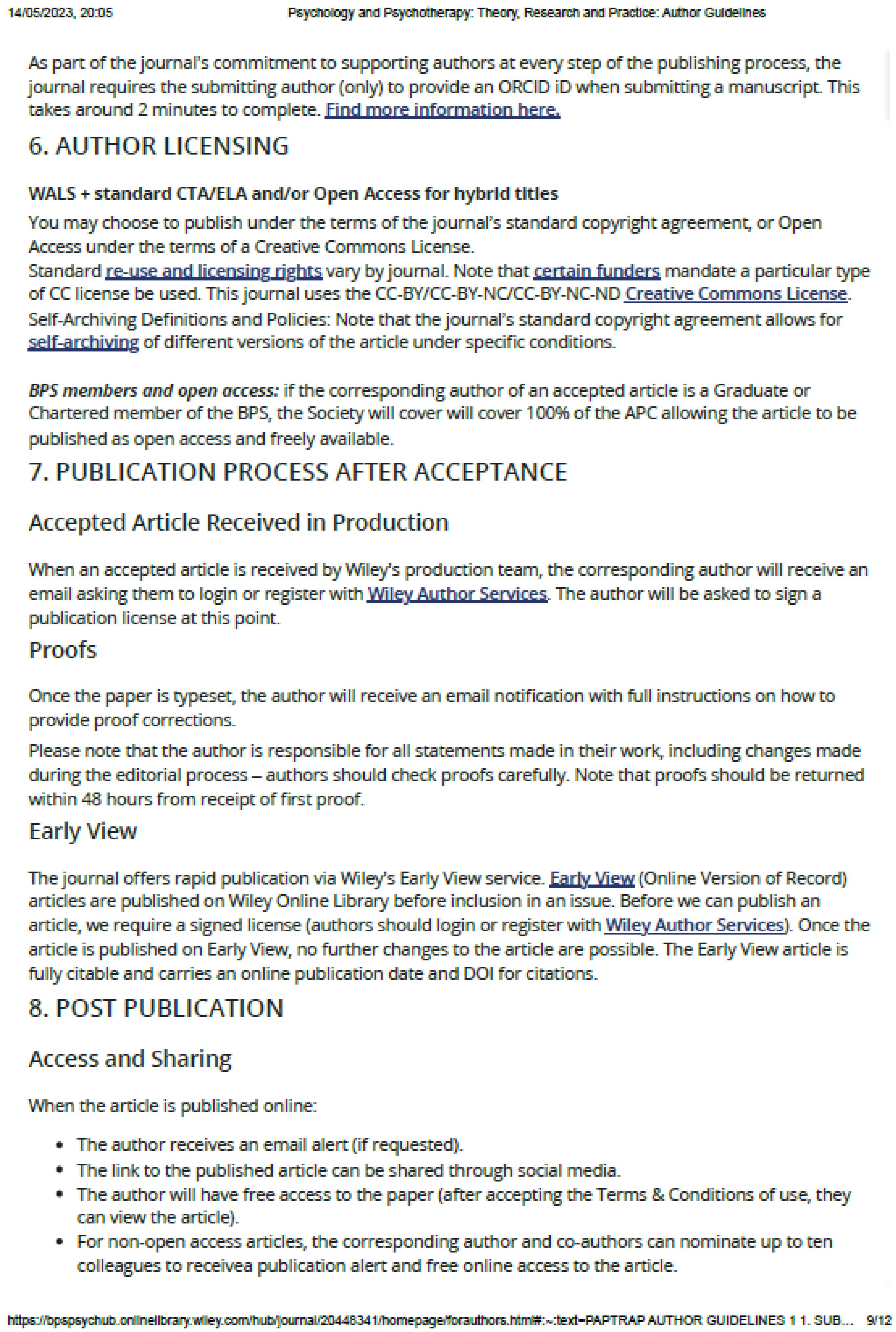

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