Exploring British Pakistani Muslims' Experiences of Family Involvement in Family Work for Psychosis: An Interpretative Phenomenological Analysis

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

Introduction: Research suggests that British South Asian individuals, including those of Pakistani heritage, face a higher risk of developing psychosis compared to White individuals. Pakistani culture, Islamic teachings and clinical guidelines strongly emphasise family support, cohesion, and emotional connection. Despite this, little is known about the experience or effectiveness of family work (FW) for British Pakistani Muslims experiencing psychosis. Most research on FW has focused on quantitative outcomes for individuals and carers, in which British Pakistani Muslim voices remain largely unheard. This is problematic as some Pakistani studies suggest that individual therapy approaches may not be culturally appropriate. UK-based research has similarly highlighted the importance of family involvement in mental healthcare for South Asian communities. The current study, therefore, aimed to address this critical gap by providing an in-depth exploration of British Pakistani Muslims' experiences and understanding of family involvement in FW for psychosis.

Method: A qualitative approach was used. Five British Pakistani Muslim individuals who had participated in FW within the context of psychosis were recruited from Early Intervention in Psychosis Services (EIPs). Semi-structured interviews were conducted and analysed using Interpretative Phenomenological Analysis.

Results: Six Group Experiential Themes were identified: 1) A Test of Family Support and Commitment; 2) Opening Up: A Journey to Safety; 3) Healing Through Connection; 4) Integrating the Heart, Mind and Soul; 5) Navigating Systems: Family Work in an EIP Context; and 6) The Toll of Therapy.

Discussion: Findings are discussed in relation to broader theories and literature on mental health, family support, cultural and religious principles, systemic factors, and FW approaches for psychosis. The study's strengths and limitations are considered, followed by an examination of implications for clinical practice and future research. Key themes include access to FW, implicit narratives, perceived benefits, and the importance of cultural and religious sensitivity.

Table of Contents

List of Tables

Chapter 1: Introduction

This chapter begins by defining key terms commonly used in research involving individuals who do not identify as White, as well as those relevant to the current study. An overview of biological and psychological understandings of psychosis is provided. The significance of family in Pakistani culture and the Islamic faith is also explored. Existing literature on psychosis within the Pakistani Muslim community is then reviewed, much of which is situated within broader research on South Asian populations. This is followed by a discussion of the barriers South Asian (including Pakistani) individuals face in accessing mental health (MH) services, and their experiences of engaging with Early Intervention in psychosis (EIP) services. The chapter concludes by examining literature on the significance of family involvement in mental healthcare for Pakistani Muslims, the utility of family work (FW) for psychosis, and key gaps in existing knowledge informing this study.

Race, Ethnicity and Culture

The terms ‘race’ and ‘ethnicity’ are often used interchangeably; however, understanding their differences is crucial due to their origin and implications. While historically primarily considered a biological trait based upon physical characteristics (e.g. skin colour), the socially constructed aspects of race are increasingly recognised. These constructs have been used to discriminate against certain individuals, reinforcing White power and privilege (Atkin et al., 2022; Hicks & Butler, 2020). Research indicates that there is no scientific evidence for distinct racial categories, due to the high level of variability in individuals placed under the same category. In contrast, ethnicity encompasses culture, traditions, religious beliefs, language, place of origin, tribal affiliation and shared ancestry between individuals of specific social groups (Atkin et al., 2022; Santos et al., 2010). It is therefore vital that researchers are mindful of their use of terminology, which may obscure the similarities and differences between individuals and perpetuate racial hierarchies.

According to Abdulla (2018), ‘culture’ can be defined on two levels: expression (e.g., music, arts, heritage, and cultural places), and ideas (e.g., belief systems, values, and norms that may govern social behaviour). Similarly, Causadias et al. (2018a) define culture as “an integrated constellation of practices, symbols,

values and ideals that are constructed and shared by a community, transmitted from one generation to the next, constantly renegotiated and subject to change, and operating at the individual and societal level". Importantly, this suggests that communities may share similar cultural practices, but these may evolve and be expressed differently on an individual level. This has relevance for British Pakistani Muslims likely exposed to multiple belief systems, values, and practices related to culture, religion and MH.

Defining Pakistani

Pakistan is one of the many countries that make up the region of South Asia, which also includes Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, and Sri Lanka (Nakandala, & Malik, 2015; ONS, 2011). Although South Asian individuals share some similarities in terms of cultural values and experiences, this is not a homogeneous community group due to diversity in languages spoken, country of origin and religious practices. Notably, Pakistan itself consists of multiple ethnic groups, including Punjabis, Sindhis, Balochis and Pathans (Karim et al., 2004). Furthermore, while Pakistan is a predominantly Muslim country with Islam as the main religion, other faith groups also exist, including Christians, Hindus and Sikhs (Pakistan Bureau of Statistics, 2017). Over 70 different languages are spoken across Pakistan; however, Urdu is the official language (Ayres, 2009; Eberhard, 2020).

In the UK, Pakistanis are the second-largest South Asian group (2.7% of the population), after Indians (3.1%), followed by Bangladeshis (1.1%) (ONS, 2021). Most of the British Pakistani population identify as Muslim, with many originating from the region of Azad Kashmir (Faulkner, 2011; ONS, 2011). The 2021 census showed that Punjabi and Urdu are the third and fourth most spoken languages in the UK after English, both of which are widely spoken within the Pakistani community (ONS, 2021). The term 'first-generation' refers to individuals who first migrated to the UK, while the terms 'second-generation' and 'third-generation' refer to their children and grandchildren, who were subsequently born in the UK.

Defining Muslim

The Arabic definition of "Muslim" is someone who submits to the will of God (*Allah*), and the term is specifically associated with the religion of Islam (Muhsinin, 2019). In submitting to God, Muslims are instructed to follow the guidance outlined in the Qur'an (considered the direct word of Allah) as well as the teachings of the Prophet Muhammad (peace be upon him ﷺ) concerning theological beliefs, moral principles, social values, behavioural conduct and ethical issues (Sabry & Vohra, 2013). Notably, differences in opinion about certain beliefs (e.g., the rightful Caliph following the death of Prophet Muhammad ﷺ), understandings of Islamic law (Sharia), interpretations of scripture, and practices of connecting with God have led to the formation of multiple Islamic sects (Gilliat-Ray, 2010; Hamid, 2011). These include Sunni, Shi'a, Wahabi, Salafi, Barelvi, Deobandi and Sufi (Iqbal, 2022). Nonetheless, there is considerable similarity among these sects regarding the core tenets of Islam, including but not limited to: believing in the oneness of and worshipping Allah alone, believing in the final messenger Prophet Muhammad ﷺ, and engaging in regular prayer, fasting, and charity.

At the same time, literature recognises variability in the use of the term 'Muslim' and the meaning individuals assign to it. This is unsurprising as the Muslim population is very ethnically diverse with Islam being practised worldwide, and this diversity also exists within the British Muslim community (Weatherhead & Daiches, 2015). Meer (2008) observed that individuals' self-identification as Muslim is not synonymous with specific religious practices or levels of religiosity. This aligns with research showing that for earlier first-generation Pakistani Muslims, Islam was often intertwined with cultural practices that guided life in the UK post-migration, while maintaining a connection to their homeland (Akhtar, 2014). However, Akhtar (2014) notes that for many second and third-generation Pakistanis, the Muslim identity has become increasingly distinct and a means to differentiate from their parents' cultural practices. Moreover, growing up in multicultural Britain has allowed young Muslims to see the similarities and differences in how Islam is practised across various ethnic groups, with many seeking universality in Islamic principles. In doing so, it has particularly empowered young Muslim women to pursue education and employment and make key decisions for themselves (e.g. choosing who to marry), in line with the rights granted to them in Islam.

Literature has also highlighted the term ‘Cultural Muslim’, referring to non-religious individuals who may still identify as Muslim due to their family background, upbringing, or socio-cultural context (Rassool, 2015). This ultimately demonstrates that identifying as Muslim does not necessarily imply religiosity, with some Muslims having more connection to Islamic beliefs than others. There is also variability in those who identify as ‘practising’, as some may adhere more to certain principles or engage in greater voluntary worship than others. This is relevant to the current study as British Pakistani Muslims may align with different aspects of their identity in unique ways, which may impact their experiences related to family and MH.

Importance of Family in Pakistani Culture and Islam

Pertinent to the current study is the high value placed on family relationships within the Pakistani Muslim community, influenced by both culture and religion. In general, research has shown that South Asian communities tend to be collectivist, families typically comprise a broad network that is more close-knit, and family and community ties are an integral component of South Asian culture (Ballard, 1994; Shariff, 2009; Werbner, 2002). Furthermore, due to the hierarchical structure of many South Asian families, there is an expectation that parents and older relatives are obeyed, respected and looked after within the family, with the family’s welfare and upholding honour being overall priorities (Ballard, 1994; Franceschelli, 2013; Gunasinghe et al., 2019; Shariff, 2009).

Within Islamic scripture, the family unit is also regarded as a fundamental foundation for society (Alwani, 2007). As such, marriage is considered an integral aspect of the Muslim family structure through which relationships develop, and all individuals in the family have their own rights and roles to uphold at different life stages. While the nuclear family itself is considered sacred and important, there is an emphasis on maintaining ties with extended family members and the wider community for mutual support.

To illustrate, Allah speaks about family as a source of comfort and love, particularly within the context of marriage:

And of His signs is that He created for you from yourselves mates that you may find tranquillity in them; and He placed between you affection and mercy. Indeed in that are signs for a people who give thought. (The Qur'an, 30:21)

In addition, Allah emphasises the rights of parents in the Qur'an, which are also mentioned in the Hadith:

And your Lord has decreed that you do not worship except Him, and to parents, good treatment. Whether one or both of them reach old age [while] with you, say not to them [so much as], 'uff,' and do not repel them but speak to them a noble word. (The Qur'an, 17:23)

And We have enjoined upon man [care] for his parents. His mother carried him, [increasing her] in weakness upon weakness, and his weaning is in two years. Be grateful to Me and to your parents; to Me is the [final] destination. (The Qur'an, 31:14)

A man asked the Prophet Muhammad ﷺ: Who among people is most deserving of my good company? The Prophet said, "Your mother." The man asked, Then who? The Prophet said, "Then your mother." The man asked again, Then who? The Prophet said, "Then your mother." The man asked once more, Then who? The Prophet said, "Then your father." (Al-Bukhari, 5971; Muslim, 2548)

Similarly, multiple Hadiths highlight the importance of responsibility and kindness towards family:

The Prophet Muhammad ﷺ said: Each of you is a shepherd and each of you is responsible for his flock. The leader is a shepherd and is responsible for his flock, a man is the shepherd of his family and is responsible for his flock; a woman is the shepherd in her husband's house and is responsible for her flock." (Al-Bukhari, 7138; Muslim, 1829)

The best of you are those who are best to their families, and I am the best among you to my family. (Al-Tirmidhi, 3895)

> *A father gives his child nothing better than a good education.* (Al-Tirmidhi, 4977)

> *He is not one of us who does not show mercy to our young ones and esteem to our elderly.* (Al-Tirmidhi, 1919)

With regards to community, maintaining strong connections and providing mutual support is strongly encouraged in the Hadith:

> *The Prophet Muhammad ﷺ said: The believers, in their mutual love, mercy, and compassion, are like one body. If one part of the body feels pain, the whole body reacts with sleeplessness and fever.* (Sahih al-Bukhari, 6011; Sahih Muslim, 2586)

> *He is not a believer whose stomach is filled while his neighbour goes hungry.* (Sunan al-Kubra, 19049)

> *Shall I not tell you what is better than fasting, prayer, and charity? It is mending discord between people. Ruined relationships are the shaver (destroyer).* (Sunan Abi Dawood, 4919)

Psychotherapy with Muslim Families

Research on psychotherapy with Muslim families remains limited, highlighting a substantial evidence gap. In one literature review, Weatherhead and Daiches (2015) identified four key themes important for culturally sensitive psychotherapy with Muslim families. These include: a) self, where identity is often relational and embedded within family, community and faith, rather than solely individualistic; b) family dynamics, including the influence of family structures, roles, hierarchies, and gender expectations on shaping experiences and interactions; c) causation, in which distress is understood as a combination of psychological, social and spiritual factors; and d) coping strategies, with families often drawing on faith, community and social networks alongside professional support. Each of these has direct implications for therapeutic practice; for example, understanding family dynamics and coping strategies may inform culturally sensitive systemic interventions.

However, Weatherhead and Daiches (2015) emphasise that very few empirical studies have examined the delivery or outcomes of family or couples therapy with

Muslim families. Most publications provide conceptual guidance, cultural commentary or general MH research, rather than evaluations of therapeutic interventions. To illustrate, Daneshpour (2016) provides one of the few comprehensive guides to family therapy with Muslim families in Western contexts, consolidating theoretical frameworks, case examples and practical strategies. The author highlights the importance of considering religious and cultural values, extended family dynamics, and communication norms, whilst drawing on established family therapy approaches (e.g. structural, narrative and post-modern systemic). Although invaluable for clinical practice, this guidance is primarily conceptual and does not include empirical outcome data. Only a small number of studies since 2015 have begun to address this gap, though the overall evidence base remains limited, particularly for British Muslims. Most research has been conducted in Muslim-majority countries (notably Iran and Turkey) and predominantly focused on couples rather than family therapy interventions. These are often adapted using Islamic principles, and the studies themselves frequently employ quasi-experimental or case-study designs (e.g. Jafari et al., 2023; Kılınçer, 2023). Where interventions have not been culturally or religiously adapted (e.g. Amiri et al., 2022), approaches such as Acceptance and Commitment Therapy and Solution-Focused Therapy have been applied to couples in a Muslim-majority context. While these show promising results for improving relationships, they provide little insight into how established family therapy approaches might be experienced or their effectiveness for Muslim families, especially in the UK.

Importantly, Weatherhead and Daiches (2015) acknowledge that Muslim families are not homogeneous and that there is overlap between Islamic and cultural practices. Building on this, the strong connections Muslims maintain with family and community members may reflect the belief that they are part of one large community (*ummah*), regardless of ethnic background or nationality, underscoring the importance of mutual support. Yet, family and community cohesion may also be amplified by patterns of migration to Western countries. It is therefore essential to consider the uniqueness of each Muslim family, likely influenced by broader cultural and social factors.

History of Pakistani Migration in the UK

The UK experienced an influx of predominantly male Pakistani migrants during the 1950s and 1960s, who were recruited as labourers in various manufacturing industries (Luthra & Platt, 2017; Sharma, 2019). This was influenced by the 1947 Partition of India and Pakistan, and the displacement of Pakistani individuals in the 1960s caused by the construction of the Mangla Dam in Azad Kashmir, with Britain playing a key role in both. The resulting compensation package from the British government alongside the 1948 Nationality Act, granted Pakistani individuals the right to reside in the UK, which subsequently increased economic migration. Introduction of the 'voucher system' in the 1960s further encouraged economic migration, as individuals already residing in the UK could obtain jobs for their family and friends, leading to the arrival of middle-class professionals (e.g. doctors, teachers, and engineers). This process strengthened family and community ties, leading to a greater concentration of Pakistani individuals in similar geographical areas. However, due to subsequent law changes, what began as a temporary migration to earn an income resulted in the permanent settlement of many Pakistani individuals who had initially come with the intention of returning. A second influx of Pakistani individuals occurred in the 1970s, primarily through family reunification, which also facilitated the migration of other family members for employment purposes. Despite additional restrictions being placed on family reunification, migration of Pakistani women increased in the 1970s and 1980s due to extended family marriages. However, family reunification dramatically decreased by around 2012-2013, largely due to stricter criteria being applied.

Kalra (2007) argues that government rules around family reunification were centred around the ideal of White nuclear families, which overwhelmingly undermined the concept of family in the Pakistani community. To illustrate, Pakistani families value kinship characterised by upholding connections and obligations towards extended family members (e.g. grandparents, aunts, uncles and cousins) as well as the wider ancestral kinship group (known as the *Biraderi*). Unsurprisingly, Sharma (2019) highlights how early first-generation Pakistani individuals insisted on maintaining ties with their families in Pakistan and holding onto their cultural and religious heritage. This meant that they invested time in

socialising with fellow Pakistani community members outside of work, and emphasis on maintaining connections with family and culture was reflected in family structure and relationships. The concept of kinship was additionally extended to individuals who originated from their village or local area, as Kalra (2007) notes how the shared struggle to settle in the UK forged strong bonds based on friendship.

Defining Psychosis

There has been much debate regarding the conceptualisation of psychosis over the years, particularly between the medical and psychological professions. Within the field of psychiatry, psychosis is defined as a set of symptoms outlined in different diagnostic manuals, including the *International Classification of Diseases, 11th Revision* (ICD-11; World Health Organisation [WHO], 2019) and the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition, text revision* (DSM-5-TR; American Psychiatric Association [APA], 2022). According to these, psychosis is a prominent feature of various MH conditions, including 'schizophrenia', 'schizoaffective disorder', and 'brief psychotic disorder'. Furthermore, symptoms of psychosis are classified into 'positive' and 'negative'. Positive symptoms refer to hallucinations (sensory experiences, such as hearing voices in the absence of external stimuli) and delusions (fixed false beliefs, such as others wanting to harm the individual). Negative symptoms refer to a decrease in emotional expression, reduced motivation, and social withdrawal. Other symptoms of psychosis may include 'formal thought disorder' (disorganised thinking and speech) and 'catatonia' (psychomotor disturbances). Psychotic symptoms may also be accompanied by affective symptoms such as low mood or 'mania', as psychosis commonly co-occurs with other MH conditions such as 'bipolar disorder' (Chakrabarti & Singh 2022).

Despite being widely used in mental healthcare, these diagnostic systems have been criticised for concerns regarding their reliability and validity, oversimplification of complex MH experiences, insufficient consideration of cultural context, and their overall utility in clinical practice (Bredström, 2019; Parnas, 2015). The DSM-5-TR (2022) has sought to address some of these concerns by updating language to be more culturally sensitive. However, broader conceptual issues such as the reduction of complex subjective experiences into categorical

diagnoses and the tension between medical and psychological models of psychosis remain relevant. Though these manuals continue to be revised, there is now advocacy for alternative approaches to psychiatric diagnosis, such as psychological formulation to develop a more holistic understanding of MH experiences and difficulties (Johnstone, 2018). One example is the Power Threat Meaning Framework (PTMF), which argues that difficulties often labelled as psychiatric symptoms may be understood as survival responses to adverse or challenging life experiences (Johnston & Boyle, 2018). This framework therefore considers a broad range of social, relational, cultural, biological and psychological factors that may lead to individuals experiencing distress.

Other alternative models specific to psychosis include the Psychosis Continuum model (DeRosse & Karlsgodt, 2015), which proposes that experiences lie on a spectrum as their impact varies between individuals, and do not always warrant a diagnosis. This model complements the 'Hearing Voices Movement', initiated in the 1980s by Dutch psychiatrist Marius Romme, journalist Sandra Escher and voice hearer Patsy Hage (Goozee, 2015). Through their research, Romme and Escher discovered that voice hearing did not necessarily indicate 'mental illness', as the experience was more common than previously thought and less distressing for some individuals. Furthermore, voice hearing was often linked to difficult life experiences, supporting the idea that individuals could learn to cope by developing a different relationship with their voices and addressing the underlying causes. This understanding of voice hearing has shown relevance cross-culturally. Luhrmann et al. (2015) found that American individuals were more likely to describe their voices as intrusive. In contrast, Indian and African individuals described their voices as "providing useful guidance" and being "morally good". The plausibility of the continuum model is therefore emphasised, as distress associated with the experiences of psychosis appears to vary across cultural contexts.

In support of these ideas, the Recovery Model (Leonhardt et al., 2020) challenges the medical model's primary emphasis on diagnosis and symptom reduction. Instead, it advocates for empowering individuals experiencing psychosis to lead more fulfilling lives, while taking into account their social, relational, and cultural contexts. These perspectives suggest that the diagnostic label of psychosis may not fully capture the complexity of individuals' experiences, as those with

similar ‘symptoms’ may experience distress in varying degrees. Furthermore, the importance of understanding the underlying factors contributing to experiences of psychosis is highlighted, as cultural and social factors influence how these experiences are interpreted and managed. For this thesis, I will use the term psychosis when discussing experiences associated with this label, as it remains the most frequently used term within the literature.

Defining ‘Family Work’ and ‘Family Involvement’

Within this study, family work (FW) is used as an umbrella term encompassing any psychologically informed therapeutic intervention involving both the individual experiencing psychosis and their family. This includes Family Interventions (FIs), Systemic Family Therapy (SFT) and Open Dialogue (OD) network meetings. Family involvement refers specifically to family members’ attendance or active engagement in FW sessions.

FIs for psychosis are broadly defined as structured, evidence-based psychological therapies that share similar underlying components, including: psychoeducation, stress and emotion management, communication enhancement, and collaborative problem-solving (Burbach, 2018; Claxton et al., 2017). These interventions may be delivered individually or to multiple families simultaneously, at the family home or within a MH service, and in the presence or absence of the individual experiencing psychosis.

In contrast, SFT explores how families’ belief systems and interaction patterns contribute to ongoing problems, with an emphasis on developing new narratives and meanings (Burbach, 2018). SFT has evolved significantly since its emergence in the 1950s, with early models positioning the therapist as the expert and interventions being more directive. Over time, SFT has shifted its attention to the stories families tell and the meanings they attach to their experiences through the use of circular questioning. As a result, MH difficulties are understood as relational as opposed to being located solely within the individual, with change being achieved through altering family interactions. Although SFT and FIs have traditionally been separated in clinical practice, there is now advocacy for a more integrated approach, guided by assessment and formulation. This involves combining both

psychoeducation and systemic principles to meet families' specific needs (Bertrando, 2006; Burbach, 2018; Onwumere et al., 2011).

OD is a more recent systemic approach that has gained attention and shown promising outcomes for EIP services, initially developed in Western Lapland (Seikkula et al., 2003). OD emphasises the critical role of social and support networks in caring for individuals experiencing psychosis, and adopts a dialogical and flexible approach. A key principle underpinning OD is psychological continuity, which fosters trust, emotional safety and sustained collaborative engagement between families, individuals, and professionals. Importantly, these principles align closely with the aims of FW and reflect the broader ethos of EIP. Together, these approaches all highlight the beneficial role of involving families in the care of individuals experiencing psychosis.

Causes of Psychosis

From a biological perspective, psychosis has been linked to differences in neuroanatomy, neurotransmitters, neurobehavioural functioning and chromosomal variants, with some research suggesting a genetic basis (Cardno & Owen, 2014; Erlenmeyer-Kimling et al., 2000; Fusar-Poli et al., 2012; Kesby et al., 2018). In contrast, psychological perspectives propose that psychosis can be explained by differences in cognition and unconscious processes influenced by earlier life experiences, including information processing deficits, reasoning biases, and psychological defences to cope with unbearable aspects of reality (Kuipers et al., 2006; Martindale & Summers, 2013). In support of this, Moskowitz et al. (2019) argue that some experiences of psychosis, including 'hallucinations' and 'delusions', may be understood as dissociative responses. Dissociation is defined as "a psychological process whereby parts of an individual's experiences, memories, or aspects of themselves become separated or disconnected from conscious awareness, often in response to overwhelming stress or trauma" (Moskowitz et al., 2019). The researchers therefore challenge biological understandings of psychosis and advocate for trauma-informed psychological interventions, rather than relying on medication.

While these explanations highlight some of the potential mechanisms involved in the development of psychosis, there is increasing evidence for the cumulative effect of environmental and social factors. These include social deprivation,

inequality, and urban living (Kirkbride et al., 2014; Sundquist et al., 2004; Werner et al., 2007; Wicks et al., 2005), early impaired social functioning (Cornblatt et al., 2012), cannabis use (Austin-Zimmerman et al., 2024), repeated trauma and Post-Traumatic Stress Disorder (Alsawy et al., 2015; Ayub et al., 2015; Shevlin et al., 2008), and adverse childhood experiences, particularly abuse and maltreatment (Flinn et al., 2025; Freeman & Fowler, 2009; Sheffield et al., 2013; Zhou et al., 2025). Importantly, research has identified that individuals from racially minoritised backgrounds in Western countries are at a higher risk of psychosis than White individuals, and this increased risk is strongly linked to social disempowerment and identity-based exclusion, influenced by social disadvantage (Jongsma et al., 2021b). The researchers also highlight limited evidence supporting increased biological or genetic risk in certain ethnic groups, noting that psychosis rates vary considerably within the same ethnic group depending on country of residence and majority or minority status. This emphasises the critical role of environmental and social factors in the development of psychosis.

While purely biological understandings have been challenged, recent reviews support a more integrated perspective of psychosis as a complex, multidimensional phenomenon shaped by both biological and environmental factors (Owen et al., 2023; Tandon et al., 2024). One model that explains this interplay is the Stress Vulnerability Model (Zubin & Spring, 1977), which suggests that individuals with genetic vulnerabilities are more likely to develop psychosis when exposed to significant external stressors. However, Read et al. (2008) offer an alternative interpretation, arguing that biological differences may not necessarily be inherited, as brain changes associated with psychosis are also observed in abused children. This perspective suggests that early trauma can heighten physiological sensitivity to stress, increasing the risk of psychosis later in life. Within clinical practice, this multifaceted view aligns with the Biopsychosocial Model (Engel, 1977), a widely adopted framework that encourages consideration of biological, psychological, and social factors.

Psychosis in the British South Asian community

Much of the research on British Pakistani individuals is situated within the broader literature on South Asian communities, which often primarily includes

participants from Indian and Bangladeshi backgrounds. The evidence base for psychosis risk among South Asian individuals is mixed and varies by study design, geographical region and the specific ethnic groups included. Several studies have indicated a higher risk of psychosis among South Asian individuals in the UK than individuals of a White ethnicity (Bourque et al., 2011; Coid et al., 2008). However, findings specific to British Pakistani individuals are more limited. Some geographically focused studies have suggested that Pakistani and Bangladeshi individuals may show higher rates of psychosis than other South Asian groups within certain regions (e.g. West Yorkshire), though these patterns are not consistently observed across the UK and should be interpreted with caution (Kirkbride, 2017; Saleem, 2019). Additionally, after Black African and Caribbean groups, British South Asian individuals appear to experience higher rates of hospital readmission compared to White British individuals (Halvorsrud et al., 2018). This illustrates a potentially complex picture of how British South Asian individuals access MH services for psychosis. Cultural factors may influence this, as South Asian individuals report high levels of stigma around psychosis and fears of rejection from the wider community, making them less likely to seek support from MH services (Islam et al., 2015; Penny et al., 2009). For those who do access MH services such as EIP, there are concerns around a lack of consideration of culture and religion by clinicians (Vyas et al, 2021). This may present an additional barrier for South Asian individuals to engage with such services.

However, the general categorisation of South Asian individuals in MH research is problematic, as religion appears to be a key factor for understanding how Pakistani individuals make sense of their MH difficulties, particularly psychosis. Specifically, studies have shown that a large proportion of South Asian Muslims, particularly those from Pakistani and Bangladeshi backgrounds, attribute psychosis to supernatural causes (e.g. ‘Jinn possession’, ‘Black Magic’ or ‘Evil Eye’) or a combination of supernatural and biological causes (Bhikha et al. 2015; Islam et al 2015; Mirza et al. 2019; Patel et al. 2023). As these are important concepts within the Islamic faith, Pakistani and Bangladeshi Muslims often turn to faith healers for support with their MH difficulties, even when taking psychiatric medication (Hussain et al. 2021; Bhikha et al. 2015; Mirza et al. 2019; Vyas et al., 2021). These

findings suggest that religious beliefs play an important role in how South Asian Muslims access support for their experiences of psychosis.

It is important to note that historically, Muslims did not associate MH difficulties with demons, and this idea appears to have originated from Europeans in the Medieval period (Sabry & Vohra, 2013). Prominent Muslim scholars such as Ibn Sina (founder of Modern Medicine) instead viewed MH problems as having a psychological basis. This later led to the development of the first psychiatric hospital in the world, located in Iraq, where MH problems were treated using psychological therapy and medication (Sabry & Vohra, 2013). One factor that may have contributed to how South Asian Muslims currently understand MH problems is Western colonisation, particularly in countries like Pakistan.

Jinns, Black Magic, and Evil Eye

According to the Qur'an, Jinns were created from a smokeless fire and are invisible to humans, although humans are visible to them (Al-Ashqar, 2003; (Qur'an, 15:27). Despite being created differently, Jinns share similarities with humans which include, eating and drinking, marrying, having children, following different religions, having good and bad qualities and experiencing death. Though it is believed that Jinns largely co-exist with humans, evil Jinns can cause harm through possession, which may result in physical, mental and social difficulties that resemble symptoms of MH problems (Abdussalam-Bali, 2004; Al-Habeeb, 2004; Karim et al., 2004; Khalifa & Hardie, 2005). As Jinns are thought to be much more powerful than humans in their abilities, they may be invoked by magicians to inflict harm on others through Black Magic, a form of 'witchcraft' (Khalifa et al., 2011; Lim et al, 2018). Evil Eye, on the other hand, refers to an envious glance by another human being, which can be detrimental to the affected person's mental or physical health (Dein et al., 2008; Mullick et al, 2012). Faith healers are therefore considered an appropriate resource through which difficulties associated with Jinn Possession, Black Magic and Evil Eye may be resolved (Syed, 2003). While this indicates why some British Pakistani Muslims may turn to faith healers instead of MH services, research has identified multiple other barriers which may be linked to cultural beliefs and experiences of accessing MH support in the UK (Kapadia et al., 2017; Patel, 2021).

In support of this, one study exploring spiritual healing methods in Bradford showed that Pakistani-Kashmiri individuals continued to show allegiance to faith healers from their own heritage, despite experiencing exploitation and dissatisfaction with the outcomes of spiritual interventions (Hussain & Dein, 2018). Although the reasons for this were not explored, this indicates that for some Pakistani Muslim individuals, spiritual explanations are not the only factor influencing their decision to seek alternative avenues of MH support. Consequently, the experiences of British Pakistani Muslims require separate exploration as some factors may be relatively distinct to this group, such as who they feel able to disclose their difficulties to and involve in their care.

Barriers to Accessing MH Services

Access to healthcare is increasingly understood as a multidimensional concept, encompassing issues such as knowledge about services, their availability and affordability, and treatment acceptability (Levesque et al., 2013). For British Pakistani Muslims, discouraging factors include: a) limited understanding and awareness of MH difficulties or services; b) stigma, shame and concerns about family honour; and c) clinicians' lack of cultural understanding and mistrust of clinicians.

Limited Understanding and Awareness of MH Difficulties or Services

Several studies have highlighted that British Pakistani individuals are at higher risk of MH problems than White individuals (e.g. Gask et al, 2011; Rees et al., 2016; Weich et al., 2004). However, British Pakistanis often interpret and report psychological distress in terms of somatic symptoms rather than MH difficulties (Karasz et al., 2019; Lloyd, 2006; Mian & Grossman, 2012; Mumford et al.,1991). Additionally, British Pakistanis more readily identify social, familial and cultural stresses as likely contributors to depression (Birtel & Mitchell, 2023; Karasz, 2005; Malik, 2000), compared to psychosis (e.g. Islam et al., 2015; Vyas et al., 2021). This suggests that there may be differences in how British Pakistani Muslims understand different MH problems, which likely influences the support they access.

Moreover, multiple studies have found that Pakistani individuals have less knowledge about MH difficulties or the availability and utility of MH services

compared to White individuals (Gilbert et al., 2004; Patel, 2023). In some studies, family members have been reported to actively avoid physical proximity with individuals experiencing psychosis due to beliefs around it being contagious (Islam et al, 2015; Vyas et al, 2021). Factors that may contribute to a lack of understanding include: a) limited awareness of MH difficulties and availability of MH services in Pakistan, which may continue to be perceived as Western concepts by British Pakistani families; b) presence of language barriers particularly for first generation individuals and; c) lack of clarity around the role of MH clinicians (Hussain et al., 2021; Kapadia et al., 2017; Tabassum et al., 2000).

Some recent studies have highlighted generational differences in awareness of MH problems within the British Pakistani community, with second-generation individuals showing an increasingly better understanding or holding dual explanatory models (Hussain et al., 2021; Patel, 2023). This is prevalent in psychosis studies, where British Pakistani individuals often attribute their experiences to a combination of religious and biological factors, which may be an attempt to reconcile understanding from both cultures (Patel, 2023; Vyas et al., 2021). Second-generation British Pakistanis may therefore be more willing to access and accept psychiatric support from MH services than first-generation individuals. However, gaps in engagement with other interventions, such as psychological therapies, may remain. Though not psychosis specific, one study demonstrated that holding the belief that MH difficulties had biological causes reduced intention to access psychological interventions in British South Asian Muslims (Pilkington et al., 2012). In another study, second-generation South Asian women reported beliefs that therapy would not be able to provide solutions to their problems and that having therapy would imply that they were “crazy”, which were seen as potential deterrents (Moller et al., 2016).

Very little research has explored British Pakistani families’ perspectives and understanding of psychosis. One notable exception is an IPA study by Penny et al. (2009), which explored family members’ experiences of caring for relatives receiving support through an EIP service. Family members described their relatives’ experiences in terms of spiritual, social and relational changes or difficulties, rather than psychological or psychiatric issues (Penny et al., 2009). Some families attributed psychosis to life stressors, conflicting social values and family difficulties,

whereas others attributed psychosis to supernatural causes, e.g., black magic. Subsequently, many families valued social and relational solutions, emphasising social engagement, spending more time with family (including getting married), and spiritual support, such as turning to God and faith healers. While this study provides rich insights into caregiver perspectives, it has several limitations. The study used a small sample typical of IPA and was conducted in a single geographical area, limiting generalisability across British Pakistani families. Importantly, it did not include the perspectives of individuals experiencing psychosis themselves, providing little insight into how these may differ from those of family members.

Nevertheless, these findings suggest that British Pakistani Muslim individuals who interpret their experiences of psychosis through psychological or psychiatric explanations may understand them differently from their family members. Such differences could shape the support they access and engage with, and how they interpret different interventions. This gap in service-user perspectives provides a clear rationale for the current study, which focuses on how British Pakistani Muslims experiencing psychosis navigate family involvement in FW and reconcile personal and familial narratives.

Stigma, Shame and Concerns about Family Honour

MH stigma is characterised by stereotypical beliefs, prejudice, and discrimination from the general public directed towards people with MH difficulties (Corrigan & Watson, 2002). MH stigma may lead to self-stigma where individuals internalise the stereotypes and prejudice held by others and, in turn, discriminate against themselves (Corrigan et al., 2011). Both public and self-stigma have been found to reduce the likelihood of individuals accessing MH services even when they recognise that support is needed (Corrigan, 2004). This highlights the detrimental impact of stigma on individuals with MH difficulties. For some, the difficulty in seeking support may be exacerbated by family members and social contacts distancing themselves, due to experiencing the same prejudice and discrimination known as ‘stigma by association’ (Bos et al., 2013; Crowe & Lyness, 2014; Phelan et al., 1998). Although research on Pakistani families specifically is limited, studies have indicated that having a family member with MH difficulties may be damaging to South Asian families’ social status and success (particularly marriage prospects),

due to rejection from the wider community (e.g. Gilbert et al., 2004; Islam et al., 2015; Lauber & Rössler, 2007; Vyas et al., 2021). This may lead to Pakistani individuals and families concealing MH difficulties and avoiding contact with MH services, ultimately reinforcing MH stigma.

Multiple studies have shown that British South Asian individuals display higher levels of stigma towards people with MH difficulties, compared to White individuals. One study of young British South Asian individuals showed that people with psychosis were perceived as more dangerous, and this translated into less willingness to support, greater avoidance, and beliefs that they should be segregated (Ahmed, 2019). This is complementary to Tabassum et al.'s (2000) research on British Pakistani individuals specifically, who expressed a strong reluctance to marry, socialise or allow their children to interact with individuals suffering from MH difficulties. In addition to this, there is a wealth of literature highlighting Pakistani individuals' concerns of stigma associated with their own experiences of MH problems and accessing MH services. With regards to MH services, Pakistani women report that stigmatising attitudes from family and the community, such as being seen as "crazy", are strong deterrents for seeking help (Kapadia et al., 2017; Moller et al., 2016). This is accompanied by beliefs that MH difficulties should not be spoken about outside of the family due to fears of being talked about negatively within the community. Gilbert et al. (2004) found that British South Asian women were less likely to use MH services, as this could bring shame upon the family if others found out about their difficulties, and seeking support was seen as a sign of weakness. These factors may reduce the likelihood of individuals with psychosis and their family members seeking support from MH services. However, many women also recognised that the burden of maintaining family honour contributed to and exacerbated MH difficulties (Gilbert et al., 2004).

Several other studies have shown that stigma is a major concern for British Pakistani Muslims across genders, especially for those experiencing psychosis (e.g. Bikha et al., 2015; Islam et al., 2015; Mirza et al., 2019; Patel et al., 2023; Vyas et al., 2021). In addition, focus groups with South Asian (including Pakistani) parents of young people experiencing MH problems showed that stigma and fear of gossip were major barriers to accessing secondary MH services. (Bradby et al., 2007). However, families who had accessed MH services emphasised the need to minimise

stigma by challenging negative beliefs associated with MH problems. Furthermore, Pilkington et al. (2012) found that concerns around shame and honour were significant factors in predicting lesser intention to access psychological interventions in first-generation British South Asian (including Pakistani) Muslims. Whereas higher levels of education and acculturation predicted increased intention to access psychological interventions in British-born South Asian Muslims, with no significant association being found for shame or honour. This suggests that when accessing MH services, there may be variations in how stigma affects different individuals from the British Pakistani Muslim community, which may be more complex for those navigating influences from two different cultures.

Clinician's Lack of Cultural Understanding and/or Mistrust of Clinicians

A few studies have commented on the dilemma faced by Pakistani individuals concerning the ethnicity of MH clinicians. Cultural similarities have been shown to increase trust and openness, whereas stereotypical and racist remarks and culturally insensitive interventions increase the likelihood of disengagement from services (Moller et al., 2016; Bowl, 2007). In their systematic review, Kapadia et al. (2017) found that Pakistani women reported a preference for clinicians of the same cultural background as they felt that their problems would be better understood. These findings are reflected in other research focusing on psychosis, which highlighted concerns around the lack of training and consideration of culture and religion by EIP clinicians (Islam et al., 2015; Vyas et al., 2021), which may be rooted in institutional racism (Prajapati & Liebling, 2022). On the other hand, Pakistani women have also expressed strong fears that clinicians from their own background may disclose their difficulties to family or community members, a finding consistent across studies (e.g. Gilbert et al., 2004; Prajapati and Liebling, 2021). This explains why some South Asian (including Pakistani) individuals may prefer to see White clinicians for matters perceived as being more stigmatised (Moller et al. 2016). In the context of therapy specifically, Moller et al. (2016) found that second-generation South Asian women (including those from Pakistani backgrounds) reported a similar dilemma about having therapy or counselling with White vs. Asian counsellors/therapists. This is important as a large majority of women in the sample had never participated

in therapy, supporting the idea that community-level beliefs surrounding therapy may be a sufficient deterrent for Pakistani individuals.

It is important to acknowledge that choice around the clinician's ethnicity may not be an option for all Pakistani individuals, as language barriers and use of interpreters have been identified as factors that impact first-generation Pakistani individuals' knowledge and experience of MH services (Kapadia et al. 2017). Explanations for this include difficulty translating Western MH terminology due to these concepts not existing in the languages spoken in Pakistan, and descriptions of individuals' experiences being misinterpreted by interpreters and clinicians (Patel et al., 2023; Tabassum et al., 2000). Similar findings have been found in the context of EIP services, where the availability of respectful professionals who are culturally aware and access to competent interpreters who maintain confidentiality have been identified as key factors that impact overall experience (Islam et al., 2015). Subsequently, these cultural issues may increase Pakistani individuals' reluctance to seek MH support if clinicians are perceived as threatening or dismissive of their cultural identity and experiences (Prajapati and Liebling, 2021).

The Cultural Influences on Mental Health (CIMH) model (Hwang et al., 2008) attempts to capture how culture influences MH difficulties and treatment. Within this framework, researchers define culture as the "attitudes, values, beliefs, and behaviours shared by a group of people" and highlight the impact of "culture-related experiences" such as "acculturation and being an ethnic minority" (Hwang et al., 2008, p. 212). According to the CIMH model, cultural factors impact MH by influencing the following domains: 1) prevalence of MH difficulties; 2) causes and course of difficulties; 3) expression of distress; 4) diagnosis and assessment; 5) coping and help-seeking; and 6) treatment/intervention. Understanding how culture impacts British Pakistani Muslims' experience and sense-making of FW for psychosis is therefore fundamental for developing culturally sensitive MH services.

Early Intervention in Psychosis

EIP services were developed to support the needs and recovery of individuals at risk of, or experiencing a first episode of psychosis, with support usually being offered for 3 years (Murphy & Brewer, 2011; NICE, 2016). In the UK, EIP services are typically made up of a multi-disciplinary team that provides a range of

pharmacological and psychological interventions e.g. Cognitive Behavioural Therapy (CBT) and FIs, social care support such as housing or debt management, relapse prevention work and crisis management, general family/carer support, monitoring of physical health and lifestyle, and support with education, employment, and training (NICE, 2016). Early intervention is thought to prevent the negative outcomes associated with longer durations of untreated psychosis (DUP), usually defined as the period between the emergence of the first symptom of psychosis and starting MH treatment (Harrigan et al. 2003; Marshall et al., 2005). A DUP of more than six months is considered long, as the first six months are seen as a critical period that influences outcomes (Bhui et al., 2014; Drake et al., 2020; Singh et al., 2015), with shorter DUPs being associated with better outcomes in terms of symptomology, overall functioning and quality of life (Albert et al., 2017; Marshall et al., 2005; Penttilä et al., 2014; Perkins et al., 2005).

Although studies have shown that South Asian individuals often turn to spiritual healers and encounter MH services only after a crisis (Singh et al., 2013; Islam et al., 2015), research has not found a clear link between different explanatory models and longer DUPs (Bikha et al., 2015; Singh et al., 2015). One review suggested that South Asian individuals may have briefer DUPs compared to other ethnic groups (Halvorsrud et al., 2018); however, this was based on a small number of studies, and the differences did not reach statistical significance (Bhui et al., 2014; Ghali et al., 2013; Singh et al., 2015). Only one study showed a significantly shorter service DUP for South Asian individuals, defined as the point of referral to an EIP service (Ghali et al., 2013). More recent studies have not consistently replicated this finding, indicating that evidence for shorter DUP in South Asian populations is limited and may vary by context or subgroup. Some research suggests that higher rates of involuntary admission among South Asian compared to White individuals (Gajwani et al., 2016; Halvorsrud et al., 2018; Kirkbride et al., 2006; Oduola et al., 2021) could facilitate earlier referral to EIP services, potentially shortening service DUP. However, this relationship remains uncertain across studies. Furthermore, these studies do not distinguish between different South Asian groups, making it difficult to determine DUP in the Pakistani community specifically.

Family Work for Psychosis

A key driver in the development of structured FIs for psychosis was the association found in early research between high Expressed Emotion (EE) and increased risk of relapse (Barrowclough and Hooley, 2003; Butzlaff and Hooley, 1998; Dixon & Lehman, 1995; Leff, 1976). High EE is characterised by three factors: a) Criticism; b) Hostility; and c) Emotional Overinvolvement (EOI), and has been used as a standardised measure to assess how families interact with individuals experiencing psychosis (Leff and Vaughn, 1985; Vaughn and Leff, 1976). However, differences in EE levels between British Pakistani individuals and other ethnic groups do not accurately predict relapse. In one seminal review and follow-up work, Hashemi & Cochrane (1999) raised concerns about the cultural validity of standard EE measures for Pakistani Muslim families. This is because Pakistani Muslim families exhibited higher levels of EOI than Indian Sikh and White British families, and psychosis relapse was only better predicted when the clinical threshold for EOI was raised to reflect cultural norms. Hashemi & Cochrane (1999) also found higher levels of EOI in the general Pakistani population compared to White British families, flagging concerns that Western EE measures may pathologise culturally normative patterns of interaction. The researchers also commented on the dangers of using EE as an independent measure to understand distress and relapse, emphasising the need to account for broader sociocultural influences. This is because Indian Sikh participants appeared to benefit from social and community support through their place of worship, a resource less commonly described by Pakistani Muslim participants.

More recent studies on EE in South Asian individuals have shown similar cultural variations. In a non-clinical study by Shaikh et al. (2023), many participants reported high levels of EOI within their family contexts. However, when accompanied with higher perceived warmth, anxiety and depression scores appeared to be buffered, whereas criticism and not feeling understood were associated with increased distress. Additionally, Ramanathan, et al. (2024) explored perceived EE in South Asian individuals experiencing early psychosis. They found that EE in this context was nuanced and culturally shaped, beyond what is captured by the traditional Western model. This is because warmth and care were often present;

however, feeling understood and having autonomy determined whether EE in relationships was perceived as positive or negative. Some factors that influenced this included caregivers' acceptance of MH difficulties, acculturation, communication styles, and family values. These findings underscore the significance of cultural awareness in understanding how specific aspects of caregiving are navigated and perceived within South Asian families.

Regarding the evidence that FIs reduce EE, research has produced mixed results. In one systematic review and meta-analysis, FIs were found to reduce criticism at the end of treatment with a large effect size, and this was maintained up to 2.5 years later (Claxton et al., 2017). However, there was no impact on emotional overinvolvement. In another meta-analysis of randomised controlled trials, FIs reduced levels of EE in some studies; however, the findings were equivocal in others (Pharaoh et al., 2010). It was also unclear whether the significant reduction in relapse and hospital admissions was mediated by a reduction in EE (Pharaoh et al., 2010). Lack of clarity around the relationship between EE and relapse is also reflected in Claxton et al.'s (2017) review, which showed that FIs reduced relapse at the end of treatment but not at follow-up, and no evidence was found for reductions in length of hospital admissions.

Nevertheless, multiple other benefits of FIs have been identified for both individuals with psychosis and their families. Studies have shown a large effect size for FIs improving symptoms of psychosis up to two years later, even though these improvements were not present at the end of the Family Intervention (Claxton et al., 2017). In support of this, Ma et al. (2020) conducted a meta-analysis to assess the effectiveness of a specific, integrated Family Intervention for psychosis. They found that Cognitive Behavioural Family Intervention (CBFI) was effective for reducing positive and negative symptoms of psychosis post-intervention, though evidence was stronger for delusions than hallucinations. Furthermore, FIs have been found to improve social and general functioning in individuals, improve carer wellbeing, reduce carer burden and improve overall family functioning at the end of treatment; however, there is mixed evidence for whether these effects are maintained at follow-up (Claxton et al., 2017; Pharoah et al., 2010; Ma, et al., 2018).

Conversely, less attention has been given to assessing the effectiveness of SFT for psychosis. One randomised control trial showed that SFT, compared to

psychiatric treatment alone, was effective for decreasing hospital admissions, reducing relapse rates, and increasing medication compliance (Bressi et al., 2008). However, reduced relapse was not maintained at 2-year follow-up. In another small-scale study involving individuals at risk of psychosis, SFT was found to reduce experiences of psychosis and low mood, and improve self-esteem and social support (Shi et al. 2017).

While OD is considered a framework for practice rather than a distinct systemic intervention, research from Western Lapland has shown efficacious results for individuals experiencing psychosis (e.g. Seikkula, et al. 2011). This has led to the piloting and implementation of OD across UK EIP services (e.g., Burbach et al., 2015; Hendy et al., 2015; Jackson, 2015), with large-scale randomised controlled trials now being conducted, e.g., ODDESSI (Pilling et al., 2022).

Considering the importance of family in the Pakistani community, FIs are majorly under-researched within this population despite being recommended by NICE guidelines as part of the treatment package for early psychosis (Lincoln & Pedersen, 2019; NICE, 2014). As a result, there is limited evidence available regarding whether FIs or SFT are effective for British Pakistani individuals. One important contribution is Husain et al. (2021), who developed and assessed the feasibility of a culturally adapted FI in Pakistan. Adaptations addressed multiple layers of cultural context, including: language (translation into Urdu and use of less stigmatising terminology), simplified psychoeducation (integrating cultural and religious explanatory models and accounting for lower education levels), acknowledgement of extended family structures and collectivist responsibilities as part of recovery, and implementation of culturally sensitive communication and conflict management strategies respecting privacy norms. The intervention also merged existing FI and South Asian specific manuals for Schizophrenia, modified case vignettes to reflect local norms, and adapted delivery to overcome practical barriers to access. The study yielded promising results in terms of recruitment and retention, though further research is needed to establish its clinical effectiveness (Husain et al., 2021). However, this intervention was designed for families in Pakistan and therefore reflects cultural, social and structural contexts that may significantly differ from those of British Pakistani Muslims living in the UK. While the findings highlight the importance of culturally informed FIs, it remains unknown

how FIs in general are experienced by British Pakistani Muslim families or individuals experiencing psychosis in the UK. Furthermore, it is unclear how British Pakistani Muslims experience family members' involvement, which may require navigating differing generational perspectives, explanatory models of MH, and experiences related to UK MH services.

More broadly, FW may be especially relevant in mental healthcare, as according to Family Systems Theory, individuals cannot be understood in the absence of their families due to being emotionally interconnected and interdependent (Brown, 1999; Bowen, 1978). While families are complex systems with unique patterns of communication, functioning, and rules, each member is also viewed as having their own role and purpose within the system (Hammond, Cheney & Pearsey, 2015). Family members therefore impact one another through patterns of interaction, and as a result, may have a key role in the development and maintenance of psychological distress.

Gaps and Rationale for the Current Study: Experience of Family Involvement

Although evidence for FW specifically is limited, research suggests that family involvement in mental healthcare may be significant for British Pakistani individuals. In one review focusing on British South Asian individuals, family involvement was identified as important for helping family members to understand and support loved ones with their MH difficulties (Prajapati & Liebling, 2022). However, MH services were criticised for often dismissing this and only involving family members when an interpreter was needed. Other studies have highlighted concerns regarding the suitability of individual psychological interventions for Pakistani individuals, as these do not consider the role of family. In one study conducted in Pakistan, individuals expressed that some CBT concepts were incompatible with their religious, community and familial values, as CBT tends to be more individualistic (Naeem et al., 2009). Subsequent cultural adaptations of CBT for psychosis incorporating family involvement have been evaluated in Pakistan, showing promising results (Habib et al., 2014; Husain et al., 2017; Naeem et al., 2015a). Although these findings suggest that some Pakistani individuals may prefer family involvement in psychological interventions, overinvolvement and lack of cooperation by family members have also been identified as barriers to therapy

(Naeem et al., 2014). Furthermore, these findings may not accurately reflect the views and experiences of British Pakistani individuals, as the study was conducted in Pakistan. Naeem et al. (2015b) acknowledge this and emphasise that when working with British South Asian Muslims from more individualistic cultural contexts, therapists should be cautious in weighing up the pros and cons of involving family in these interventions. This is because the same value may not be placed on family involvement by individuals residing in Western societies, such as the UK, as those living in South Asian countries like Pakistan.

To extend on this, research exploring the lived experiences of British South Asian individuals receiving support from EIP identified several key themes that may hinder family involvement. Vyas et al. (2021) found that British South Asian (including Pakistani) families tended to conceal family members' difficulties and avoid conversations about psychosis due to concerns around stigma and shame. Participants in this study also held strong beliefs that stigma would be very harmful to them and their families, consistent with research showing that stigma is a major barrier to seeking MH support in the Pakistani community (e.g. Gilbert et al. 2004). It is therefore possible that British Pakistani individuals experiencing psychosis may not wish to involve family in therapeutic interventions within settings that may be stigmatising for both. Moreover, some family members in Vyas et al.'s (2021) study were reported to distance themselves from individuals experiencing psychosis, due to a lack of understanding about what psychosis was. This may be an additional barrier for British Pakistani individuals to involve family members in their care, even if they wish to do so. However, this study did not specifically explore the experiences of British Pakistanis regarding family involvement in psychological interventions and therefore, only tentative conclusions can be drawn.

In another study, British Pakistani families identified social and faith-based support as the most suitable treatment approaches to ameliorate psychosis related difficulties, despite attributing psychosis to family issues, conflicting social values, and life stressors (Penny et al., 2009). Though not explored, one possible reason may have been that families were unaware of the availability of psychological interventions, particularly FW. With evidence indicating that FW is beneficial for those experiencing psychosis, these findings highlight the need for greater insight into how British Pakistani individuals view and experience family involvement in

these interventions. Furthermore, it is fundamental to understand how British Pakistani Muslims experiencing psychosis view their family in relation to their recovery, as research has indicated that South Asian families may be experienced as both caring and isolating (Faulkner, 2011; Vyas et al., 2021).

Importantly, FW might provide British Pakistani individuals with a valuable space and resources to speak about their difficulties with family members. This is because language barriers have been identified as preventing British South Asian individuals from sharing their experiences of psychosis with their relatives (Vyas et al. 2021). Additionally, some Pakistani individuals (particularly second generation) may be less concerned about stigma and more open to FW due to having a better understanding of MH difficulties (Hussain et al., 2021). However, they may find it challenging to involve parents, grandparents, and other family members from older generations, who are more concerned about shame and honour (Pilkington et al., 2012). Considering these factors, it is essential to understand what family involvement in FW is like for British Pakistani Muslim individuals, where MH difficulties are discussed within the family context, and family members may need to adapt to support them.

Aims and Research Question

The primary aim of this study is to carry out a detailed exploration of how a small sample of British Pakistani Muslim individuals experience and understand family involvement in FW for psychosis. The study also aims to explore how individuals: a) experience and make sense of changes in their family relationships, roles and identity; b) make sense of their family's involvement in relation to their treatment and recovery; and 3) make sense of their difficulties related to psychosis before and after taking part in FW.

It is hoped that the current study provides more insight into the experiences of British Pakistani Muslim individuals engaging in FW for psychosis, as research in this area is still very limited. This has the potential to inform culturally inclusive service provision and provide direction for future research to better understand how cultural factors shape FW for psychosis. The study addresses the following research question: *How do British Pakistani Muslim individuals experience and make sense of family involvement in FW for Psychosis?*

The following Method chapter will outline in detail how this qualitative study was conceptualised and conducted.

Chapter 2: Method

This chapter begins by outlining the study's design, ontological and epistemological positioning and justification for choosing Interpretative Phenomenological Analysis (IPA) as the methodological approach. This is followed by a reflexive statement. A summary of the data collection and analysis procedures is subsequently presented, including ethical considerations, inclusion and exclusion criteria, recruitment, data collection and analysis methods, and quality measures.

Design

Qualitative methodology was chosen for this study. This is because qualitative approaches facilitate a deeper exploration and understanding of individuals' experiences, the meanings they attach to them, and how experiences and meanings are created (Elliot et al., 1999; Denzin & Lincoln, 2005). This approach contrasts with quantitative methods, which are better suited to testing predetermined hypotheses and identifying causal relationships between variables through statistical analysis (Barker et al., 2002; Denzin & Lincoln, 2005; Pietkiewicz & Smith, 2014). To meet the aims and focus of this study, a qualitative approach was therefore considered appropriate, allowing British Pakistani Muslim individuals to share their rich and unique experiences in their own words. Moreover, it felt imperative to provide Pakistani Muslims a voice within research due to them often being broadly categorised as 'South Asian', despite the considerable heterogeneity within this group.

Ontological and Epistemological Positioning: Critical Realism

Ontological positions sit on a spectrum with the two extreme ends ranging from 'realist' to 'relativist'. A realist position proposes that a single reality exists independently of individuals and is made up of stable structures (Willig, 2001). However, a relativist position maintains that reality is socially constructed between individuals and therefore, multiple realities may exist simultaneously (Willig, 2001). Epistemological positions also sit on a spectrum, with positivism on one end and constructivism on the other end. Positivism adopts the stance that true knowledge can be obtained and generalisable claims can be made about the world, whereas constructivism asserts that knowledge is produced and interpreted by individuals

based on factors such as language, culture, and context (Madill et al., 2000; Ponterotto, 2005; Willig, 2012). In the case of Critical Realism, an external material world is viewed as existing independently of individuals; however, 'pure' knowledge of this cannot be obtained as individuals' access reality through their own subjective lens, engaging with it at different levels (Danermark et al., 2002). A Critical Realist perspective, therefore, takes a more realist position ontologically but a more subjectivist position epistemologically.

Critical Realism aligns with my own position as a researcher, which is largely influenced by my identity as a Muslim and a Trainee Clinical Psychologist. From an Islamic perspective, an objective reality created by Allah exists independently of human perception, which encompasses both the seen (physical and material realm) and the unseen (metaphysical and spiritual realm). However, human knowledge and understanding of these are mediated by revelation (e.g., the Qur'an) and spiritual guidance (e.g., Hadith). In the context of this study, I take the position that structures such as family and the MH system exist and operate independently of individuals. However, participants' experiences and understanding of family involvement in FW for psychosis are shaped by different factors such as language, culture, religious beliefs, and social context. This is particularly relevant for British Pakistani Muslims navigating multiple aspects of their identity. This position also aligns with my values as a Trainee Clinical Psychologist, as a core aspect of clinical psychology is formulating a joint understanding with individuals of how their sociocultural context may influence their difficulties (Johnstone & Dallos, 2014). This subsequently fits with the chosen method, Interpretative Phenomenology Analysis (IPA), as the aim of the research is to explore and understand individuals' experiences of family involvement, rather than establish what is objectively true.

Interpretative Phenomenological Analysis

IPA is a qualitative research approach grounded in Phenomenology, Hermeneutics, and Idiography, which aims to explore how individuals make sense of their lived experiences (Smith et al., 2009; Pietkiewicz & Smith, 2014). It typically involves the collection of rich, personal accounts, followed by a detailed case-by-case analysis that builds understanding from the data. IPA has been widely applied in psychosis research, including studies on the experiences of South Asian

individuals (Patel et al., 2023), stigma in individuals accessing EIP (Vyas et al., 2021), and Pakistani families' accessing EIP support (Penny et al., 2009). However, no study to date has explored British Pakistani Muslim individuals' experiences of family involvement in FW in the context of psychosis.

Phenomenology

Phenomenology was first introduced by Husserl, who argued that to understand human experience, it is necessary to consciously turn to the phenomenon being experienced while setting aside our automatic preconceptions (Shinebourne, 2011; Smith et al, 2021). Heidegger later developed and challenged this idea, arguing that individuals cannot be separated from their historical, social, and cultural contexts as they are deeply embedded within them. IPA aligns more closely with Heidegger's view, as it considers experience as something that must be interpreted rather than merely described. This interpretative process, known as 'hermeneutics,' is shaped by both the participant's and the researcher's previous experiences and understandings of 'being in the world'. Interpretative Phenomenology, as used in IPA, differs from Descriptive Phenomenology (developed by Giorgi), which aims to set aside presuppositions through 'bracketing' and describes the components that make up an experience (Shinebourne, 2011; Smith et al, 2021). Instead, Interpretative Phenomenology seeks to understand and provide detailed descriptions of experiences while also eliciting meaning (Smith & Eatough, 2008). Consequently, the researcher plays an active role in the meaning-making process through co-constructing insights when engaging with participants' accounts.

Hermeneutics

IPA recognises that while individuals attempt to make sense of their own experiences and social worlds, the researcher is simultaneously attempting to make sense of the individual's interpretations (Smith, 2004). This process is known as 'double hermeneutics'. It is therefore essential that the researcher adopts a critical and reflective approach, considering how their own background and assumptions may shape the sense-making process. As interpretation is dynamic, it is often not possible to predict which preconceptions or biases will be relevant. Instead, the researcher's understanding develops through engagement and movement between

both the individual parts and the overall data set, a process known as the hermeneutic circle (Smith, 2007; Shinebourne, 2011). IPA allows for multiple levels of interpretation, which may involve critical questioning of the individual's account to draw out and uncover deeper meaning. However, such interpretations must remain grounded in the individual's own words and narratives (Smith et al., 2009). IPA consequently involves an iterative analytic process in which the researcher continually refers back to the data to refine and deepen interpretations.

Idiography

An idiographic approach refers to the detailed, in-depth exploration of an individual's nuanced experience, which contrasts with a nomothetic approach that seeks to identify general laws across populations (Krauss, 2005; Smith, 2004). The aim of IPA is therefore not to produce generalisable claims across large groups. Instead, IPA involves a detailed analysis of each individual's account, based on the premise that individuals can become the unit of study through offering unique insights into their lived experiences of a phenomenon (Smith et al., 2009; Larkin et al., 2006). While the focus is on individual meaning-making, patterns of similarity and difference within shared experiences can be identified through comparison across participants' accounts. Moreover, greater clarity around nomothetic findings may be achieved by connecting idiographic insights generated through IPA to existing psychological literature and theory.

Other Methodological Approaches Considered

Several methodological approaches are available for qualitative research, each with their own philosophies and frameworks for collecting and analysing data (Lyons & Coyle, 2016). One such approach is Grounded Theory (Glaser & Strauss, 1967), which aims to develop an explanatory theory of phenomena and social processes (Starks & Trinidad, 2007). This approach did not not seem appropriate for the current study, as although Grounded Theory can examine experience, the aim was not to develop a theory about how ethnicity and religion influence individuals' involvement of family in FW for psychosis. Instead, the aim was to explore how British Pakistani Muslims experience family involvement in FW and the meanings they attach to it. Another approach considered was Narrative Analysis, which

explores individuals' experiences through stories of events. This approach examines how individuals construct narratives around their experiences by focusing on the content, structure, sequence and function of these narratives (Riessman, 2002; Smith et al., 2009). Although participants were invited to share narratives of their experiences for the study, the primary focus was to explore how British Pakistani Muslim individuals make sense of their experiences rather than examine how these narratives are constructed and shared. As a result, IPA was considered the most appropriate approach compared to Grounded Theory and Narrative Analysis.

Reflexive Statement

A strength of IPA is that it acknowledges the researcher's active role in the research process, recognising that interpretations of individuals' accounts are shaped by both the participants' meanings and the researcher's own perspective (Willig, 2012; Pietkiewicz & Smith, 2014). As such, IPA encourages researchers to stay as close to the participant's words as possible and take a reflexive position throughout, which includes the use of practical tools such as a reflective journal. Regarding this study, I am aware of the degree of similarity between my own and participants' experiences, due to being from the same cultural and religious background. While this may allow for a deeper understanding of participants' experiences, I am cautious of how my identity could affect the expression of experience, and the influence of my own ideas or beliefs on interpretations regarding what is important (Smith et al. 2021). As practised by many qualitative researchers, including those using IPA, I will now outline my own personal characteristics and my proximity to the study's focus.

I am a 29-year-old British, Pakistani Muslim woman, born and raised in the UK. My early experience of family involved growing up in a single-parent household with my two siblings, and having very little physical contact with my extended family, the majority of which reside in Pakistan. However, after a spontaneous trip to Pakistan in my early twenties, I became really close with my extended family, which undoubtedly made me value the importance of these relationships. A testimony to this is the fact that I have travelled to Pakistan six times to visit family over the course of this project alone. Throughout my life, I have witnessed and heard both the benefits and challenges of living in a large extended

family versus a small family network, based on my own experience as well as those of my family, friends, colleagues, and clients I have worked with. My interest in 'psychosis' first began whilst working as an Assistant Psychologist on an acute ward in a geographical area with a higher population of Pakistani people. This was the first time I met people from the Pakistani community who had been given a diagnosis of psychosis. My experience of working on the ward was often quite frustrating due to the emphasis on antipsychotic medication, with psychological therapy being a much later option. This was surprising to me as family almost always featured as a prominent component in the stories of Pakistani individuals admitted onto the ward, whether this was in contributing to distress, maintaining it, or family members being a fundamental source of support. Subsequently, my interest in family therapy was sparked by the opportunity to participate in initial family sessions facilitated by the Clinical Psychologist on the ward, with the hope that these sessions would be continued under the EIP service following discharge. This was a refreshing experience, considering that my first encounter with family therapy was a poorly facilitated initial session involving my own family, which to some extent continues to have a damaging impact.

It is important to reflect that whilst I have some experiences of family that may resonate with the participants of this study, I have never experienced psychosis or needed my family to become involved in my care for severe MH difficulties. Similarly, despite our shared ethnic and religious background, participants will not have had identical experiences of family or hold similar attitudes towards MH support. Given the stigma and concerns around MH in the Pakistani community, there is also a possibility that participants may feel less comfortable sharing their experiences with me, particularly due to my role as a MH professional. Conversely, participants may feel more open to sharing their experiences with me compared to a researcher from a different ethnic and religious background, based on the assumption that I would hold a better understanding. It is therefore imperative to ensure that I do not make premature interpretations about participants' experiences based on my limited perspective, particularly within the interview itself.

Procedure

Ethical Approval and Considerations

Full approval was obtained through the NHS ethics approval system (reference 23/IEC08/0042) and from the Research and Development departments for three out of the five NHS Trusts approached, who were able to identify potential participants (Appendix A). The key ethical considerations for the study were informed consent, managing potential distress, and maintaining privacy and confidentiality.

All participants were current EIP service users with lived experience of psychosis. They were initially approached by their own clinicians or therapists, who were best placed to determine whether it was appropriate to invite them. This approach protected participants' confidentiality, as their contact details were only shared with the researcher once they had agreed to hear more about the study. It also helped ensure participants' safety and reduced the risk of feeling pressured to participate. However, this recruitment method may have introduced selection bias, as clinicians could have invited potential participants perceived as having more positive experiences or outcomes.

Clinicians explained the study, provided a participant information sheet (PIS) and gave eligible participants one week to consider participation. Upon arrival for the interview, capacity was formally assessed to confirm that participants could understand and retain information about what was required of them, as well as the potential associated risks. Only participants who had the capacity to provide informed consent at the start of the interview were included. The PIS was also reviewed with the participant to ensure that informed consent was obtained. Participants were then asked to sign a paper consent form if participating in person, or provide verbal consent, which was recorded if they were participating online. They were also clearly reminded at multiple points of their right to withdraw. A £20 gift voucher (Amazon/Love2Shop) was offered to participants to compensate them for their time and effort, which they were only made aware of once they had arrived for the interview, to avoid feeling pressured or coerced into participation.

A protocol was devised with clinicians to outline the procedure that would be followed to minimise the risk of distress during and after the interviews. This was clearly communicated to all participants, including the option to participate in a second interview should the first one need to be stopped. All participants were

offered regular breaks during the interview and debriefed after. As the interviews were asking participants to reflect on their experience of family involvement in FW for psychosis, there was a potential that participants would disclose difficult interactions or conflicts that had occurred related to their difficulties or FW. Participants may also have been worried about disclosing details of their experiences holding high levels of stigma within their social context, particularly due to our shared ethnic background. It was hoped that building rapport, transparency about the research process, and emphasising confidentiality would reduce the likelihood of participants becoming worried about this. It was also anticipated that the interview would be seen as an opportunity for participants to share some of their experiences that they may not have shared previously; however, precautions were taken to minimise emotional distress. The PIS additionally included a list of support sources should this have been required.

Research has highlighted that Pakistani individuals express concerns around confidentiality when speaking to MH clinicians of the same background, due to high levels of stigma and shame (e.g. Gilbert et al., 2004; Prajapati and Liebling, 2021). These concerns may extend to researchers from the same background when discussing MH difficulties and experiences of FW. Multiple considerations were therefore made to ensure confidentiality. Interviews took place in a private space chosen by the participant, ensuring that they could not be overheard by others. Interviews were also recorded using my secure University of Leeds Microsoft Teams account and could not be accessed by others. Participants were informed that identifiable information would not be shared with anyone during the research process unless they indicated that there was a risk of harm to themselves or others. In this case, risk information would need to be shared with appropriate MH clinicians, which would be discussed with the participant beforehand, where possible. Participants were encouraged to only share what felt comfortable and explicitly given the option to not answer questions if necessary. It was also made clear that information shared in the interviews would not be discussed with clinicians involved in their care, and transcripts would be completely deidentified. Participants were given the option to choose a pseudonym for themselves, which would be used when reporting the analysis, including quotes from the interview. The PIS included a detailed summary of how participants' data (including contact

details, consent information, interview recordings, and transcripts) would be used, stored and deleted as part of the study.

Recruitment

This study specifically focused on individuals experiencing psychosis rather than their family members or dyads. As IPA requires a homogeneous group of participants, purposive sampling was used. Homogeneity was established based on participants' shared experience of being from a British Pakistani Muslim background and taking part in FW for psychosis. I initially aimed to recruit between 6-10 participants from EIPs who had participated in FW within the last 12-18 months. This was in line with IPA's recommended sample size for an in-depth analysis of individuals' experiences (Smith et al., 2009) and included individuals who had completed FW or were currently undertaking it. As enough participants could not be recruited from EIPs initially, recruitment was extended to Community Mental Health Teams (CMHT). I was mindful, however, that experiences of family involvement could differ for those with more prolonged experiences of psychosis. Despite a small number of potential participants being identified by clinicians, none agreed to take part. Recruitment was also extended to those who had completed FW up to two years ago, which similarly did not result in more participants being identified.

In total, EIP and CMHT clinicians were approached across four large NHS Trusts in the North of England and one in North London, who acted as gatekeepers. Detailed information was provided and discussed in team meetings to allow clinicians to identify suitable participants who satisfied the inclusion and exclusion criteria. Despite the study being inclusive of non-English speakers, the PIS and consent form were primarily produced in Urdu and Punjabi. This is due to these being the most commonly spoken languages in the British Pakistani population and because of my own fluency in these languages. Clinicians initially discussed the PIS with potential participants. If they were interested in participating, clinicians requested permission for their contact details to be shared with the researcher. I then contacted potential participants to discuss the PIS with them and answer any questions they had about the study. The PIS was also emailed to them for reference. Approximately 20 potential participants were identified and approached by

clinicians, of which nine expressed interest and consented to their contact details being shared. Overall, only five participants could be recruited from two EIPs in the North of England. No exclusions were made in terms of gender or generation. PIS and consent forms in other languages were not required.

Inclusion Criteria

- Individuals who self-identified as being from a Pakistani Muslim background.
- Had engaged in a psychologically informed piece of FW for their experiences of psychosis, within the last two years.
- First experience of engaging in FW.
- Spoke English, Urdu, Punjabi or any other language spoken in Pakistan.
- Had the decision-making capacity to consent and take part in an interview of up to 90 minutes.
- Age 18 or above.

Exclusion Criteria

- Lacked capacity to provide informed consent at the time of the interview.
- Currently experiencing acute features of psychosis that would make it difficult to engage in an interview.
- At risk of becoming significantly distressed if they took part in the study (based on clinical judgement of the clinician involved in their care and the researcher at the time of the interview).
- Under the age of 18 years.

Rationale for Focusing on Individuals

Most existing research on FW has focused on family members and carers, while studies involving British Pakistani Muslim individuals tend to explore broader cultural narratives around therapy and MH. This study addressed an important gap by examining how British Pakistani Muslims experiencing psychosis navigated potentially differing perspectives and expectations around FW and MH within their families. Focusing on individuals allowed for an in-depth exploration of their experiences and sense-making, while situating these within broader cultural and

familial contexts. This focus directly informed the analysis, as each participant was treated as a distinct case in line with IPA's idiographic principle, enabling patterns and themes to emerge across accounts while remaining grounded in personal experiences. A strength of this approach was the rich insight it provided into individual perspectives, while a limitation was that family members' experiences were not directly represented. Additional limitations related to recruitment and participation included the possibility of memory gaps, increased likelihood of distress during interviews, and challenges in recruiting individuals with lived experience of psychosis.

Semi-Structured Interviews

For IPA studies, the most popular method utilised to gain detailed accounts of individuals' experiences is semi-structured interviews, supported by an interview guide produced by the researcher. Compared to structured interviews, semi-structured interviews allow for flexibility and topics to arise in real-time without being overly restricted to predetermined categories, which may limit exploration (Smith, 1996). This allows the researcher to ask further questions while providing some scaffolding around the research aims (Smith et al., 2009).

However, one disadvantage of semi-structured interviews is that they can be longer than structured interviews as the researcher has less control over what the participant might bring, making analysis more complex (Smith & Osborn, 2008). Although other methods, such as focus groups, have also been used in IPA studies, their use has been criticised as there is less of an idiographic focus on individuals' experiences and interactions, and exploration of experiences between participants may be impacted by group dynamics (Love et al., 2020). Similarly, while focus groups allow for discussions that are more participant-led, accounts may be enhanced due to shared experiences, and multiple accounts may be gathered simultaneously, participants may feel less comfortable sharing certain personal experiences in group settings.

In the context of this study, it was assumed that some aspects of individuals' experiences could have been distressing, and individuals may have been concerned about the stigma associated with accessing FW. This may be amplified in a setting involving other members of the same community. Considering these issues and little

being known about Pakistani Muslim individuals' experiences of family involvement in FW for psychosis, semi-structured interviews appeared to be the most appropriate method to ensure rich accounts of individuals' experiences could be captured. The interview schedule was developed using guidance from Smith et al. (2021) and the supervisory team, who provided feedback on whether the questions would allow participants to adequately share sufficient information to answer the research question (Appendix D). The interview schedule was also peer-reviewed by other Trainee Clinical Psychologists familiar with IPA to ensure that questions were suitable for exploring participants' experiences and meaning-making. Attempts were made to pilot the schedule with experts by experience through university and local service contacts. However, no volunteers came forward, so Patient and Public Involvement (PPI) could not be achieved.

Interview and Transcription Procedure

Participants were given the option to have the interview online or in person. Interviews ranged from 70-108 minutes in duration. Additional demographic information was collected at the end of the interview, and participants were asked if they would like to receive the study's results once it was completed.

All interviews were transcribed verbatim using the guidance of Pietkiewicz & Smith (2014). This included all spoken words, repetitions, and stutters, as well as inaudible material and non-verbal utterances or gestures. Any identifying features were removed to protect participants', family members' and clinicians' identities.

Analysis

I followed the six steps outlined in the guidance by Smith et al. (2021) to complete the analysis process. The aim of this was to produce themes that captured participants' experiences and how they made sense of them (Smith & Shinebourne, 2012). As described in detail below, I began by analysing each interview individually.

Step 1: Reading and Re-reading

This step involved familiarising and immersing myself in the data. I began by listening to each interview's audio recording. I then listened to each recording again

alongside the transcript to deepen my understanding and ensure accuracy. Following this, I re-read the transcript multiple times, making notes of my initial reflections and any preconceptions I had about participants' experiences.

Step 2: Exploratory noting

Once familiar with the data, I organised the transcript into a table with two additional columns: one for exploratory noting and another for experiential statements. For this step, I made detailed notes about the participant's account, focusing on three key aspects: descriptive (what participants said, staying close to their words), linguistic (how they talked about their experience, paying attention to specific words and phrases, pauses, emotional expression, repetition, and tone), and conceptual (my initial interpretations of the meaning behind participants' experiences). This process involved line-by-line engagement with the transcript, highlighting any text I considered significant.

Initially, I found it difficult to move beyond the surface-level events reported by participants and position myself within their lived experiences and interpretations. Supervision played a crucial role in helping me shift my focus, encouraging me to attend more closely to underlying meanings.

Step 3: Constructing Experiential Statements

Drawing on my exploratory notes, I summarised key moments of experience into concise phrases that reflected both the participants' sense-making and my own developing interpretations. I aimed to stay as close as possible to the participants' own words to ensure that experiential statements were firmly grounded in the transcript, being mindful of my own interpretative role. At the same time, these statements were shaped by my analytic insight, informed by my familiarity with the full data set. This step was important to begin synthesising participants' experiences and facilitating the development of emerging themes.

Step 4: Connections across experiential statements

This step involved writing out each experiential statement on a separate piece of paper and placing them in front of me in a random order so they were all visible. This allowed me to move away from the order in which they appeared in the

interview. I began by grouping statements together that seemed related, repeating this several times to explore different connections. The final groups of experiential statements were guided by the research question and key aspects of participants' experiences.

Step 5: Creating and Organising Personal Experiential Statements (PETs)

PETs were developed by assigning names to clusters of experiential statements that captured their overarching characteristics. Some PETs included subthemes, where smaller groups of experiential statements highlighted distinct or notable aspects of the broader theme. These were then organised into a table on Microsoft Word (see Appendix F for example), which also included quotes from the transcript that illustrated the experiential statements. I found this process quite challenging due to the focus on ensuring that PETs were interpretative and not just descriptive, which required multiple attempts to refine themes to reflect this.

Step 6: Individual analysis

Steps one to five were repeated for each interview, keeping in mind IPA's idiographic commitment to understanding each participant's unique experience. While it was impossible to remain entirely uninfluenced by the analysis of previous interviews, the considerable time gap between recruiting participants helped maintain some distance between each account.

Step 7: Developing Group Experiential Themes (GETs)

Cross-case analysis involved identifying shared experiences across the entire dataset, which then informed the GETs. This was an iterative process, which involved returning to all individual transcripts and notes to ensure that themes were grounded in participants' own words and represented multiple accounts. Also important was ensuring that themes and subthemes were coherent and distinct, capturing unique aspects of participants' experiences, and made sense hierarchically. These were similarly collated in a table with illustrative quotes from various participants.

Quality Measures

Following Smith et al.'s (2021) guidance for IPA studies, Table 1 outlines the recommended quality frameworks by Elliot et al. (1999) and Yardley (2000), alongside their relevance to the study.

Table 1

Recommended Quality Measures and Application

Recommendation	Application
Sensitivity to Context (Yardley, 2000) *Situating the Sample* (Elliot et al., 1999)	Detailed information about participants' specific characteristics and contexts is provided for readers, including demographics and the rationale for their selection. These contextual factors were carefully considered throughout data collection, analysis, and write-up. Reflexivity was maintained to acknowledge how participants' contexts may have shaped their accounts, and how my own researcher position influenced interpretation. Relevant literature was integrated to situate the findings, ensuring they remained grounded in participants' experiences and sense-making.
Owning One's Perspective (Elliot et al., 1999)	Owning my perspective involved acknowledging how my personal identity, roles, assumptions, and values may have influenced the research process and interpretation of participants' narratives. This was addressed in my reflexive statement and the discussion chapter to ensure that my role as a co-constructer of meaning was transparent.
Transparency and Coherence (Yardley, 2000) *Coherence and Consistency* (Elliot et al., 1999)	Methodological decisions are accompanied by explicit justifications, including the rationale for using IPA in relation to the research aims. Each stage of the research process is clearly outlined and logically presented, which aims to support transparency and allow readers to understand how the findings emerged. IPA principles informed the design and analysis, with efforts made to remain aligned with the study's aims. Themes are presented as part of a coherent and integrated narrative, grounded in participants' accounts.

Commitment and Rigour (Yardley, 2000) *Grounding in Examples* *Providing Credibility Checks* (Elliot et al., 1999)	Through continued efforts to recruit participants, deep engagement with their narratives, and detailed analysis, I aimed to demonstrate a rigorous and committed approach to conducting this research. Participants were quoted verbatim throughout the results section in order to ground interpretations and allow readers to assess the connection between the data and analysis. Additionally, regular discussions with my supervisors supported ongoing reflexive engagement with participants' accounts, helping me to consider any potential biases and reflect on the credibility of my interpretations.
Impact and Importance (Yardley, 2000) *Resonating with Readers* (Elliot et al., 1999)	This study offers insights into British Pakistani Muslim individuals' experiences of family involvement in FW for psychosis, an area that remains underexplored in existing literature. The findings may be of interest to MH practitioners aiming to develop more culturally responsive services, as well as readers from backgrounds similar to the participants. It is hoped that the findings will prompt further reflection, discussion and potential change within clinical practice. Additionally, the research may be of relevance to academics seeking to better understand culturally specific experiences and inform future research in this field.

Chapter 3: Results

This chapter begins with an overview of the study's participants and characteristics of the FW they completed. To protect participants' anonymity, given the small sample and sensitive nature of the topic, the presentation of demographic information has been carefully considered. This includes both a summary table and a narrative description, where some information has been omitted or generalised (including age, geographical locations, and family or household composition). Following this, individual pen portraits, PETs, and reflections on interviews are presented separately for each participant. Group-level themes and subthemes across participants' narratives are then outlined in a GETs table, concluding with a narrative of the group analysis.

Participant Information

Five participants were interviewed for the study, consisting of three women and two men, aged between 18-31. Two additional individuals had consented but were unable to participate, despite repeated attempts to arrange and conduct interviews. This was due to psychosis impacting motivation and memory. All interviewed participants were born and raised in the UK, spoke English, and self-identified as Muslim. Although not all participants reported their specific ethnic group, all had family origins in either the Khyber Pakhtunkhwa or Punjab regions of Pakistan. Four out of five participants referred to their experience of FW as *"family therapy"* (FT), while one did not use a specific term. The individual analyses are presented in the order of interviews conducted, and each account reflects the participant's own use of language. For ease of readability, omitted words are marked with ellipses and additions or clarifications are presented in square brackets.

Table 2

Participants' Demographics and FW Characteristics

Pseudonym	Generation	Involved Relatives' Generation	Type of FW	Interview Location	FW Status
Haroon	2nd/3rd	1st, 2nd, 3rd	Systemic FT (with Reflecting Team)	MH service	Ongoing
Sara	3rd	2nd, 3rd	Structured FI	MH service	Completed (within past month)
Fatima	2nd	1st, 2nd	Structured FI	Home	Ongoing
Maria	3rd	2nd, 3rd	Systemic FT + OD Network Meetings	MH service	Completed (within past month)
Raheem	3rd	2nd, 3rd	Systemic FT (with Reflecting Team) + OD Network Meetings	MH service	Ongoing

Note. 2nd = Second generation; 3rd = Third generation; FT = Family Therapy; OD = Open Dialogue

Individual Analysis

Haroon

Haroon wanted to take part in the study as he had not come across any research on Pakistani Muslims' experiences of FT, which he felt was *"extremely needed".* He reported that his experiences of psychosis began during the COVID-19 pandemic, including episodes of low mood and *"hypomania",* which were distressing for his family. He was later diagnosed with bipolar disorder by a private clinician. Haroon then trialled different medications and started individual therapy through EIP, which helped manage his experiences. This led to a referral for FT, which he was keen to take part in. Initially, only his father and brother agreed to take part, with his mother, sister and brother-in-law joining later.

Key for Haroon was **managing the *"struggle"* between optimism and family members' initial reluctance**: *"I wanted all my family... to come because I know they've struggled so much in the past... I want them to be able to... let go of that and peel through it"* (pg. 7). He expressed *"disappointment"* towards his mother's initial refusal which he attributed to earlier generations valuing *"hard work and achievement"* over *"inner work"*, shaped by *"poverty"* and migration experiences. He also felt frustrated that therapy was unfamiliar and *"taboo"* in the Pakistani community, due to emphasis on stoicism and concealing family issues: "*you just kind of take it on the chin and... move on through life... without really rectifying any of these issues"* (pg. 2).

Critical for Haroon was **admiring family members' loyalty and sacrifice,** recognising that involvement was less challenging when mental healthcare focused solely on him. He particularly appreciated his mother and sister's eventual participation: *"it was quite a difficult thing to... sit there and talk about your feelings... [mum's] always been quite resilient and strong... it's difficult to break that facade all of a sudden and talk with strangers and your family... about these things"* (pg. 10).

Haroon similarly described **overcoming discomfort and adjusting to FT.** He initially felt *"uncomfortable"* to speak openly in front of his family, therapists and the reflecting team: *"In Pakistani culture, neither males or females… talk about… their inner feelings and their deepest… insecurities... traumas and things like that"* (pg. 8) however: *"eventually we started to open up and talk about deeper issues"* (pg. 4). He also learned how FT differed from other MH appointments and individual therapy: "*instead of just one perspective, one person's issues, you get loads of people's combined... ideas about things"* (pg. 5).

Fundamental for Haroon was **feeling safe, significant, and held by family therapists,** valuing their empathy, skills and *"non-judgemental"* approach: *"I didn't expect… other people to care about my family... what we're feeling and... react so emotionally and... caringly about it... I thought it'd be more cold and clinical... but I'd say it's more emotionally warm"* (pg. 12). and "*they ask very pertinent questions… expand on what we're talking about and help us delve deeper... capture the emotion of it"* (pg. 12).

Haroon ultimately described **experiencing connection and liberation through FT**: *"we talk differently, more openly in FT and about different topics that we don't really talk about at home where I guess the emotional shields are up"* (pg. 32). FT helped draw connections between their experiences, fostering unity: *"it built up into… talking about… trying to stop that generational trauma in our generation… and help our children and our children's children to break free from that"* (pg. 1). His family and therapists' support also empowered him to challenge internalised beliefs around stoicism, perfectionism, and success that caused him distress: "*it's like breaking idols... in your head that tell me what to do and... say to be perfect"* (pg. 2). This helped him embrace emotional expression, which felt liberating: *"in Pakistani Muslim culture… men aren't supposed to show their emotions... cry and really let out everything.... it was quite cathartic… a realisation moment that it was okay to do that"* (pg. 19). Additionally, FT enabled him to adopt a more meaningful sense of identity and purpose: *"now I see myself as like… a new leaf has turned... healing people... helping people go to therapy and... realise… the depths of their soul."* (pg. 23). Outside of FT, Haroon noticed positive changes in his mood and relationships, as he felt *"heard"* and supported around his MH struggles: "*we're just… less arguments, more friendly with each other and… we understand each other more"* (pg. 21) and *"it's helped me deal with unresolved issues apart from [bipolar disorder] which have helped clear my mind and... focus on getting better"* (pg. 29).

Also validating for Haroon was **viewing FT as spiritually congruent,** as sessions integrated *"stories from the Qur'an",* upheld the importance of family and community cohesion, and fostered deeper connection with spirituality: *"[FT's] not just about the mind… it really delves deeper into your soul… letting your soul.... and your heart speak for itself... listening to them instead of irrational ideas that have been put into your mind. And like coming to your own conclusions about life"* (pg. 13).

As this was my first interview, I was initially nervous about capturing Haroon's experience accurately. When arranging the interview, Haroon gave very brief responses, and I worried about not being able to ask the 'right' questions to allow him to share his story fully. However, my concerns quickly subsided during the interview, as Haroon gave very detailed and reflective answers with minimal

prompting. I got the sense that his openness reflected the confidence he had developed through FW, and I valued his honesty in sharing his journey and the realisations he had as a result of his experience. I also felt grateful that he had agreed to participate whilst fasting during Ramadan, which highlighted how significant his FW experience had been for him.

Sara

Sara's participation appeared to be motivated by her positive experience of FT and her relationship with the family therapist who approached her for the study. Sara described that her experiences of psychosis developed in her teens, which she initially attributed to *"black magic"* and *"jinns"* and tried to cope with alone. Despite her brother also struggling with psychosis, her family had kept this hidden from her, and she remained unaware of what psychosis was until she shared her own experiences with her mother. Her mother then took her to the GP, who referred her to EIP, where she began FT. Though she initially avoided FT, she participated with her mother, and her sister later joined for one session.

Significant for Sara was **conflict between accepting and avoiding FT**. Her initial acceptance was shaped by her mother's encouragement, fear of attending appointments alone, and concern for her mother's wellbeing: *"I understood that it was a lot on her... two of her children... going through the same thing. Because she was completely like a mess when my brother came back with it, so I just didn't wanna put her through anymore… I did this for her"* (pg. 2). However, internalised stigma towards MH and therapy, her father's and brother's resistance, and FT being unheard of in the Pakistani community intensified her anxiety: *"I used to think therapy was for psychos... I was so scared... didn't wanna do it... I used to try sleep in, and my mum used to wake me up"* (pg. 5). She also feared confidentiality breaches by the therapist: "*I didn't know at first... my information's safe... I thought... everyone's gonna know"* (pg. 19)

Sara additionally described **fearing judgement and rejection***: "I just didn't wanna open up… tell my whole life story… especially with my mum there... I was even more scared... things that I've not really told anyone"* (pg. 5). She particularly worried that voicing the full extent of her MH difficulties would confirm them and damage her relationships: *"if I… opened up and said what I was going through…*

out loud… then it'd actually be reality… [mum] would look at me different... I'm not gonna be... the same person that I was to her" (pg. 6). Needing MH support further threatened her sense of identity within her family, triggering feelings of shame and inferiority: "*you always hear... Pathans are so strong... hardheaded... but I just felt like I wasn't"* (pg. 32).

However, over time, Sara felt **more confident to "open up"**, due to her mother's active participation and support in FT: *"without my mum… I probably would have been more closed off… mum also spoke a lot for me... because I didn't really know how to... get my words out"* (pg. 5) *and "she was really supporting and... understood everything"* (pg. 6). FT subsequently became a *"safe space"* where she could openly express her feelings and opinions: *"no one's gonna judge you... it's not like when you're at home and... if you say something out of line... you'll get told off... get into trouble"* (pgs. 14-15). This newfound confidence allowed Sara to involve her sister and open up to her family about all aspects of life, including her MH*: "now I could say anything to my mum… I'm not scared... once I opened up to my mum it was easier to open to... my sisters... brother... dad"* (pg. 3).

Despite this, Sara reflected that **FT is challenging,** as she felt a sense of pressure and internal conflict about whether to make significant life changes: "*[mum and therapist] were like you need to stop smoking… I didn't know what to do because I was doing that for so long... so it was really hard... changing my lifestyle, and habits* (pg. 2).

An important change in Sara was **embracing and valuing family's care**, due to her parents' and siblings' noticeable efforts to understand and support her with her MH struggles: *"my sister used to make sure I took my [sleeping] tablets… that I used to pray… and my mum used to make sure I... go to sleep on time... I didn't think I was going crazy anymore... I was going back to normal"* (pgs. 15-16). This *"strengthened"* their relationship: *"our bond is a lot better now... I know that if I go through anything... I can go to [sister]... She's like my at-home therapist"* (pg. 9). Feeling empowered by her family's and therapist's support also helped her understand and manage her MH experiences better: *"I knew that they [unusual experiences] were there, but I was just thinking... I'm not gonna let it... stop me from going out or... doing something. Because I… used to... keep myself trapped in my*

house" (pg. 16) and *"a MH condition is like serious but… it's nowt to be... scared of"* (pg. 25).

This led to **striving for collective healing through therapy**: *"I wanted my brother to come… and my dad"* (pg. 9) and *"I really think everyone needs it... especially with what's going on with my brother"* (pg. 6). Though initially feeling *"upset"* by her brother's avoidance, she remained determined to involve him, albeit indirectly: "*I was thinking [FT] would just make him better so our relationship could go back to normal... I was just like... 'you're not gonna come, so I'll bring therapy to you'"* (pg. 13). She subsequently felt relieved that: *"after I've come to therapy... my brother went [for individual therapy] and... my auntie's doing [FT] as well. So... more people in my family... are doing it and... it's helping them"* (pg. 7).

Sara also described **reconnecting with her faith,** as her family's involvement prompted reflection on her lifestyle choices: *"being Muslim… smoking... you're not allowed to… I was like, 'oh my God, I've like ruined my life'… but that kind of made me stop as well... just being scared and... upset"* (pg. 32).

With Sara being one of my youngest participants and her repeated requests to reschedule, I was initially worried that she had accepted out of politeness rather than genuine interest. However, I later felt that her occasionally being distracted by her phone in the interview showed that she was less concerned with impressing me as a researcher or providing desirable answers. Instead, she was able to share her experience more authentically. Her detailed answers related to her family's involvement also reassured me that her positive account was not just a reflection of her relationship with the family therapist, and I felt glad that her experience had such a significant impact on her perspective.

Fatima

Fatima's participation appeared motivated by a desire to raise awareness of how FT could be beneficial for other Pakistani Muslim families. She described having a *"psychotic episode"* after the birth of her first child, which she attributed to post-natal depression and feeling isolated in the COVID-19 pandemic. Though her experiences of psychosis quickly subsided, she continued to struggle with low mood, experiencing postnatal depression again after her second child. Fatima was primarily treated with medication under EIP until her Care Coordinator suggested

FT to improve her relationship with her mother, one of her main carers. She was keen for all family members to participate, initially including her parents, husband, brother, and sister-in-law. However, only her husband remained consistently involved over time.

Key for Fatima was **navigating different attitudes towards MH support.** She felt surprised and appreciative of her parents' efforts to understand her MH difficulties and encouragement to access mainstream services: *"how they've reacted very different to a normal… Pakistani couple would, that's opened my eyes… they're more like... talk about your feelings… be open… do what you need to do"* (pg. 57). She also valued her husband's willingness to participate, despite being wary of MH services and preferring religious support: *"he's quite reluctant around asking for help when it comes to these kinds of services"* (pg. 8) and *"I was more open to [FT], so he was like, 'okay fine I'll do it'"* (pg. 11). For Fatima, frustration towards therapy being *"taboo"* in the Pakistani community motivated her participation: *"why not talk about your problems if it's going to bring a solution?... But I think in our culture... community, it's more like 'no, just keep it hidden'... and it doesn't help anybody"* (pg. 57). Her spiritual teacher's encouragement to access secular services and therapy being increasingly *"advocated for"* within the Muslim community, offered crucial validation that FT was Islamically acceptable: *"I talked to my sheikhs... they said... go seek MH support... they were quite open to that"* (pg. 46).

Fatima also described **wrestling with duty and abandonment,** as her mother and husband remained involved long-term as her main carers, eliciting mixed feelings of gratitude, guilt, and disappointment: *"my husband for instance… you're in it. So, you can't really... push back even if you want to. Or my mother… with my sister-in-law, she could so she did"* (pg. 23). However, despite her sister-in-law's withdrawal evoking a sense of abandonment, Fatima empathised with her decision: *"she didn't really want to be part of... my journey and like this side of it... that really hurt me because she was there in the beginning… but that's fine, maybe it was getting too hard for her mentally"* (pg. 23).

Within FT, Fatima described **managing conflicting feelings towards openness**. She initially felt uncomfortable speaking openly in front of her parents due to cultural and familial norms and feared judgment from her family when *"really low"* and experiencing *"paranoia"*. At the same time, Fatima felt frustrated

by her husband's reluctance to open up*: "maybe it's a man thing... I'll talk a lot more whereas he will just stay silent. And I always struggle with that... like, 'why don't you talk about how you feel?'"* (pg. 12). However, she felt pleased that: *"as the other sessions have gone on... we're trying to be more and more open"* (pg. 5).

Significant for Fatima was **building mutual understanding and confidence through challenging conversations.** FT helped her understand her family's unspoken feelings, perspectives and struggles related to the severity of her MH difficulties: *"my family can speak how they feel, especially my husband… I know... what they're going through… because it's always been about me. But I guess it affects people around me... just as much"* (pg. 1). Expressing her own MH struggles and feelings also increased Fatima's confidence to open up, and led to more compassion: *"we know the triggers and... signs a lot better than we used to. It's not... 'oh... she's being dramatic'. It's... 'there's actually something there that's bothering her'"* (pg. 50). Similarly, her family's acceptance of her MH difficulties and how to support her made her feel heard: *"Before it was like 'call the doctor straight away… get someone out... we need to fix it'. But now it's... 'we just have to deal with it as a family because the doctor can't always do something'"* (pgs. 29-30). FT additionally helped address family and marital issues, allowing feelings, expectations, and perspectives to be expressed openly: "*sometimes it brings out things that you never really would talk about in your normal day-to-day life... some hard truths to get used to"* (pg. 2). Fatima especially valued the family therapist's skills in: "*listening... coming up with ideas and... getting us to open up a bit more about how we feel… arguments can get heated... because we're quite opinionated... so if there is a third person there to mediate... that's always good"* (pg. 2). Over time, Fatima noticed improved communication, acceptance of differences, and stronger connections, especially with her mother, brother and husband: *"in my relationship with my spouse... we're more understanding... towards each other… instead of just... being like 'oh gosh not again'… we're navigating this journey of marriage and MH at the same time"* (pg. 28).

Overall, Fatima expressed that **FT through the NHS is valuable,** as having access outweighed her dissatisfaction with medication: *"private therapy is quite expensive, so to have something given to us that we don't have to initially pay for... it's been really good"* (pg. 2). She also valued how FT was tailored to her practical

needs, supporting her own and her husband's participation: *"I can watch the kids... whilst I'm having the therapy which is so much easier for me… it would be a lot harder for my husband to go [to the service], he'd probably… be more reluctant... Whereas at home it's different"* (pg. 24).

Though this interview took place in a different setting, I felt at ease which seemed to mirror Fatima's comfort in sharing her experience. I felt grateful that Fatima had invited me into her home to share her story, and for her interest in my study. This perhaps reflected the trust and confidence she had developed in clinicians and MH services over time, including in FT. However, her openness also appeared tied to a sense of regret that earlier access to FT may have prevented or lessened the severity of her difficulties. This left me feeling both sad and hopeful about the potential benefits of this project, through which her experience could be shared with others.

Maria

I got the sense that Maria wanted to participate to support my research, as she placed high importance on helping others. She reported struggling with her MH due to several factors, including multiple bereavements and work stressors. She initially sought help from her GP to take time off work, who prescribed her anti-depressants that she did not feel she needed. Maria later recalled having an assessment with her family after having a *"breakdown*" and being referred to EIP by her GP. Though she was initially unsure about needing support from EIP and apprehensive of FT, Maria attended with her mum, and her sister joined for some sessions.

Maria expressed **feeling supported to begin FT**, valuing her mother and sister's encouragement and guidance: *"having my mum... and my sister there was quite good because they were directing me towards the way I should be going... towards some sort of light"* (pg. 19) and *"my sister said '[FT] would be good for you' because she's had CBT before"* (pg. 8). Maria also felt reassured by her mother's positive attitude towards MH and therapy: *"[mum holding stigma/shame] would have really put me off... I probably wouldn't have taken part"* (pg. 11).

Significant for Maria was **feeling heard, connected, and unburdened**, as her mother and sister's involvement helped her voice her distress, and also understand how family members' MH difficulties and broader family issues affected them: *"It*

was quite nice to have their opinions... because we don't openly talk about [feelings]... them hearing me as well" (pg. 3) and *"I think it's made us a bit more understanding, between me and my mum"* (pg. 32). Feeling heard and understood by therapists similarly felt validating, and alleviated worry and guilt: *"just talking about everything makes you quite self-soothed... maybe it was bottled in... because what I was doing with my story [prior to FT] was... I kept repeating it to my family and... maybe they had enough of me. Whereas the [therapists] didn't"* (pg. 21). Maria particularly appreciated therapists' curiosity, flexible approach, and *"open-ended questions"*, which helped overcome initial feelings of FT being *"intrusive"* and *"intimidating"*: *"they just got us to talk about things that we never usually talk about, in a really comfortable way to be honest"* (pg. 4). Though sometimes emotionally challenging, FT also offered a sense of security and *"relief"* for her and her family: *"[mum] got upset didn't she once… that stood out to me... I felt kind of like down... but then I was... thinking that [therapists] are here to help... sometimes it's good to get it out"* (pg. 25). Additionally, Maria appreciated how FT encouraged self-reflection within her family context: *"[FT's] not something that you just... talk crap about your family... it's something that makes you think and delve into your life... your struggles or whatever it is that you're going to talk about"* (pg. 21). This helped her overcome unhelpful expectations around her identity, increasing self-compassion: *"I'm a [care professional]... obviously, that's part of my identity. So, helping people is something that comes natural to me... [but] I feel like I'm kinder to myself now"* (pg. 34).

Subsequently, Maria described **understanding and accepting her MH struggles.** Support from her family and therapists enabled her to make sense of factors that contributed to her distress: *"therapy sessions were quite useful in making me think about things differently... Seeing things from... family's views. And even the therapists'"* (pg. 16) and "*Although obviously I knew [psychosis] runs in my family, I just didn't think I would get it... something that... anyone can get really"* (pgs. 37-38). Crucially, this growing understanding gave her confidence to share her *"triggers"* with her brothers outside of FT. FT was ultimately central to her recovery: *"Now when I look back [FT] has definitely helped me. It's brought me back to my normal self, how I was"* (pg. 1).

However, Maria also reported **facing barriers to family involvement.** She felt disappointed by her brothers' not *"understanding how FT helps"*. She similarly expressed regret that practical issues hindered her younger brother's, father's, and extended family's' involvement: *"I've got my younger brother... but then he works... It would have been beneficial for him as well"* (pg. 14), "*I would have liked my dad to be involved if he spoke English more"* (pg. 10) and *"it's a shame that my whole family weren't involved… it would have just made us see a bit more eye-to-eye with one another"* (pg. 22). In contrast, she appreciated her mother and sister's involvement, attributing this to them having a better understanding of MH and viewing therapy more favorably: *"Because I think [mum] was born here... she understands that [FT's] not like, a shameful thing... it's good"* (pg. 11).

Maria felt reassured that **FT aligns with Islamic practices of seeking support,** such as seeking *"guidance"* through prayer and close relationships: "*I think the Prophet [Muhammad, pbuh] went through something... like a depression... he probably didn't get therapy [laughs], but he must have talked about it somehow... with his companions"* (pg. 41). This connection validated her participation, offering contentment that FT was spiritually valuable despite MH and therapy being stigmatised in the Pakistani community: *"having a MH problem is something that can bring shame to a family... if I did think about [FT] culturally... I would have been quite hesitant to speak about stuff... Religiously, it would have been quite... insightful... but culturally... really damaging"* (pg. 44).

I felt relaxed throughout the interview with Maria, likely due to my growing confidence as an interviewer. I also felt a sense of connection with Maria due to her interest in getting to know me as a fellow Pakistani Muslim woman, and my role as a Trainee Clinical Psychologist. Maria spoke passionately about her role as a care professional and the importance of research to improve practice, which I additionally found inspiring. Most importantly, I valued Maria's openness and honesty regarding her experience of FW, especially in the context of her family relationships and the realisations she had related to her identity and MH experiences.

Raheem

Raheem's participation appeared motivated by his positive experience of EIP overall, which included FW. He described that his experiences of psychosis felt like

he had been placed *"in a prison"* or *"split reality"* influenced by multiple stressors and life events. His family's concern for him led to his mother taking him to the GP, which Raheem reflected was beneficial, as his GP encouraged him to seek support from EIP. Though initially apprehensive of participating in FW, Raheem attended with his mother, and his brother joined for one session.

Raheem described **being led into FW through trust and reassurance.** He valued his mother's practical support, guidance and encouragement to access services and FW: *"my mum was... guiding me like saying they're lovely people... that helped... me be more open and honest and... more drawn to [therapists]"* (pg. 19). He also trusted her MH knowledge and experience: *"she was a [MH professional] ... obviously that helps"* (pg. 21).

Additionally, Raheem shared that **feeling held by the wider system fosters trust and motivation to engage** with EIP and in FW: *"[GP] was really... supportive and really caring... he told me to come to [EIP]... with it being a psychosis service, I thought maybe it was too much... but literally like coming here... it's been... really life changing"* (pg. 1) and *"I spoke to [Social Recovery Worker] at the start... she helped me realise that I wasn't in a prison... it helped me sort of be more calmer... be myself... not worry about... other people... that helped me come back more"* (pg. 5).

However, Raheem described **negotiating initial fears of judgment and disclosure** in FW**,** as opening up to family and therapists risked negative consequences: *"I really was against medication... watched movies as well and... was thinking about mental asylums... I was a bit scared.... thinking... obviously, I don't want anything like that to happen to me"* (pg. 15) and *"I was thinking... I haven't really spoken about MH... to my brother... I just didn't know how it would go"* (pg. 31). Additionally, Raheem's preference for attending appointments "*alone"* and fear of judgement heightened his anxiety: *"at the start I was quite scared and anxious... thinking there's a lot of people"* (pg. 31) and *"if my family's there... then I'll probably be more careful in terms of what I say and do"* (pg. 9).

At the same time, Raheem described **drawing on family support to manage anxiety**: "*moments where I feel a bit anxious... or I don't feel fully comfortable... my mum is there to... help me... she knows me more than the [therapists]... she's able to make sure I get the best support I can... And then, if sometimes I'm not being open*

and honest about certain things... mum will guide me" (pg. 45). His mother and brother's involvement also increased his confidence to be more open with other family members outside of FW: "*now, literally I say things to my family... where a few years ago before coming to [EIP] I probably wouldn't have... just everything... like things I talk about to the [therapists]"* (pg. 54).

Raheem emphasised **building trust through *"kindness",* cultural understanding, and respect,** particularly valuing therapists' integrity: "*it's really beautiful to have that inner peace... not feel worried or anxious... not think... people are going to throw me into a mental asylum... give me meds that I don't need or take me to the hospital when I don't need to go"* (pgs. 36-37). He also appreciated non-Muslim therapists' *"understanding and knowledge about Islam"* and their willingness to *"adapt"*, enabling him to be *"open and honest"* about his religious beliefs, often intertwined with his MH experiences: *"it's really nice... to talk about things like Jinns and... Islam. And... no one at [EIP] judges"* (pg. 58). This reduced his fear of FW and he reflected that it was just as important as *"speaking to Imams and going down an Islamic path"*.

Also significant for Raheem was **making sense of psychosis through FW,** as it provided a space to explore "*different theories... beliefs... ideas and... things that are going on*". This helped him: "*realise... how much my family are there for me... At the start... I was going through a lot... I was a bit paranoid... stressed and anxious... But like now, Alhamdulillah [praise be to God]... I don't feel like that"* (pg. 56). He ultimately felt a greater *"sense of security... safeness, and... confidence"*.

Additionally, Raheem developed a **greater sense of autonomy around his care,** as he felt more confident choosing the support he accessed: *"sometimes... I don't wanna burden... or stress my family. So instead of talking about them types of things at home, I'd rather come into the [service]... but knowing that I can talk to my family... it's really nice to have that"* (pg. 53) and "*I can just... come in [to EIP] whether by myself or with my family"* (pg. 36).

He subsequently felt ***"blessed and grateful"* for family's positive attitudes towards MH services**: *"my family have been there for me... supported me, and... are willing to come to meetings with me... I guess a lot of [Pakistani] families probably wouldn't... a lot of families would just say... 'why are you going to the*

[therapists]?... pray more and... speak to an Imam if you've got problems'" (pg. 22). This support was crucial as he reflected that: *"when I actually started to suffer from MH, I just thought... I knew better and I don't need to... come to [EIP] or go to the GP. But I realise that I actually did. So even though I thought I knew about psychology, clearly I didn't"* (pg. 62). FW subsequently reaffirmed his family's support: *"[family] know that... my MH is good... I'm supported... safe, and I'm in a good state of mind"* (pg. 10).

After hearing how Raheem's experiences of psychosis had made him fearful of others, I felt incredibly grateful that he had agreed to share his story with me. This was the longest interview, and I did not sense reluctance at any point, evident in his lengthy answers. Raheem spoke about the significance of discussing religion within FW which allowed him to open up and I wondered whether my identity as a Muslim interviewer made him more comfortable discussing this. I also wondered whether his interest in psychology and less anxiety around FW contributed to his openness. At the end of the interview, Raheem gave me a necklace he had made in a craft group to thank me for my time. I was touched by this gesture and felt glad that his experience helped him build trust around others.

Group Analysis

A total of 6 GETs and 17 corresponding subthemes emerged from cross-case analysis. These are outlined in relation to each participant in Table 3. Each GET is discussed individually, including exploration of similarities and differences between participants.

Table 3

Overview of GETs and Group-level subthemes for each participant

GETs	Subthemes	Participants				
		Haroon	**Sara**	**Fatima**	**Maria**	**Raheem**
A TEST OF FAMILY SUPPORT AND COMMITMENT	*Hopes and Wishes for Family Involvement*	X	X	X	X	
	Mothers: The Heart that Drives Support		X	X	X	X
	Family First: Feeling Valued and Grateful	X	X	X	X	X
	Let Down by Family	X	X	X	X	
	A Missed Opportunity		X		X	X
OPENING UP: A JOURNEY TO SAFETY	*Initial Anxiety and Discomfort about Family Involvement*	X	X	X	X	X
	Apprehension of MH Services and Family Work	X	X		X	X
	Greater Sense of Safety and Confidence	X	X	X	X	X
HEALING THROUGH CONNECTION	*More Understanding, More Compassion*	X	X	X	X	X
	Embracing Family's Care		X			X
	Stronger Family Bonds	X	X	X	X	X
	Self-Awareness and Empowerment	X	X	X	X	X
INTEGRATING THE MIND, HEART AND SOUL	*Harmony between Family Work and Islamic Principles*	X	X	X	X	X
	A Spiritual Awakening	X	X			
NAVIGATING SYSTEMS: FAMILY WORK IN AN EIP CONTEXT	*"Pros and Cons" –Value of Accessing FW through EIP*	X	X	X	X	
	"It's like a Family" – A Multi-Disciplinary Team Approach	X			X	X
THE TOLL OF THERAPY		X	X	X	X	

A Test of Family Support and Commitment

All participants expressed how family involvement was a test of their family's support and commitment, which became apparent at different points of their FW journey. For some, their family's involvement was important from the beginning, and their willingness to participate elicited strong feelings of either gratitude or disappointment. In contrast, participants who were initially apprehensive about involving family came to greatly value their family members' commitment and efforts to support them. Participants also reflected on how their efforts to involve family members became a test of their own support and commitment towards them. Subthemes include: *'Hopes and Wishes for Family Involvement'; Mothers: The Heart that Drives Support'; 'Gratitude for Family Support'; 'Let Down by Family'; and 'A Missed Opportunity'.*

Hopes and Wishes for Family Involvement

All but one participant expressed hopes and wishes for family involvement, invested in the possibilities and outcomes of FW.

Haroon, Sara, Fatima, and Maria expressed hopes that their families' involvement would be mutually beneficial for them, help improve relationships, or both. For Haroon, this hope was shaped by his own positive experience of individual therapy: *"they've struggled so much in the past... I see that they're carrying that kind of stuff [family issues and trauma] with them, and I want them to be able to... let go of that and peel through it"* (pg. 7). He also felt optimistic that FT would bring them closer together: *"I explained... [FT's] like therapy but more to do with how… we interact with each other and... can move forward and... heal together, instead of just on your own"* (pg. 4). While Sara wished for both her father's and brother's involvement, she placed particular importance on her brother's participation: *"We were like really close... best friends... When he got poorly.... everything just changed.... he didn't used to speak to us... wasn't making time for me... I was thinking [FT] would just make him better so our relationship could go back to normal"* (pg. 13). Like Haroon and Sara, Fatima viewed FW as a *"good initiative"* to improve her relationship with her mother, one of her main carers: *"I was really struggling with communicating... my needs... she wouldn't really understand... and it would like, annoy me.... [Care Coordinator] introduced FT so that we could bond*

on a different level... hopefully she could understand what I'm feeling... and I could understand why... she would do stuff... because... it was causing a rift in our relationship" (pg. 4). Though Maria did not explicitly state her reasons, her specific request for her older brothers to join suggests a possible hope that FW would also be beneficial for their experiences of psychosis.

Additionally, Maria and Sara hoped that their family members' participation would enhance their own experiences of FW. For Maria, her mother and sister's involvement meant receiving the right MH support: *"I see them as important in taking part and in taking care of me. Because obviously they know how I am... my routines... what I was like before... my personality"* (pg. 37). For Sara, her mother's participation would help to manage her anxiety: *"I came with my mum first because I didn't wanna do it alone"* (pg. 3).

Raheem did not express any specific hopes or wishes around his family's involvement, which appeared to be related to his preference for accessing MH support *"alone"*.

Mothers: The Heart that Drives Support

Although other family members were mentioned, all but one participant highlighted their mother's pivotal role in their journey into services, particularly in accessing MH support and engaging in FW initially.

Sara and Raheem both described how their mothers' encouragement and practical support to go to the GP and EIP were critical. Sara reflected: *"before therapy... [mum] used to be like, 'I'm gonna get you booked in, go doctors... it'll be fine... I'm here'... And I used to cry all the time and... she used to be like, she'll come with me... we went to the doctors first... came here [EIP]. And then... everything happened really quick"* (pg. 27). Raheem similarly described: *"not wanting to go to doctors and my mum was like you know 'we'll go doctors'... And same with [EIP], like I was thinking I don't really wanna go... and my mum was like, 'come on let's go... So that's why the two of us went together"* (pg. 30).

Additionally, Sara, Maria, and Raheem reflected how their mothers' guidance, encouragement, and practical support helped them participate in FW initially. For Sara, her mother's practical support was crucial due to her attempts to avoid FW: *"I was so scared. I didn't wanna do it... I used to try sleep in. And my mum used to*

wake me up" (pg. 5). Raheem similarly reflected that his mother's practical support streamlined the process of starting FW: *"I guess because it was the first time we were coming in and... I went with my mum to the GP, and that's how we was here. So, I guess we just both came together"* (pg. 16). His mother's guidance was also fundamental: *"when I actually started to suffer from MH, I just thought... I knew better and I don't need to... come to [EIP] or go to the GP. But [now] I realise that I actually did. So even though I thought I knew about psychology, clearly, I didn't"* (pg. 62). Maria similarly appreciated her mother's and sister's practical support and encouragement to participate in FW: *"they were directing me towards the way I should be going... with the therapy... When the assessment process started, I remember... I wasn't like my normal self in terms of... my appearance and whatnot. So, they were directing me towards some sort of light"* (pg. 19). Her words *"towards some sort of light"* reflect the trust she placed in their guidance, at a time when she may have struggled to make the best decisions for herself. Their participation in FW also provided reassurance: *"them starting therapy with me at the beginning... that helped... to just ease the way through"* (pg. 20). This was crucial, as she *"would have been... very hesitant",* if offered individual therapy initially.

For Fatima, both her mother's and father's unwavering support at different points of her MH journey indirectly contributed to her acceptance of FW. She valued their compassionate response when they first learned about the severity of her MH difficulties: *"I thought... when I did try to commit suicide the first few times, my parents would be like 'oh, my God!... you messed up... you've done something really bad'. But they were actually loving and caring, and I think that's what I needed... They were more... "we're here, we're going to support you. It's okay'"* (pg. 51). Her parents were also instrumental in her seeking MH support from mainstream services: *"if it stayed with my husband, I don't think we would have gone down the NHS route, but my parents were quite open to that. They were like no we need to"* (pg. 58). Additionally, Fatima appreciated her parents' efforts to understand her MH difficulties and learn how to support her: *"my parents were actually like doing research... my brother would send [them] articles in Urdu... about... suicide and MH... they were reading articles on stuff... they've never read in their lives before. And they were giving it to my father-in-law, my mother-in-law... telling them to read more... and be more open"* (pg. 52). Similarly, Fatima admired her parents'

encouragement to speak about her MH struggles: *"how they've reacted very different to a normal... Pakistani couple would... that's opened my eyes to so many things. I think sometimes I'm more... backwards... than my parents are. They're more like... 'talk about your feelings... be open... do what you need to do'. And I'm like, 'no... it can be... black magic and all that kind of stuff'... So, I think they're very open like that, even though they're quite old"* (pg. 57).

Haroon was the only participant whose experiences did not fit under this subtheme. Though his mother supported him to take medication regularly, his father played a pivotal role in Haroon accessing services: *"My dad has basically been the most involved... making meetings with... care coordinators, talking with doctors about medication... he's been really proactive in it and... I thank him for that"* (pg. 11). His mother's support was also not integral to his acceptance of FW.

Family First: Feeling Valued and Grateful

All participants expressed gratitude for their family members' willingness to take part in FW, which demonstrated their support and commitment. This appreciation was greater for family members who prioritised participants' needs and their relationship, despite facing their own anxieties and reservations.

Haroon, Sara and Raheem were grateful for their families' willingness to participate, despite the unhelpful norms and taboos surrounding MH and therapy in the Pakistani community. Haroon especially admired his mother and sister's later participation, overcoming their initial reluctance related to therapy being unfamiliar, undervalued, and frowned upon: *"it was really a difficult step for a lot of family members... especially for my mother because she... was raised in Pakistan... it wasn't a normal thing for any type of therapy, never mind FT... It's like a taboo... everyone's supposed to be really strong and it's hard to be vulnerable… in Pakistani culture"* (pg. 3). Raheem shared similar sentiments: "*I'm really blessed and grateful that my family have been there for me... supported me and... are willing to come to the meetings with me... I guess a lot of [Pakistani] families probably wouldn't... a lot of families would just say... 'why are you going to the [therapists]?... pray more and... speak to an Imam if you've got problems'"* (pg. 22). He attributed this support to: *"My family Alhamdulillah [praise be to God]... were born in England and… my mum she was a [MH professional] ... obviously, that helps... And I guess just my*

family... having an open mindset" (pg. 22). Maria also valued her mother's positive attitude to FW: *"Because I think she was born here... she understands that [FT's] not like a shameful thing... [mum holding stigma/shame] would have really put me off... I probably wouldn't have taken part"* (pg. 11).

Sara was especially moved by her mother's willingness to prioritise her wellbeing over concerns about stigma and judgement: *"I know my mum was like scared at the beginning... but then it became normal to her... my mum didn't really care, nobody can say owt... it was more about me... she just cared about me getting better"* (pg. 21).

Fatima and Sara valued their family members' participation, despite their personal reservations and discomfort. Fatima appreciated her family's growth, humility, and open-mindedness to FW, reflecting their commitment to prioritising her care needs: *"because I'd been dealing with MH for like a couple of years at that point, my family are more open to these kind of things... a couple of years back they probably wouldn't be, but now it was more...'we want the help, we will try any means to get it'"* (pg. 8). This reinforced their consistent efforts to adapt and support her through her MH struggles: *"when I did get ill... I needed them more hands-on… that was all very different for them as a concept, but they did their best"* (pg. 46). Fatima also acknowledged the significance of her husband's participation as: *"he was always against the medical side of the MH issue. He's a very religious person so he believes that religiously, you can solve a lot"* (pg. 11). Similarly, Sara appreciated her sister's later involvement, empathising with her initial anxieties: *"it was more normal for my mum because she started with me... But my sister, she was like, 'don't wanna go, don't know what this is about, I'm scared'... I think her views on therapy were like really weird as well... she didn't wanna talk because she finds it hard to open up... But then, once she came, she was like 'it's actually alright'"* (pg. 11).

Fatima and Haroon were also grateful for family members' commitment to FW, despite the challenges it posed. Fatima admired her family's willingness to confront underlying issues in FW, despite the shame, fear and avoidance of this in the Pakistani community: *"culturally it was quite different for them to talk about their feelings... what they're going through, and... how it's been for them"* (pg. 46) and *"I think it's such a taboo for people... if we talk about our problems, it'll became*

a lot more... in our culture... community, it's more like, 'no, just keep it hidden'... we won't talk about it, and it doesn't help anybody" (pg. 57). However, Fatima voiced feelings of guilt related to her mother and husband's long-term involvement as her main carers: *"when you see me low it's quite hard... So even if they don't wanna see me... like my husband for instance he can't… like you're in it... you can't really like push back even if you want to. Or my mother"* (pg. 23). Haroon similarly acknowledged his family's personal struggles and discomfort to be vulnerable in FW: *"I'd say it's a lot easier for [family] to be involved in other parts of my care because... it's the hardest thing for us... to talk about ourselves... inner feelings... desires... trauma and... inner world... It's a lot easier to... talk about other things... like the physical world... medication and... setting up meetings"* (pg. 11). Additionally, Haroon felt grateful that his family's involvement reduced feelings of isolation: *"It felt good because… I wasn't the only one who was there. And... it wasn't like, everything was about me, and... I could share that experience with them"* (pg. 15).

Let Down by Family

All but one participant expressed that, though they understood and empathised with family members' reasons for not participating, they still felt let down by their refusal or withdrawal from FW.

Haroon, Maria and Sara felt disappointed by their family member's refusal or avoidance of FW. Though his mother later agreed to participate, Haroon felt let down by her initial refusal: *"At first, like gut reaction was probably a little bit of disappointment, like 'oh I wish [mum] would come'. But I guess from further reflection... I could empathise... because it's hard to break those... moulds... or those ideas that have been deep set in your mind... get rid of those instantly and... try different things"* (pg. 11). He also felt frustrated that her reluctance seemed tied to unhelpful norms in the Pakistani community around stoicism and not disclosing vulnerabilities: *"you just kind of take it on the chin and... move on through life... without really rectifying any of these issues"* (pg. 2) and *"I'd say probably it's a cultural thing where... if you open up, you're seen as weak... just toxic like, ideals... you're seen as weak... seen as... moody"* (pg. 10). His words *"rectifying any of these issues"* signify frustration towards his mother's reluctance to take an active role, and

the potential impact of this on him and the family. Haroon further expressed disappointment that she perhaps did not value therapy in the same way he did: *"what's seen as valuable is hard work and achievement... because I guess my grandparents came from... dire poverty... they barely had any clothes and food to eat, and like were on the streets... Inner work and like therapy... I think are extremely valuable personally but... in Pakistani culture... it's not seen as valuable"* (pg. 10).

Like Haroon, Maria felt disappointed that her brothers did not value FW: *"I have heard about [FT] a few years ago... because my brothers have got MH as well... but they never really cooperated with it"* (pg. 4) and "*I don't see them understanding how family therapy helps... I did ask them... but they just said no"* (pg. 15).

Sara also felt let down by her brother's unfulfilled promises: *"he always just said I'll come next time... And he never did"* (pg. 11) and *"I was more upset because... I love my brother, my brother's like, my best friend"* (pg. 12).
In contrast, Fatima felt *"hurt"* by her sister-in-law's withdrawal, evoking feelings of abandonment and loss: *"in the beginning when I got really ill, she was one of my main like carers... really looked out for me... But then as the time went on, it got harder for her to be there for me... she was here for like maybe a session or two... but... recently... I found out that she didn't really want to be part of... my journey and... this side of it. And that really hurt… but that's fine... maybe it was getting too hard for her mentally"* (pg. 23).

A Missed Opportunity

While Sara, Maria, and Raheem identified several factors that hindered family members' involvement, they reflected on their own roles within this. This stemmed from the realisation that family members could have supported the FW and potentially benefited from it, had participants acted differently. The missed opportunity therefore became a test of their own support and commitment towards their families.

While Maria expressed regret that her father, younger brother and extended family members could not participate due to work commitments and language difficulties: *"I would have liked my dad to be involved if he spoke English more"*

(pg. 10), this seemed tied to the realisation that she had taken a more passive position: *"[family involvement] just kind of happened, no conversations whatsoever"* (pg. 14), and had resigned to the idea that they would not be able to: *[dad] works full time... and then he's not around sometimes, so he's quite busy... but... no I've never spoken to him about [FW] to be honest"* (pg. 12) and *"everyone's got busy schedules haven't they, so I didn't know when everyone's free"* (pg. 13). Similarly, Raheem's own fear of MH services prevented him from asking his father and sister to participate: *"they would support me... it was just my own brain... like at the time... I was quite scared"* (pg. 21).

Though Sara *"understood"* and appreciated her father's attempts to join FW, there was a sense of regret that she had asked too late: *"I wasn't upset with him because I knew he was genuinely trying to get time off work... but it's just... from when I asked him and when my therapy finished, there wasn't enough time"* (pg. 12). Sara also expressed regret and feeling helpless about not being able to change her brother's perspective and convince him to join FW: *"At the time when he started therapy, he didn't really have... a good experience... wasn't in the right... mindset. Like he was just seeing it as... four walls and two people... So, I feel like... he was thinking, it's like going back to his... trauma, coming [to FT]. But it wasn't like that"* (pg. 12). However, Sara felt determined to involve him, even if indirectly: *"I was just like you know what, you're not gonna come so I'll bring therapy to you"* (pg. 13).

Haroon and Fatima's experiences did not fit under this subtheme. For Haroon, there was a sense of relief that he had been able to *"convince"* his mother and sister to participate over time: *"I think it was quite appealing for them because we definitely have had issues in the past... a lot of arguments and... unresolved issues. So... they were on board... because of that"* (pg. 4). Whereas, Fatima expressed resignation that her mother's language barrier and difficulty engaging with the format of FW sessions made her short-term participation inevitable: *"she really struggles to sit down... so she's not really part of the meeting in one sense... doesn't understand the English, so she'll just... be doing her own thing... there is a point of her being here, but there isn't at the same time"* and *"I've understood that's her nature... she's not trying to be rude... But I think.... the first six months she was kind of there, so... she has picked up on a lot over that time"* (pg. 10). Having FW at

home also supported her own and husband's participation: *"you don't have to put in the cost of going to the [service] and... dropping the kids off somewhere... I can watch the kids at the same time... which is so much easier... and my husband working from home... Monday to Friday 9-5 is the time you can do therapy, and that's the time he works. So... it would be a lot harder for my husband to go [to EIP] ... he'd probably struggle with that... and be more reluctant"* (pg. 24)

Opening Up: A Journey to Safety

All participants described how opening up in FW was initially anxiety-provoking and uncomfortable, as they worried about being perceived negatively by family. For many participants, FW was also anxiety-provoking due to concerns around what it would involve and mistrust of MH services. However, over the course of FW, all participants described a journey to feeling safer and more confident to open up, with some being further along than others. Subthemes include: *'Initial Anxiety and Discomfort about Family Involvement'; 'Apprehension of MH Services and Family Work'; and 'Greater Sense of Safety and Confidence'.*

Initial Anxiety and Discomfort about Family Involvement

All participants expressed initial anxiety and discomfort around their family's involvement in FW, fearing potential negative consequences. This was shaped by cultural and familial norms surrounding openness, therapy being unfamiliar, and broader stigma surrounding MH.

Sara and Raheem both felt worried that revealing their MH struggles and personal lives would change how their families saw them, potentially damaging their relationships. Sara shared: *"I just didn't think that [mum would] look at me the same... I'm not gonna be like the same person that I was to her"* (pg. 6) and *"my sister didn't know anything about me... that I was going through... It was the same thing with my mum... I just didn't want her to look at me different... think that I was a psycho and... crazy. And like obviously... smoking and... certain things that you're not... really supposed to do. And... things that just ended up coming out in therapy... I just didn't want her to find out... it was just scary"* (pgs. 9-10).

Raheem expressed similar concerns: *"I was quite.... anxious because I was thinking... I haven't really spoken about MH... to my brother... I just didn't know how*

it would go" (pg. 31) and *"sometimes I'm more open like when I'm by myself... I can just be myself more... obviously, if my family are there... I'll probably be more careful in terms of what I say and do"* (pg. 9).

Haroon, Sara, and Fatima felt apprehensive about being *"vulnerable"* in front of their family and therapists, as it conflicted with cultural norms around stoicism in the Pakistani community. Haroon found it challenging to speak openly about his MH difficulties and emotions: *"there's this culture... especially with... British Pakistani Muslim males... they have this idea of like being hard and gangster... you can't be vulnerable... can't talk about these things because it's seen as a weakness... that hardwiring from a young age... was quite difficult to overcome"* (pg. 5). His reference to *"British Pakistani Muslim males"* suggests a dual influence of cultural expectations placed on males both within British society and the Pakistani community.

Sara also worried that needing support would threaten her cultural identity within her family, invoking feelings of shame and inferiority: *"I was just scared... you always hear like Pathans are so strong... hardheaded... you're supposed to be strong... but I just felt like… I wasn't"* (pg. 32). This was intensified by her fear that: *"if I opened up and said what I was going through... like said it out loud... it'd actually be real"* (pg. 6).

Fatima described similar discomfort in speaking openly about her feelings: "*The first session was really weird... a lot of people… doing a lot of talking... because when you grow up in an Asian household, you don't really like to talk about your feelings... especially in front of your parents"* (pg. 5)

Additionally, Fatima, Sara and Raheem expressed that speaking about themselves was generally anxiety-provoking and uncomfortable in the beginning. For Fatima, this conflicted with her family's norms: *"my family, they're not very... talk about your problems kind of people. They're more... you figure it out yourself... that's how we've grown up... Especially my parents... once we got married, it was more like 'we're not going to interfere... you want our advice, we'll give it to you, but you can do whatever you want'"* (pg. 45).

Sara also expressed: *"before FT... I wouldn't open up to no one"* (pg. 14) and *"it is scary... to open up... in front of your parents… your siblings... it's just weird"* (pg. 17).

Similarly, Raheem's preference for doing things *"alone"* contributed to his anxiety*: "when this whole kind of thing first started, I remember going to the cinemas and I'd go by myself... I loved that... So then initially coming to places like [EIP]... I was quite anxious because I was thinking... I've kind of preferred being alone"* (pg. 7). This was amplified when FW involved a reflecting team, compared to just one or two therapists: *"I was quite scared and anxious... thinking there's a lot of people"* (pg. 31).

Maria did not express any anxiety around her family's involvement, feeling content that she could be open with them: *"I told my cousin that 'oh my mum's involved', and she was like, 'oh you should have it [therapy] separately'. And then I was like, 'no it's alright, like I don't have anything to hide'"* (pg. 9).

Apprehension of Mental Health Services and Family Work

Sara, Raheem, Haroon and Maria described apprehension of MH services and FW, with some participants mistrusting clinicians and services, while others had negative preconceptions about what FW would involve.

Sara and Raheem both feared that FW would have negative consequences. Sara initially worried about confidentiality breaches by the family therapist: *"It was scary... I didn't use to speak... I just... used to sit here... let my mum speak for me. And... nod in my head... because I didn't know.... my information's safe... [therapist] can't go around and say... 'she said this, this and that'. Like she can't tell anyone"* (pg. 19). Sara attributed this to stigma surrounding MH services in the wider Pakistani community: *"you hear it a lot in Asian communities... 'once you go to therapy... that's gonna be on your record and everyone's gonna know that you went'... like older aunties... they're just like... 'everyone's gonna know what you went through'. And I was like 'uh uh [shakes head], I wouldn't want that'"* (pg. 20).

For Raheem, fear of being forcefully medicated and hospitalised made him reluctant to participate and speak about his MH experiences initially: *"I was worried... what the [therapists] would say... I was looking at psychosis... thinking... it's more of a MH problem than anxiety and depression"* (pg. 11) and *"I really was against medication... I kind of watched movies as well, and I was... thinking about mental asylums and things like that. And I was a bit scared... obviously I don't want anything like that to happen to me"* (pg. 12).

In contrast, Haroon and Maria were apprehensive of what FW would involve. Haroon feared that he and his family would be judged and criticised by therapists, as the concept of FW was unknown: *"the typical idea of therapy where you're sitting on a couch and some guy's asking you questions about your life... very coldly... diagnosing you... I thought [family] therapy was more like that... more of an affront... point fingers at you... 'why do you think this?', and more judgmental"* (pg. 13).

Similarly, Maria feared that FW would involve conflict: *"I just thought it'd be something like... how you see on the TV... arguments or something like that would happen"* (pg. 4). She felt further apprehensive as FW was initially *"intrusive"* and *"intimidating"*, due to the personal nature and depth of questions asked by the therapists: *"because [therapists] were asking me things... that normally people wouldn't... 'how did it make you feel?'... about family and... how did I get ill... And then [therapists] coming into my home... it is... at first... intimidating and intrusive"* (pg. 7).

Fatima did not express the same apprehension, which appeared to be related to the trust she and her family had developed towards MH services and clinicians due to the severity of her MH difficulties.

Greater Sense of Safety and Confidence

All participants described a greater sense of safety and confidence to open up as FW progressed, attributing this to support from both their family and therapists. However, the extent to which participants felt able to be open outside of FW varied.

For Sara and Raheem, their family's involvement played a crucial role in fostering safety and confidence, as it made them feel heard and understood. Sara attributed this to her mother's active participation in FW: *"seeing my mum so comfortable.... enjoying it. And it was helping my mum a lot as well. So, like I kind of built that trust"* (pg. 20). Her mother's support and compassion in sessions also helped her open up: *"without my mum... I probably would have been more closed off... mum also spoke a lot for me as well, because I didn't really know how to speak or get my words out"* (pg. 5) and *"she was really supporting and... understood everything"* (pg. 6). Sara additionally valued her mother's non-authoritative and non-critical position in FW: *"when I was in therapy, it was like my mum's not my*

mum right now... we're on the same level" (pg. 21) and *"it's not like when you're at home and... if you say something out of line... you'll get told off... Like you genuinely can't get in trouble when you're in FT"* (pg. 14). For Raheem, his mother's support was similarly crucial for opening up about his MH difficulties: *"it feels safe... knowing that my mum's there by my side... if there's moments where I feel a bit anxious and nervous, or... I don't feel fully comfortable... my mum is there to like, help me"* (pg. 43) and *"obviously, she knows me more than the [therapists]... she's able to make sure I get the best support I can receive... if sometimes I'm not being open and honest about certain things... she'll guide me"* (pg. 45).

In contrast, all participants highlighted the significant role family therapists played in helping them feel more safe and confident. Sara described how she built trust and overcame concerns about confidentiality breaches: *"because of the way that [therapist] is... I just got really comfortable with her... she like, created such a safe space... I knew that no matter what I say to her, it's gonna stay between us"* (pg. 19). This helped her realise: *"it's better to let everything out than just keep it bottled up, because then it just sits there, and it makes it worse"* (pg. 6).

For Raheem, several aspects of the therapists' approach were crucial, especially their *"kindness"*: *"I've been in a bad place for a while... my family have always loved me... been more than kind to me... been there for me. But sometimes... if a stranger is kind... it's a nice feeling"* (pg. 16). Also significant was their understanding and respect for his religious beliefs: *"I didn't talk about Islam as much as I did later on... I guess that's just feeling... able to be more open... the [therapists] were so supportive and.... they never judged me"* (pg. 63) and *"I didn't expect that.... I didn't think [non-Muslim therapists] would have as much knowledge about Islam.... that's the main reason why I keep coming back... it just gave me a lot of confidence"* (pgs. 26-27). The therapists' transparency and integrity similarly reduced Raheem's fear over time: *"I was made to be put at ease... things like... 'that's not what we do, we're here to help and support you... we're not just going to throw you into a mental asylum'"* (pg. 12) and *"I was... really glad I wasn't put on medication... that also helped me... come back more"* (pg. 12).

For Haroon, the therapists' warmth and expertise allowed him to open up about his emotions, MH difficulties, and family issues: *"I didn't expect it to be this open… other people to care about my family... what we're feeling and like react so*

emotionally and... caringly about it... I thought it'd be more cold and clinical... but I'd say it's more emotionally warm" and *"the family therapists... ask very pertinent questions... expand on what we're talking about... help us delve deeper... capture the emotion of it... reflect questions back at us so we can reflect on ourselves to heal"* (pg. 12). This created a safe space to talk about *"deeper issues"* contributing to distress: *"our culture never really talks about these deeper issues of trauma and... generational trauma... all these... deep ideas that are entrenched in the subconscious of our society… it never really bubbles to the surface... [but] I think that FT is a place where it does"* (pg. 19).

Fatima similarly valued how the therapist supported them to address marital issues: *"therapist is really good at listening... coming up with ideas and... getting us to open up... we've been married for 7 years but we can't talk about certain things because it triggers the both of us... So, if there's a third person that can be like... 'you both have to put what you feel and then understand what the other person is saying'... that really helps"* (pg. 3). Like others, Maria appreciated the therapists' warmth, curiosity and flexible approach: *"they just got us to talk about things that we never usually talk about, in a really comfortable way"* (pg. 4).

Subsequently, all participants shared how FW helped them be more open with family, which for Sara, Raheem, Fatima, and Maria, extended into their daily lives. Sara expressed: *"once I opened up to my mum it was easier to open to... my sister... brother... dad"* (pg. 3), including: *"what's going on in college... relationships, friendships, everything... which is quite hard with Asian parents, you don't really talk about... certain things"* (pg. 22). Raheem described a similar process: *"now, literally I say things to my family... where a few years ago before coming to [EIP] I probably wouldn't have... personal, MH, things that are going on... just everything"* (pg. 54). This provided a sense of relief as: *"it just helps a lot... getting things off your chest... psychosis, it's sort of like... ideas or... beliefs about what's going on... And just being able to talk to [family]... helps with MH so much"* (pg. 58).

For Fatima, addressing underlying issues in FW increased her confidence to *"confront"* her mother about comments she perceived as unhelpful: *"I can... have a better conversation than I would before... I would have just... thought about it again, and again... she's meaning the worst thing possible... a fat battle in my head until one day I... exploded"* (pg. 43). She also felt more confident talking to her family

about her MH struggles: *"once something bad's happened, I'd try to... just bury it under the carpet and not talk about it... [now] instead of bottling it up, I can actually talk about my feelings, what I'm going through, and what the other person understands... so it's not like 'oh I have to hide something, or... I'm feeling a certain way, and I can't express it'"* (pgs. 16-17).

Maria similarly felt more able to share her MH experiences, *"triggers"*, and experience of FW with *"everyone"* in her *"immediate family",* which she also hoped would benefit them: *"because I've experienced it... if anyone else was to go through it, then it would be easier for them to go through like, this kind of approach"* (pg. 32).

Though Haroon felt more confident talking about deeper issues and expressing his emotions in FW: *"at some points... I got so emotional that I was starting to cry... I did feel quite happy about it because it was quite cathartic... a realisation moment that it was okay to do that"* (pg. 19), he struggled to carry this openness into his daily life at this stage of his journey: *"we talk differently, more openly in FT, and about different topics that we don't really talk about at home where I guess the emotional shields are up"* (pg. 13).

Healing through Connection

All participants valued the connection with family and therapists through FW, which had positive implications for their MH recovery and relationships. These include family members becoming more understanding and compassionate towards their MH, being more receptive to family's care, stronger family relationships, and increased self-awareness. Subthemes include: *'More Understanding, More Compassion'; 'Embracing Family's Care'; 'Stronger Family Bonds';* and *'Self-Awareness and Empowerment'.*

More Understanding, More Compassion

All but one participant shared how their experiences of FW led to greater understanding, empathy and compassion from their family, both from those who participated and those who did not.

Fatima, Haroon, and Sara appreciated how their families became more understanding and accepting of their MH struggles, and how to support them.

Fatima expressed: *"they were trying to understand... it's not just something that is in my head... there's services like this out there for a reason... Because there were certain terms that will be said... 'she's like, lazy in the mornings'... And... the [therapist] would say... 'look, it's not about the laziness, it's the depression... the worry of the day... about what's gonna happen'"* (pg. 41). She also noticed a change in how family responded to her distress: *"Before it was like call the doctor straight away... get someone out... we need to fix it. But now it's more like, we just have to deal with it as a family... because the doctor can't always do something... it's gonna be a little bit of a time then she'll get better"* (pg. 30).

Haroon similarly shared: *"sometimes I go through low mood still where you know I stay up... a little late and wake up late... And they're just very understanding... they don't tease me for it... lecture me about it... reprimand it... they just understand... let me go through it."* (pg. 27). Sara also noticed more understanding and patience: *"if I was acting a certain way at home, [mum] would understand... before she'd be quick to be like, 'oh my God what are you doing like, what the hell?' Or like she'll snap easy... if I didn't wake up on time... or like clean... But like when we did therapy... she gives me time… because it's just about motivation"* (pg. 4).

Additionally, Sara and Maria appreciated their families' increased efforts to support them with their MH struggles. Sara described more physical support: *"my sister used to make sure I took my [sleeping] tablets and… that I used to pray… and my mum used to make sure I used to go to sleep on time... I didn't think I was going crazy anymore, I'd think... I was going back to normal"* (pg. 16). She also felt more protected: *"when it would just be me and my mum [in FT], my sisters used to be like... 'you always stick up for her, you never stick up for us'. But then when my [middle] sister came, it was like having my mum on my side and now my sister... So, if my older sister used to say anything... I knew that they'd be there for me... even my brother at that point, or my dad"* (pg. 15). Maria similarly felt more heard, understood, and emotionally supported by her family: *"I do get more empathy from them.... since having like my MH problems... they listen more as well"* (pg. 34).

However, for Haroon, feeling supported by his family and therapists within FW appeared to be more significant than in daily life: *"I've got something to look forward to with FT. Like if I'm going through a low patch... where my mood is down,*

and I can't really go anywhere... I feel like FT... gives me a boost every time I go" (pg. 29).

Raheem's experiences did not fit under this subtheme, as FW reaffirmed his family's existing understanding and support, rather than increasing them: "*I've always known my family are there for me"* (pg. 56) and *"my family knowing that I'm well and I'm okay... my MH is good... I'm supported... safe, and I'm in a good state of mind... I guess that's why they wanted to come with me, just to make sure"* (pg. 10).

Embracing Family's Care

Sara and Raheem both reflected how FW helped them recognise the value of their family's care and support for them, allowing them to embrace it.

Sara became more accepting of her family's care, both within FW and in her daily life: *"I wanted my family there… I think they're just a support system"* (pg. 26) and *"I know that if I go through... anything outside my house... I can go to [sister] and... open up to her about it. She gives good advice as well, she's like my at-home therapist"* (pg. 9). This was a significant shift as she previously distanced herself from family: *"I was the really, 'oh whatever, family, they're there' [gestures to the side]"* (pg. 26).

Raheem expressed similar changes in how he perceived and responded to his family's care: *"even though I just think in my brain 'oh, I don't want to burden or stress my family', my family would never feel like that... they'd want me to be more open and honest with them"* (pg. 55) and "*if I'm having a stressful day... I can just tell my family... And my family don't just turn around and say 'Raheem, what are you on about?'... they actually listen to me... care for me, and they're there for me. And I'm really, really grateful for that"* (pg. 59).

Stronger Family Bonds

All participants described how FW strengthened relationships, even with family members who did not directly participate. This was due to increased connection, better communication and greater acceptance of one another.

For Haroon, Fatima and Sara, FW helped resolve underlying issues in their relationships. Haroon described how FW *"strengthened"* relationships: "*because*

we're talking about these deeper issues... all the arguments and stuff they're superficial but what's behind the arguments is what really counts" (pg. 20) and *"with my dad... more tolerance for [him] not being perfect and not being good at things... and more openness and dialogue... My brother and my sister I'd say that we're just... less arguments, more friendly with each other and... we understand each other more because... things we would ridicule each other about are now, in FT, things that we celebrate"* (pg. 21). While Haroon felt some sadness towards his mother's lesser involvement, he felt hopeful about the possibilities of her future participation: *"she's probably been impacted the least because she hasn't gone as much as other family members and... opened up as much... hopefully in the future she will... but that's a journey that she needs to go on I think"* (pg. 21).

Fatima also felt grateful for more understanding, closeness and acceptance in her relationships: *"In my relationship with my spouse... we're more understanding I think towards each other... instead of just like being like 'oh, gosh not again'... we're navigating this journey of marriage and MH at the same time"* (pg. 28), *"my mum, I think she's understood me a lot more better over the time"* (pg. 26), and *"my oldest brother... I think [after] having this therapy... we've become a lot closer and can talk about feelings again"* (pg. 28). A key aspect of this was realising and understanding the impact of her MH difficulties on her family, especially her husband: *"I know how they feel and what they're going through… because it's always been about me. But I guess it affects people around me as well just as much"* (pg. 1).

Sara shared similar sentiments about her relationship with her mother and sister: *"I think me and my mum bonded a lot more through it"* (pg. 4) and *"our bond is a lot better now... before we didn't used to speak"* (pg. 9). Also significant for Sara was how FW helped her process unresolved feelings towards her parents, leading to greater understanding and connection: *"when my brother came back, everything... flipped... I wasn't getting neglected, but I felt like I was getting neglected because.... my brother was so poorly... so he was getting a lot of their attention... But at the same time... it was like so new to everyone... my mum didn't even know what psychosis was, so it was... hard for everyone"* (pg. 22). Sara particularly valued how FW improved her relationship with her brother, even

without his direct involvement: *"I kind of just ended up telling him everything and he... understood. So, like our relationship has gone back to normal now"* (pg. 13).

For Maria and Raheem, having deeper conversations brought them closer together. Maria appreciated how her mother and sister's participation allowed them to hear each other's experience of MH difficulties and wider issues within the family: *"It was quite nice to have their opinions and see what they thought... because we don't openly talk about [feelings] sometimes... Also like... them hearing me as well"* (pg. 3) and "*I think it's made us a bit more understanding, between me and my mum"* (pg. 32). Raheem described how his relationship with his family became stronger as he realised how much they cared for him: *"I think it's just brought us closer together... being able to be more open and honest and talk about things that maybe I wouldn't have talked about before coming to [EIP]"* (pg. 53).

Self-Awareness and Empowerment

All participants shared how FW was empowering in helping them develop a better understanding of their MH difficulties and supporting their recovery. Some participants also described gaining greater clarity over their sense of identity. For the majority of participants, both their family and therapists played a pivotal role in this. Haroon, Sara and Fatima, Raheem and Maria all expressed how support from their family and therapists allowed them to gain a better understanding of their MH difficulties, which was empowering and helped reduced distress. For Sara, FW helped her accept and manage her MH experiences: *"I knew that they [unusual experiences] were there, but I was just thinking... I'm not gonna let it like, stop me from going out or like do something because I... used to like, keep myself trapped in my house"* (pg. 16) and *"a MH condition is like serious but… it's nowt to be... scared of"* (pg. 25). This was a significant shift as prior to FW, she thought she *"was fine and just overreacting"*. FW also helped Fatima overcome self-criticism and develop a more compassionate understanding of her MH difficulties: *"it was an eyeopener for me because I was like, 'maybe I am being lazy in the morning, maybe I just don't want to get out of bed'... but no... the worries... the thoughts of the day, and how I'm going to get through it... that's what makes it so hard"* (pg. 42) and *"I think we know the triggers and the signs a lot better than we used to. It's not... 'oh*

she's just... being dramatic'. It's... 'there's actually something there that's bothering her'" (pg. 59).

Raheem felt supported to explore "*different theories... beliefs... ideas and... things that are going on",* which reduced distress around his MH experiences: *"at the start... I was going through a lot of things... and I was a bit paranoid... stressed and anxious... But like now Alhamdulillah [praise be to God]... I don't feel like that"* (pg. 56) and *"I just feel a sense of security and safeness, and like confidence"* (pg. 48). Maria similarly reflected: "*the therapy sessions were quite useful in making me think about things differently... seeing things from... family's views. And even the therapists' views"* (pg. 16). For Haroon, FW provided more clarity around his MH difficulties and underlying issues: "*It's helped me come to terms with [bipolar disorder]... deal with unresolved issues apart from it, which have helped clear my mind and... focus on getting better"* (pg. 29).

Haroon and Maria shared how FW helped them understand their difficulties and experiences within their family contexts. For Haroon, FW helped him recognise how his experiences and struggles were interconnected with his family's and provided a sense of agency to *"break free"* from unhelpful patterns: *"it built up into… talking about… trying to stop that generational trauma in our generation… and help our children and our children's children to break free from that"* (pg. 1). For Maria, FW helped her contextualise and accept her MH difficulties: *"[FT's] not... you just... talk crap about your family... it's something that makes you think and delve into your life... your struggles, or whatever it is that you're going to talk about"* (pg. 21) and *"I feel like [FT's] affected my understanding of my MH experiences because [psychosis] runs in my family. Although obviously I knew... I just didn't think I would get it... anyone can get it really... so that's kind of changed my thinking"* (pg. 38).

Additionally, Haroon and Maria reflected how FW empowered them to challenge unhelpful internalised beliefs and expectations that contributed to distress, helping them develop a more compassionate sense of identity. For Haroon, this was tied to perfectionism and the pressure to succeed: *"I've put a lot of pressure on me as a kid... to get really high grades and like perform... it caused a lot of trauma.... wanting to be perfect at everything and... not make any mistakes... FT helped a lot with that... showed that my family were there to support me and the... family*

therapists were there to.... guide me... And we came up with the term... 'breaking idols'... in your head, that tell me what to do and... say to be perfect" (pg. 2). Being appreciated by his father also allowed Haroon to adopt a more meaningful sense of identity: *"he's been on... a self-realisation journey of... how he's treated his kids in the past... he says because of me... And because of my individual journey, he got inspired to go into his own self-discovery... therapy journey"* (pg. 20) and *"now I see myself as like... a new leaf has turned because it's more about healing people... helping people go to therapy... realise… the depths of their soul and... how... delving into that can help their life"* (pg. 23). Maria also described increased self-compassion: *"I'm a [care professional] ... obviously, that's part of my identity. So, helping people is something that comes naturally to me... [but] I feel like I'm kinder to myself now"* (pg. 34).

FW similarly helped Raheem develop greater autonomy over his care: "*sometimes I do feel that I don't wanna burden... or stress my family. So instead of talking about them types of things at home, I'd rather come into the [EIP]... but knowing that I can talk to my family if I'd like to... Alhamdulillah [praise be to God]... it's really nice to have that"* (pg. 53).

Integrating the Mind, Heart, and Soul

All participants spoke about how their FW experience allowed them to reflect on different aspects of their lives, including their MH, relationships, and identity; how their Islamic beliefs and values were honoured and incorporated; and how FW did not contradict Islamic practices of seeking support. Some participants also shared that FW allowed them to reconnect with spirituality in a meaningful way. The broad focus of FW and the way that participants felt that it complemented their religious beliefs was significant, as it appeared to integrate aspects of their mind, heart and soul. Critically, the integration of the mind, heart, and soul is a fundamental concept in Islam for living a righteous and fulfilling life. Subthemes include: '*Harmony Between FW and Islamic Principles'* and *'A Spiritual Awakening'.*

Harmony between Family Work and Islamic Principles

All participants reflected that their experience of FW aligned with their religious beliefs, and FW was an acceptable means to access support for their MH.

For Fatima, encouragement from her religious teachers and therapy being *"advocated for"* in the Muslim community was validating: *" my sheikhs... said 'if you can go seek MH support... then go for it... yes, we'll read on you... give you stuff to read [Islamic scripture]... but you still need to get the help you need'"* (pg. 46) and "*I found that therapy is so big in Islam as well... there's so many... Islamic therapists... females, males, for couples therapy... individual therapy... It's so advocated for now"* (pg. 47). FW also aligned with Islamic teachings that discourage *"backbiting": "you're talking about how you're feeling with the person there... it's even better because you're not backbiting them... you're getting help"* (pg. 7).

Haroon appreciated how FW upheld Islamic values of family cohesion, and his religious beliefs were *"integrated"* into sessions: *"it's really good.... Islamically speaking... bringing your family together... into one space where you talk about things because… obviously Islam has a really big emphasis on family... [and] we do talk about... stories from the Qur'an and how... we could learn from them... we've really integrated it well into our sessions"* (pg. 30). He felt further validated that: *"there's a big emphasis on family in [Pakistani] culture as well... you take care of your parents when they're old... always sticking together as a family no matter what. I think those kinds of ideas really did help us go to FT"* (pg. 30).

Similarly, Maria reflected that FW mirrored Islamic practices of seeking support through prayer and close relationships: *"From a religious perspective, I think it's quite good... you're talking about your feelings... and it's helping you mentally... Because obviously, when you go to pray then like in a sense, you're seeking out some sort of... guidance... therapy was... a bit like guidance as well"* (pg. 9) and *"I think, the Prophet [Muhammad, pbuh] went through something that was... a bit like a depression... And he... probably didn't get therapy [laughs] but he must have talked about it somehow... with his companions"* (pg. 41).

Raheem reflected that accessing support for his MH through FW was just as valuable as seeking religious support: *"Obviously speaking to Imams and going*

down an Islamic path is good. But... speaking to [therapists] and... getting help this way is also good" (pg. 21).

Sara also felt content that: *"It was just better to open up than worry about certain things, but I don't think there was anything said out of place that would affect... my religion or my beliefs"* (pg. 33).

A Spiritual Awakening

Haroon and Sara shared how FW allowed them to reconnect with their religious beliefs and identity, which felt like a spiritual awakening.

Haroon described that FW allowed him to reflect on his life's purpose: *"it's spiritual in a way because.... it's not just about the mind... it really delves deeper... listening to your heart... your soul... trying to break free from all these... ideas that have been externally planted into you as a child... really freeing yourself and letting your soul.... and your heart speak for itself and... coming to your own conclusions about life"* (pg. 13).

For Sara, her family's involvement prompted her to reflect on whether her lifestyle choices aligned with her spiritual beliefs: *"Obviously being Muslim... certain things... like smoking.... you're not allowed to… I was... more upset about that because I was like, 'oh my God I've like ruined my life'... but that kind of made me stop as well, like just being scared and... upset"* (pg. 32).

Navigating Systems: Family Work in an EIP Context

All participants described navigating multiple systems of care - specifically, engaging in FW through the EIP, within the broader NHS. While some considered the broader implications of accessing FW within this context, others reflected on how MDT support shaped their therapeutic experience. Subthemes include: '*"Pros and Cons" of Accessing FW through EIP';* and *'It's like a Family - Unified Multi-Disciplinary Team Support'.*

"Pros and cons" of Accessing FW through EIP

All but one participant reflected on how their EIP referral provided them access to FW, considering both its personal significance and how it fit within the broader context of their mental healthcare.

An important aspect for Fatima was the ability to access FW remotely during her trip to Pakistan for a couple of months: *"the therapy continued on through Teams... that was pretty good for [therapist] to actually let us carry on... It was more like, 'okay, we'll just find another medium to do the same thing'... that's a moment that stood out because... I thought... it's all going to stop... and then when I come back... I'm going to have to start all over again"* (pg. 15). While she also felt grateful *"to have something given to us that we don't have to initially pay for" as "private therapy is quite expensive",* she reflected: *"of course... the cons to going the NHS side was I was prescribed a lot of medication which I'm still on to this day... that's not very beneficial to me"* (pg. 58).

Both Maria and Fatima expressed regret that earlier access to FW could have been beneficial for their MH. Fatima believed that FW may have prevented her MH worsening: *"I feel like if I had therapy before I got ill... if I could talk about... feeling alone.... overwhelmed... looking after our 18-month by myself... absorbed in this COVID.... not having many friends to talk to, and... the lockdown... maybe it would have prevented a lot of things that have happened... if I could even talk to my husband, which I couldn't at that point... things could have turned out a lot differently"* (pg. 49). Although Maria had previously heard of FW when it was offered to her brothers, she similarly reflected that earlier engagement may have altered her own MH experience: *"the GP did give me medication, but I didn't take [it]... when I was going to the GP, I wasn't taking [MH] seriously enough. And if I did... I would have asked for more therapy"* (pg. 17).

In contrast, Haroon and Sara focused on the positives of accessing FW through EIP. Haroon reflected: *"we wouldn't have probably gone to FT if it wasn't for me getting bipolar disorder and coming to [EIP]... I guess it's a blessing in disguise where we've managed to understand each other... a miracle really like, people coming together in a room talking about themselves, with strangers'"* (pg. 28). His use of the word *"miracle"* emphasises how profound and transformative his experience of FW had been. For Sara, FW provided a positive initial experience of MH support: "*I'd heard of like therapy... but I didn't actually know what it was... that you could do FT"* (pg. 4).

"It's like a Family" – Unified Multi-Disciplinary Team Support

Raheem, Maria, and Haroon valued the support they received from other EIP clinicians, which either enhanced their experience of FW or felt complementary.

For Raheem, support from the wider MDT enhanced his experience of FW as it contributed to building trust with therapists: *"I initially spoke to [Social Recovery Worker]... at the time, I was having… a bit of a crisis... thinking... 'where am I? Am I in prison'... she mentioned things... and I just felt really put at ease. I was like... I can just be myself... I'm safe, and... everything's okay"* (pg. 13) and *"it helped me.... be calmer and... not worry about... what people think of me"* (pg. 5). He also appreciated how his religious beliefs and cultural identity were respected by the service: *"even the adventure therapy trip we went on... the food was halal... they were really... open-minded... in terms of like different cultures... knowing loads about Islam... And obviously, there's Muslim [clinicians].... but even like, non-Muslim"* (pg. 20).

Maria and Haroon both appreciated how integrated the MDT support was, which positively impacted their overall therapeutic experience. For Maria, the MDT support felt seamless: *"I just remember having like a pre-assessment at my home... then it followed through with therapy, and I had medication as well. My journey's been quite smooth... there's not been any hurdles... and it's helped me quite a lot. And yeah, I'm really grateful for it"* (pgs. 1-2). For Haroon, his individual therapy was complementary of FW: "*going through therapy at the same time as FT... was... really helpful because I could integrate aspects of my individual therapy into FT and talk about those topics there"* (pg. 3).

The Toll of Therapy

Fatima, Haroon, Sara and Maria shared how their family's involvement in the therapeutic process had at times been emotionally and psychologically challenging for them.

For Fatima, while FW had *"overall, been a good experience",* it was emotionally challenging: *"sometimes it brings out things that you never really would talk about... some hard truths to get used to... Good, like I say, for my husband especially to express how he's feeling because he always... keeps it bottled in. But... hard... to face stuff that you wouldn't really normally"* (pg. 2). This

momentarily caused: "*a bit of... distance between me and my husband... certain truths that.... were quite hard for him to digest"* (pg. 7).

Similarly, although Haroon valued the space FW provided to be emotionally vulnerable, this had psychological and physical repercussions: *"it can be quite draining, going to FT and individual therapy... being vulnerable"* (pg. 17). Less vulnerability in daily life was therefore *"okay"*, as this made it more *"manageable"* in therapy.

For Sara, FW was *"hard"* as she felt a sense of pressure and internal conflict about whether to make significant lifestyle changes: *"[mum and therapist] were like 'you need to stop smoking... doing this and that'... I didn't know what to do because... I was doing that [smoking] for so long... So, it was really hard, like getting off of certain things... changing my lifestyle, and habits"* (pg. 2).

Maria similarly alluded to the emotional impact of FW, despite viewing it as beneficial: *"[mum] got upset didn't she once… that stood out to me... I felt kind of like down... but then I was like thinking that [therapists] are there here to help as well. So, like sometimes it's good to get it out... it's not always good to bottle it in"* (pg. 25).

Chapter 4: Discussion

This chapter reflects on the results of the current study, which primarily aimed to explore how British Pakistani Muslim individuals experience and understand family involvement in FW for psychosis. Secondary aims included how individuals a) interpret their family's involvement in relation to their care and recovery; b) experience and make sense of changes in their family relationships, roles and personal identity; and c) make sense of their difficulties related to psychosis, before and after participating in FW. Interpretive Phenomenological Analysis generated six group experiential themes: *A Test of Family Support and Commitment; Opening Up: A Journey to Safety; Healing Through Connection; Integrating the Mind, Heart, and Soul; Navigating Systems: Family Work in an EIP Context;* and *The Toll of Therapy.* Interconnected themes are discussed in relation to existing theory and literature, to answer the following research question: *How do British Pakistani Muslim individuals experience, and make sense of family involvement in FW for Psychosis?*

The findings are summarised into three key interpretative layers listed below. These layers are not part of the formal IPA analysis, but instead offer an integrative, interpretative synthesis of the six experiential themes into broader conceptual patterns. This additional interpretative step strengthens the discussion by connecting the overarching findings to existing theory and literature.

1) *Family Involvement as Emotional Risk and Relational Commitment*: experiences and understanding of family involvement in FW.
2) *Growth, Healing, and Spiritual Alignment*: experiences and understanding of FW for psychosis.
3) *Family Work in Cultural and Systemic Context*: cultural and systemic factors influencing experiences and understanding of family involvement and FW.

The chapter concludes with a critical reflection on the study's strengths and limitations, along with its wider implications for clinical practice and future research.

Family Involvement as Emotional Risk and Relational Commitment

For participants of this study, family involvement in FW was not a neutral act. It was complex and meaningful, revealing a dynamic interplay between emotional risk and relational commitment across different stages. Initially, participants faced the dilemma of who to involve, balancing hopes and expectations of loyalty and support against the risk of rejection, disappointment, or regret when family members were absent or withdrew. Once family members became involved in FW, participants experienced heightened emotional vulnerability, as disclosing personal life choices, family issues, and often stigmatised MH experiences increased the risk of judgement, rejection and/or betrayal. At the same time, opening up in FW created opportunities for empathy, repair and deeper connection. This process tested participants' trust in both their families and the MH system, with support from family and therapists resulting in increased relational safety over time. Family involvement was therefore interpreted as an act of relational commitment, made possible through emotional risk and vulnerability.

Several participants expressed *hopes and wishes for family involvement,* reflecting emotional investment in the idea that FW would be mutually beneficial, improve relationships, and family support would enhance the therapy experience. These hopes align with Family Resilience Theory (Walsh, 2006), which emphasises how families draw upon shared belief systems, emotionally expressive and open communication, and a deep sense of connectedness to adapt and grow stronger through adverse experiences. Furthermore, according to Family Systems Theory (Bowen, 1978), families are considered to be emotionally interdependent units, explaining why participants may have viewed their families as significant to their distress and healing. This is particularly relevant where experiences of psychosis may have impacted relationships, frequently associated with social withdrawal and interpersonal difficulties (Hurtado et al., 2025). For participants who identified specific family members as crucial sources of support, Attachment Theory highlights how early caregiving experiences influence later care-seeking in relationships (Bowlby, 1969). In the context of FW for psychosis, mothers and older sisters may have been seen as secure attachment figures, with participants intuitively

turning to them for emotional security, comfort and reassurance - especially at a time of heightened distress and disorientation.

More broadly, these findings demonstrate the acceptability of FW approaches for British Pakistani Muslims. While Husain et al.'s (2021) study focused on a culturally adapted FI delivered in Pakistan, the current findings suggest that existing FW approaches may still be experienced as meaningful by British Pakistani individuals. Additionally, these findings add support to Naeem et al.'s (2015) research on culturally adapted individual therapy for psychosis. Though not specific to FW, the researchers suggested that family involvement may be an essential factor for Pakistani individuals' engagement in therapy, including those living in Western societies. In light of this, participants' experiences in the current study suggest that therapeutic approaches that actively involve family members may be preferred by British Pakistani individuals in the initial stages of psychosis, with no prior therapy experience.

However, despite participants' hopes and expectations of family involvement, opening up in FW carried significant emotional risks and challenges. Many described fears of judgement, misunderstanding or rejection by family members as a result of disclosing MH struggles, family conflict, and personal life choices. With regards to discussing MH difficulties, participants' anxieties were often shaped by perceived or internalised stigma, feelings of shame and fear of judgment from family members. These findings are consistent with Nilsen et al.'s (2014) study, in which individuals reported feeling anxious and emotionally vulnerable when discussing experiences of psychosis and difficult family dynamics within FW sessions. Furthermore, research shows how MH stigma often acts as a major barrier to disclosing MH difficulties, due to worries about being ostracised (e.g. Corrigan, 2004). For some participants, the risks of engaging in FW were intensified, as family therapists were also perceived as outsiders and potential sources of judgment, punishment or betrayal, due to their power as MH professionals. This shaped whether participants themselves felt able to engage in FW initially, supporting research which shows that British Pakistani individuals often feel apprehensive about engaging with MH services (e.g. Prajapati & Liebling, 2021).

Furthermore, the FW referral itself appeared to contribute to anxiety when framed as an opportunity to repair strained relationships or connect with family in a

way that felt unfamiliar. This may be understood as a response to the significant threat posed by experiences of psychosis to participants' sense of trust and safety in relationships (Hurtado et al., 2025), contributing to initial uncertainty about whether they could safely open up to family members in this context. In addition, Family Systems Theory (Bowen, 1978) highlights how opening up in FW threatens family harmony, as disclosing personal struggles and family issues may challenge unspoken rules and expectations around emotional expression, family cohesion, and familial roles or responsibilities. These findings resonate with Kleiven et al's (2020) study, highlighting how individuals often experience ambivalence about opening up in the initial stages of therapy. In particular, individuals express worries about therapy feeling emotionally unsafe, and that disclosing family conflict or relationship difficulties would be seen as betrayal. Thus, for the participants of this study, though FW represented an opportunity for closeness and connection, it also held the risk of emotional exposure and rejection by important attachment figures and close relationships.

Yet, it is perhaps unsurprising how mothers were frequently perceived as *the heart that drives support*, rising to the test of supporting participants to initially engage with services and subsequently FW, even when not explicitly requested to do so. Studies have consistently shown how mothers disproportionately take on caregiving responsibilities for individuals with psychosis across different cultural contexts (Carroll et al., 2024; Saleem et al., 2024; Sin et al., 2021). Though specific to learning disabilities, Syed-Sabir's (2004) study also found that mothers in British Pakistani Muslim families understood maternal caregiving as a spiritual act influenced by Islamic values of *sabr* (patience) and *rahma* (compassion). Considering the challenging and enduring nature of psychosis, mothers mentioned in the current study may have similarly embodied these values in supporting participants to access MH support. Yet, participants' trust and deep appreciation for their mothers' role in their MH journeys suggests that this caregiving was experienced as emotionally stabilising and relationally meaningful, rather than an act of obligation. From an Attachment Theory perspective, this can be understood as mothers acting as reliable and emotionally available attachment figures, providing a sense of comfort and emotional security for participants. Guidance, encouragement and practical support from mothers therefore re-affirmed feelings of care and

relational commitment, especially during the uncertainty and challenges of engaging with MH services.

Building on this, participants deeply appreciated their mothers' and other family members' willingness to engage in the FW process, which they often interpreted as significant acts of emotional commitment and sacrifice. Importantly, even when initially apprehensive of their family's involvement, all participants appreciated how their family members overcame personal discomfort and cultural stigma or taboos to participate. This was experienced as confirmation that participants were *valued* and that their struggles were recognised within the family. Drawing on Family Resilience Theory (Walsh, 2006), family members' participation and engagement in FW likely reinforced participants' sense of belonging, relational security, and self-worth across several key domains. For many participants, family involvement reflected a 'shared belief system' that prioritised loyalty, collective responsibility, and recovery, as opposed to shame, stigma and discomfort. Regarding 'organisational patterns', family members' efforts to adapt their schedules and navigate cultural norms to participate in FW signalled care and protection, with participants' needs being prioritised over personal reservations, cultural taboos, or maintaining social appearances. Additionally, family involvement fostered 'connectedness' by reducing feelings of isolation, reinforcing mutual trust, and strengthening a sense of belonging within the family. Moreover, family members supported open and emotionally expressive 'communication', which increased participants' sense of *safety and confidence* to speak about their MH experiences and struggles, personal lives, and broader family and relational issues. For many participants, this openness extended beyond FW, marking a shift in family norms, where previously unspoken emotions and experiences could now be acknowledged and shared.

While family support was fundamental, participants also emphasised the critical role of therapists in enabling emotional safety and engagement in FW. Crucially, therapists were described as non-judgmental, culturally accepting and emotionally attuned, increasing feelings of safety to explore sensitive and distressing topics as a family. Furthermore, therapists were perceived as caring not only for the participant but also for the family system as a whole, thereby enhancing participants' confidence in addressing relational issues. Importantly, it was not

clinical neutrality that fostered a sense of security, but rather the therapist's compassion and attunement to each family member. Their compassionate stance, alongside respect for confidentiality, was central to building trust, not just with the therapist but in the FW process itself. This trust enabled participants to tolerate emotional vulnerability and, in some cases, assess the extent to which family members were committed to greater understanding, connection, and relational repair. In this way, therapists played a pivotal role in managing emotional risk and fostering relational commitment.

Importantly, the qualities participants identified as vital for engagement are not incidental. Instead, they reflect core principles across Systemic, Family Intervention, and Open Dialogue approaches, integral to building safety and strong therapeutic alliances when working with families and social networks (Carr, 2012; Seikkula & Olson, 2003). These findings align with previous IPA research, in which individuals described feeling contained by therapists and having a shared experience with family as essential foundations for growth and healing in FW (Allen et al., 2013). Research has also consistently shown that the quality of the therapeutic relationship shapes engagement in therapy, particularly the therapists' interpersonal skills, rather than specific components of the intervention (Holdsworth et al., 2014). The current study demonstrates how trust, emotional safety and cultural sensitivity are critical for British Pakistani Muslims' engagement in FW. Absence of these factors has frequently been identified as a significant barrier to accessing therapeutic interventions and MH services more generally (e.g., Causier et al., 2024; Prajapati & Liebling, 2021; Yasmin-Qureshi & Ledwith, 2021; Tarabi et al., 2020).

Alongside narratives of connection and support, participants also described *feeling let down by family,* where hopes for family involvement were met with refusal, withdrawal or avoidance. While participants valued the involvement of other family members, the absence of specific individuals, often those they had most hoped would participate, complicated their sense of being fully prioritised and supported. Reflecting on Family Resilience Theory (Walsh, 2006), family members' lack of engagement in FW may have been perceived as a disruption in key family processes, essential for fostering a sense of care, solidarity and collective coping during times of crisis. Similarly, through the lens of Attachment Theory (Bowlby, 1969), a mother's initial refusal to participate may have signalled a lack of

attunement to the participants' emotional distress or relational needs. When concerns about cultural taboos and stigma drove this refusal, the participant may have felt that preserving social image was prioritised over emotional connection and support. This might have evoked deeper feelings of abandonment and rejection, especially when maternal validation and involvement were desired. These findings provide novel insights into how absence, or withdrawal of family members in FW for psychosis, is experienced and interpreted from the individual's perspective. This contrasts with existing research, which has predominantly focused on family or carer involvement in terms of barriers to engagement and implementation, carer burden, and clinical outcomes (Caqueo-Urízar et al., 2015; Claxton et al., 2017; Pharoah et al., 2010; Ma et al., 2018).

Though not specific to psychosis, these findings align with Collyer et al.'s (2021) qualitative findings, which showed how individuals experienced family members' non-attendance or withdrawal from Functional Family Therapy as relational rupture. This absence often led to feelings of disappointment, loneliness and a loss of trust, both towards family members and the therapy itself. Some participants also questioned their own role in their family members' decision to withdraw, leading to self-blame about whether their actions had contributed. Family members' absence subsequently impacted on individual's sense of emotional safety and motivation to engage, eliciting conflicting feelings of hurt, frustration, and hope for future reengagement. In the context of the current study, though participants expressed feeling hurt and let down by absent family members, they were able to maintain their engagement in FW and establish a sense of safety. According to Family Resilience Theory (Walsh, 2006), this highlights that even amid relational challenges and partial participation in FW, support from therapists and involved family members was sufficient to foster resilience, aiding recovery and strengthening relationships.

Participants also similarly reflected on *missed opportunities* for family involvement, which revealed important insights into how they understood and evaluated their own relational commitment to family members. According to Meaning-Making theory (Park, 2010), individuals strive to make sense of events that conflict with their existing beliefs and expectations in a way that reduces distress and restores coherence. For many participants, fear of conflict, rejection or loss of

control initially prevented them from involving certain family members or fully participating in the FW process. Within the early stages of psychosis and FW, participants appeared to focus on survival and making sense of their MH and FW experiences, especially at a time of crisis. However, as FW progressed and emotional risk decreased, participants reflected on these earlier decisions, engaging in a dynamic meaning-making process where feelings of regret and helplessness emerged. Feelings of regret were specifically related to how family members could have benefited from or supported FW, once participants themselves came to realise the value of it. This process involved participants reflecting on their own relational commitment, alongside practical barriers such as family members' work commitments and schedules, language difficulties, and past therapy experiences. Meaning Making theory (Park, 2010) therefore, helps to interpret regret not as a fixed emotion, but as part of an ongoing process where participants balanced self-reflection with the constraints they faced, reaching an interpretation that felt emotionally tolerable and logically justifiable. This dynamic process of re-evaluation closely aligns with the principles of IPA, which explores how individuals make sense of their experiences over time. Through this lens, participants actively evaluated their own roles and responsibilities over the course of FW, rather than merely recalling events. Subsequently, even when family members were not involved, their absence became meaningful as participants reflected on what could have been possible, and what shaped their choices within their family and community contexts.

Growth, Healing and Spiritual Alignment

Building on the emotional and relational significance of family involvement, participants described how FW became a space for profound personal transformation. For many participants, this process fostered growth by facilitating a deeper understanding of their MH experiences and distress, a stronger sense of individual identity and acceptance of their family's support and care. Healing emerged through the strengthening and renewal of family relationships, which resulted in greater mutual understanding, closeness and participants feeling more supported with their MH struggles. Connection with therapists also contributed to growth and healing, as participants described feeling understood and validated,

which helped them make sense of and better manage their own MH experiences. Additionally, FW held spiritual significance, as it was experienced as congruent with Islamic beliefs and values, drew on religious scripture and supported reconnection with faith. Importantly, the FW process was not without difficulty as participants sometimes described it as emotionally, psychologically, and physically taxing. Yet, despite these challenges, FW was experienced and interpreted as a meaningful and transformative journey that ultimately aligned healing with personal and spiritual growth.

A promising finding from the study was that participants reported gaining a better understanding of their own MH experiences, as well as feeling more understood and supported by their families. Participants also described stronger family relationships and feeling more able to embrace their family's care, within and outside of FW. A core aim of all FW approaches is to support individuals and families to develop greater awareness and shared meaning-making of MH experiences (British Psychological Society [BPS], Division of Clinical Psychology, 2021). Similarly, FW approaches aim to strengthen family relationships by improving communication and fostering relational understanding. The findings of the current study therefore provide evidence for the utility of FW for British Pakistani Muslims experiencing psychosis. However, while FW approaches for psychosis are theoretically grounded, these core aims remain underexplored in research due to studies being predominantly quantitative and focusing on clinical outcomes (such as symptom reduction, relapse rates, hospitalisation, medication adherence, family burden and distress, and improved EE) (e.g., Bressi et al., 2008; Claxton et al., 2017; Pharoah et al., 2010; Ma, 2018)

Consequently, relatively few qualitative studies have explored individuals' perspectives, though some offer valuable insights into how these interventions are experienced beyond quantitative outcomes. In one study by Nilsen et al. (2016), individuals reported multiple benefits of engaging in a psychoeducational family intervention, including greater understanding and acceptance of their experiences of psychosis, recognition of early warning signs, improved communication skills, learning how to plan and problem solve, and more independence. Similarly, in Allen et al.'s (2013) IPA study of an integrated family intervention, individuals experienced FW sessions as facilitating a new sense of self and positioning within

both their families and their wider social worlds. This encompassed developing a greater sense of empowerment and personal accountability, increased self-acceptance, improved emotion regulation, and optimism about the future. An important theme that underpinned this was that FW validated multiple perspectives, contributing to changes in relational patterns and allowing individuals to create new meanings. These findings are consistent with participants' experiences in the current study, demonstrating how FW is not only beneficial for relationships and MH experiences but also enhances individuals' sense of agency, meaning-making, and personal identity. This is fundamental, as changes in sense of self and identity are commonly associated with psychosis; however, they are rarely acknowledged as part of treatment (Berthoud et al., 2019; Conneely et al., 2021).

Alongside the limited research on individuals' experiences of FW, very little attention has been given to the challenges inherent in the therapeutic process - an aspect that remains underexplored, even within the literature on individual therapy. This is despite the fact that a fundamental barrier to seeking couples therapy is apprehension about confronting painful emotions and sensitive topics (e.g. Hubbard & Anderson, 2022). Some existing studies have briefly noted the psychologically and emotionally demanding nature of individual therapy for psychosis, particularly in relation to Compassion Focused Therapy and variations of CBT (e.g. Birchwood et al., 2018; Hardy et al., 2022; Heriot-Maitland et al., 2017). This is significant as components of these modalities are often integrated within FW approaches, albeit in a less prescribed manner (i.e. exploring and confronting painful memories, thoughts and feelings). While participants similarly found these aspects challenging in FW, the findings highlighted an additional layer of relational difficulty, such as witnessing family members becoming upset or experiencing a greater sense of external pressure to make lifestyle changes. One participant also reflected on the repercussions of being vulnerable in therapy, which may be more pronounced when this involves multiple people. Although empirical research on fatigue related to vulnerability in therapy remains limited, numerous clinical commentaries and practitioner reflections identify this as a common experience (e.g. Morin, 2017; Good Therapy, 2018; The Mighty, 2019). These sources describe the emotional labour involved in opening up and processing difficult emotions as both draining and necessary for healing. It is therefore important to consider how individuals

manage the emotional, psychological and physical challenges of FW, which participants in the current study framed as beneficial for recovery and relational change.

Beyond emotional, psychological and relational benefits, all participants valued how FW resonated with their spiritual worldviews. Some reflected on how Islamic scripture and religious concepts were integrated into FW sessions, allowing them to connect more deeply with the therapeutic process. Several participants also described how FW principles mirrored core Islamic values such as family unity, conflict resolution and seeking guidance for personal difficulties. In addition, FW was especially meaningful for some participants as it fostered reconnection with their spiritual beliefs and Muslim identity. Interestingly, a recent IPA study showed that Muslim community leaders who received SFT training also experienced it as complementary to Islamic principles (Khan, 2021). Though FW approaches are not inherently religious, there is a strong emphasis within the field of family therapy on acknowledging and working with clients' religious and spiritual beliefs. One prominent example is the Social GRRAACCEESS framework, developed by family therapist John Burnham (1992; 2012). This framework encourages therapists to consider various aspects of clients' identities, including gender, race, religion, class, culture, and spirituality, that shape power, privilege, and engagement in therapeutic work.

Regarding religion and spirituality, a growing body of literature now highlights their importance in the context of FW. To illustrate, Rivett and Street (2001) argue how spirituality interacts with FW in implicit, but multifaceted ways. This includes spirituality shaping shared belief systems (family values, rituals and moral codes) affecting decision making, relational patterns (communication styles, expectations, and conflict resolution), and meaning-making and coping (making sense of suffering, MH difficulties and relational difficulties), influencing hope and resilience. Other researchers have similarly commented on how spirituality should be viewed as a resource that can enhance motivation, hope, healing, and resilience (e.g., Holmberg, 2021; Pearson, 2017). Collectively, these researchers advocate for greater spiritual literacy among family therapists to enhance the experience and effectiveness of FW, with Aldrich and Crabtree (2020) noting that even clinicians who identify as spiritual often struggle to incorporate it into their practice. This

emphasis is reflected in broader clinical guidelines (e.g., BPS, 2021; NICE, 2014) which recommend that psychological and FW approaches are delivered with cultural sensitivity. The current findings therefore demonstrate the significance of therapists honouring participants' cultural and religious beliefs, allowing them to engage meaningfully in FW.

Family Work in Cultural and Systemic Context

Fundamental to participants' experiences and sense-making was the systemic context in which FW took place, alongside the cultural and religious narratives they navigated at different stages. Many participants reflected on the *pros and cons* of engaging in FW through EIP, which predominantly centred around access. Others emphasised the value of support from the wider MDT and NHS system, which enhanced or complemented their FW experience. As expected, participants reflected on how cultural norms and religious beliefs (related to MH, therapy, and family) interacted with their experiences of family involvement and FW more generally. However, consideration should also be given to the broader cultural, religious, and systemic influences that may have shaped participants' experiences and understanding in more implicit, or less consciously recognised ways.

All participants described how FW only became available to them once they were referred to EIP for their own MH difficulties. For many, FW was a profoundly positive experience, either as part of their broader MH journey or as an introduction to MH services. However, for some participants, FW led to the realisation that earlier access may have prevented their MH from deteriorating or changed how they initially managed their experiences. One participant discussed the costs and benefits of seeking MH support through the NHS. This included dissatisfaction with the early emphasis on medication and hospitalisation, contrasting with appreciation for free access to FW through EIP later on, which was tailored to their practical needs. Despite its continued dominance across Western mental healthcare systems, the medical model has been widely criticised by both psychologists and psychiatrists (Cooke et al., 2019). Critics argue that the model's focus on biological and genetic causes of MH difficulties can individualise and pathologise experiences of psychosis. Furthermore, the model operates on the premise of diagnosis and symptom reduction, prioritising medication as the primary intervention approach. In

contrast, alternative models highlight the importance of psychological, social and environmental factors in understanding distress and supporting recovery. Examples include the Recovery model, which centres on personal empowerment, and the Power Threat Meaning Framework, which examines the impact of power, trauma and meaning-making in understanding MH difficulties (Johnston & Boyle, 2018; Leonhardt et al., 2020). The value participants placed on FW underscores the importance of practical and collaborative support that considers individuals' relationships and social contexts, as opposed to a solely medicalised view of MH.

Extending on this, participants valued how FW was integrated within or enhanced by support from the wider MDT and NHS system. For one participant in particular, early positive experiences of support from their GP and other EIP clinicians, as well as ongoing engagement with the MDT, helped to build trust that extended to their participation in FW. Interestingly, these participants were all receiving support from an EIP service adopting an Open Dialogue approach, where network meetings were commonplace. These findings demonstrate the importance of continuous, coordinated MDT support across the healthcare system, aligning closely with the ethos of both Open Dialogue and EIP (Seikkula, et al., 2003; NICE, 2016). This appears particularly integral where individuals may feel apprehensive about MH services.

Another important aspect of participants' experiences was the central role that mothers played in FW, often being the primary family member to attend and provide support throughout the process. In contrast, fathers were generally less involved, with their absence commonly attributed to work commitments or practical constraints. While this was understood and accepted by many participants, it reflects broader gendered patterns of caregiving within the family context (Carroll et al., 2024; Saleem et al., 2024; Sin et al., 2021). For one participant whose father actively engaged in FW, this involvement may have been influenced by a combination of cultural and practical factors, as his mother was first-generation. To illustrate, his mother's more subdued, practical role in supporting him with medication may be reflective of language barriers and unfamiliarity with MH services. In contrast, his father's greater acculturation, liaison with clinicians, and openness towards therapy likely supported his involvement in FW. However, this gendered pattern also appeared to extend to sibling involvement. For example, among male participants,

brothers were typically the first to attend FW sessions, whereas for female participants, sisters were more commonly involved. In one case where a female participant did not have a sister, her sister-in-law appeared to be a key source of support initially. Involvement from same gender siblings or emotionally close relatives might therefore feel more culturally appropriate and emotionally safe, especially in the initial stages of FW. These findings highlight how gender roles within British Pakistani Muslim families may shape not only parental involvement, but also sibling involvement in FW.

At the same time, there is now increasing recognition of the emotional and psychological impact of psychosis on siblings, who often play a crucial but overlooked role in supporting their affected brother or sister (Sin et al., 2012). Bowman et al. (2014) refer to siblings as "forgotten family members", who despite providing significant emotional and practical support, have often been excluded from FW or carer-focused support. These studies show that siblings often experience elevated levels of distress, isolation, and unmet support needs. Sin et al.'s (2016) findings further demonstrate how siblings of individuals with psychosis report significantly lower mental well-being than the general population, particularly sisters. Female participants in the current study similarly described how they were negatively impacted by their siblings' experiences of psychosis (feelings of loss, increased anxiety and fear, confusion, and isolation due to reduced attention from parents) and how FW provided a space to express previously unspoken thoughts and emotions as a family. This subsequently helped them feel understood, while deepening their understanding of their family members' experiences of living alongside relatives with psychosis. This is fundamental, as research has predominantly focused on family members' increased risk of psychosis through a hereditary lens, undermining the potentially traumatic experience of witnessing relatives struggle with psychosis. These findings highlight the importance of actively involving siblings in FW. This could not only improve the well-being of siblings by reducing psychological distress, but also serve as an early supportive intervention, potentially helping to mitigate the risk of more severe MH difficulties.

Given the study's specific focus on British Pakistani Muslims, it is important to consider how cultural and religious factors may have influenced participants' experiences and understanding of family involvement and FW. For example,

participants' desires for increased family unity and family members to benefit from FW reflect collectivist and Islamic values, which emphasise mutual responsibility, compassion, and preserving family ties (Ballard, 1994; Shariff, 2009; Shaw, 2000). Furthermore, within the British Pakistani community where MH stigma and taboos are prevalent, family involvement reflects a 'shared belief system' that prioritises loyalty, collective responsibility and recovery, over shame and stigma. In contrast, where family support and commitment were perceived as inconsistent or lacking, participants experienced this as deeply painful, evoking a sense of abandonment and betrayal. This is likely related to the high importance placed on family loyalty and mutual support within both the Pakistani community and Islamic teachings.

However, many participants recognised the dilemma that FW may have posed for family members. Family members may have felt torn between cultural stigma and taboos surrounding MH and therapy, and a desire to show support and commitment to their loved one experiencing psychosis. This tension mirrored participants' own experience of FW, as opening up in front of family meant navigating the same cultural expectations and fears of judgement. Previous research has highlighted the anxiety and discomfort associated with discussing MH difficulties, personal life choices, and family conflict, particularly among British Pakistani individuals (e.g. Ahmed, 2019). One explanation for this is stigma and shame often attached to MH difficulties, and how help-seeking may be perceived as a sign of personal or familial weakness (Gilbert et al., 2004; Islam et al., 2015; Tabassum et al., 2000). Additionally, the fear of being ostracised by family members due to the potential threat to family honour often inhibits disclosure (Kapadia et al., 2017; Moller et al., 2016; Gilbert et al., 2004). Mistrust towards clinicians and MH services further undermines engagement, fuelled by concerns around confidentiality breaches, coercive practices, and cultural insensitivity (Gajwani et al., 2016; Halvorsrud et al., 2018; Khawaja et al., 2022; Prajapati & Liebling, 2021). More broadly, research has shown that South Asian individuals may refrain from opening up to parents perceived as less accultured to Western society, and therefore less accepting of their viewpoints, experiences, and behaviours (Sharif et al., 2023). In one Pakistani study (Akhtar et al., 2013), criticism from parents was often linked to disapproval of certain decisions, behaviours, and lifestyle choices (e.g. smoking, disobedience to elders, not adhering to Islamic practices, poor hygiene, not earning

enough money, and academic subject choice). These findings may extend to British Pakistani Muslim families.

Yet, for participants in the current study, anticipated concerns around stigma and judgement did not materialise, as family members were largely experienced as supportive and accepting. One possible explanation for this is that many family members involved in FW were second or third generation and perceived as more open or informed about MH. For one participant whose parents were first-generation, their encouragement to speak openly about her distress increased her confidence to access MH services and later engage in FW. This was attributed to her parents' genuine willingness to learn and understand her MH difficulties, suggesting that assumptions about generational attitudes towards MH may not always hold true. To elaborate, Sharif et al. (2023) note that within South Asian families, emotional expression often takes culturally specific forms that may not align with Western norms, but are nonetheless experienced as love, duty, and care. One example of this is practical involvement and support from family rather than verbal affirmations. Participants' accounts echoed this in the current study, with emotional safety in FW also appearing to be established through various forms of family involvement. For some participants, the simple act of family members attending FW sessions was sufficient to reduce emotional vulnerability. For others, emotional safety was cultivated through the active participation, encouragement, and empathy of family members. These findings highlight how both verbal and non-verbal expressions of support play a central role in fostering individuals' sense of safety in FW, particularly when experienced as culturally meaningful forms of care.

The influence of community religious leaders also emerged as a notable factor shaping engagement and attitudes towards FW. For one participant, support from her spiritual teacher and greater advocacy for therapy within the Muslim community validated and increased her motivation to engage in FW. Although this was a unique example within the current study, it highlights the influential position religious leaders can hold within the British Pakistani Muslim community, with the potential to either encourage or deter individuals from accessing mainstream MH support. This is consistent with recent research, which found that UK-based Muslim community leaders displayed low stigma towards MH, often provided informal counselling, signposted individuals to mainstream MH services, and acknowledged

biological and environmental factors (Meran & Mason, 2019). Furthermore, recent initiatives, such as offering SFT training to Muslim community leaders in the UK (Khan, 2021), suggest a growing recognition of the importance of bridging the gap between religious communities and mainstream MH services. This points to the value of engaging faith leaders as allies to build trust, promote spiritual congruence and increase access to therapeutic interventions for psychosis, such as FW.

Strengths and Limitations

Recruitment, Sample and Interview

A major strength of this project was its novel focus, which addressed the significant gap in research concerning British Pakistani Muslims' experiences of family involvement in FW for psychosis. This is a substantial contribution to the literature, as very little is known about how individuals from this community experience therapeutic interventions for psychosis, particularly those involving family members. The study therefore provides valuable insights into the suitability and acceptability of FW, given the potential elevated risk of psychosis in the Pakistani community, and clinical guidelines recommending that FW is offered to all individuals accessing EIP services (NICE, 2014).

In addition to this, the study's use of purposive sampling and semi-structured interviews gave participants the opportunity to share aspects of their experiences shaped by their unique cultural and religious identities. This is important as previous research has often minimised and obscured critical distinctions by grouping Pakistani individuals under the broader South Asian category. Semi-structured interviews were also imperative due to the stigma surrounding MH within the Pakistani community. This approach enabled individuals to adopt a more expert position, sharing what felt most meaningful to them, with all efforts made to ensure interviews felt safe and empowering. Subsequently, richer, culturally grounded insights emerged that might not have been generated through more structured or quantitative methods.

Conversely, one of the most challenging aspects of this project was recruitment, as only five individuals agreed to participate from two EIP services in Northern England. This is despite sustained efforts to approach clinicians and recruitment being open to EIP services and CMHTs across four large NHS Trusts in

the North of England and one in North London. Clinicians consistently reflected that FW was not being offered frequently enough to British Pakistani Muslim families. This was further complicated by individuals or their families expressing a strong reluctance to take part in research, often due to the distressing nature of psychosis and the stigma associated with it. One explanation for this may be the potential risk to family honour if sensitive aspects of FW were disclosed in interviews. This is in light of barriers to engaging with MH services and therapy for the British Pakistani community, as well as stigma surrounding factors that may have contributed to the development of psychosis (e.g. abuse). Although the initial target was 6-10 participants, the final sample of five remains appropriate for IPA, which emphasises depth and richness of individual accounts over sample size. However, it is possible that only those who had relatively positive experiences of FW agreed to take part in the study, potentially limiting insight into the experiences of those who did not, particularly if negative.

Furthermore, it is possible that when reflecting on their experiences, individuals recalled or appraised challenging aspects of FW more positively, due to their overall positive experience. This is because FW sessions often take place over an extended period and are less frequent than individual therapy, which may have affected participants' recall of events. Nevertheless, the study highlights how FW for psychosis can be experienced and understood by individuals from British Pakistani Muslim backgrounds navigating various cultural and religious narratives around MH and family.

An important consideration in interpreting these findings is the heterogeneity of FW interventions participants engaged in, including structured FIs, SFT (with and without reflecting teams) and OD network meetings. This variability partly reflects recruitment constraints, as it was not feasible to recruit participants who had engaged in a single type of intervention. Despite this, the sample is conceptually homogeneous in terms of shared cultural background and focus on family involvement, aligning with IPA's emphasis on exploring rich, idiographic experiences within a clearly defined group. While heterogeneity may have influenced session content and the ways family members participated, meaningful insights into participants' experiences of family involvement can still be gained across interventions. However, this heterogeneity may limit the ability to explore

intervention-specific nuances, as certain aspects of family involvement could be shaped by the particular type of FW received.

Another important limitation of the study is that participants were predominantly young (aged 18-31) at the time of the interviews. While this is reflective of the typical age range for the onset of psychosis, it is not uncommon for individuals above the age of 35 to experience psychosis and be referred to EIP services. In these cases, family involvement may differ significantly for British Pakistani individuals whose adult children, spouses, and in-laws may be more present and take on carer roles. Additionally, generational differences may influence older individuals' perspectives and ideas around MH and therapy. These findings are therefore limited in capturing how FW may be experienced and understood by individuals above this age range.

Insider Vs Outsider Position

Another key strength of the study was my position as an 'insider' researcher (Asselin, 2003; Greene, 2014), due to my shared cultural and religious identity as a British Pakistani Muslim. This likely helped to build trust and rapport with participants and facilitated more open discussions of sensitive topics, such as MH, relational tensions, cultural issues, and faith. Being embedded within the same cultural and religious community also enabled me to take a more nuanced perspective of participants' experiences and sense-making. This was informed by my knowledge and understanding of broader narratives within Pakistani Muslim communities, both in the UK and Pakistan.

However, being an insider also presents certain disadvantages, which may influence both data collection and analysis. For example, it is possible that my insider position limited my curiosity around certain aspects of participants' experiences based on my own assumptions and worldview (DeLyser, 2001). While IPA recognises the concept of the 'double hermeneutic', there were instances where more explicit follow-up questions could have been asked to expand on participants' meaning-making of their experiences. This is something that I reflected on throughout the analytic process. Nevertheless, several quality measures were employed to mitigate the risk of over-identification with participants. This included a reflexive journal throughout the research process to capture personal reactions,

assumptions and any potential biases. Reflexivity was further supported by regular discussions with my supervisors from non-Pakistani Muslim backgrounds, prompting critical reflection on my own assumptions and biases when identifying emerging themes.

Conversely, not having personal experience of FW for psychosis positioned me as an outsider to the phenomenon under investigation. This distance may have limited the depth of understanding I could bring to certain aspects of participants' narratives. Additionally, while my role as a Trainee Clinical Psychologist with connections to EIP facilitated greater access to participants, it introduced another layer of complexity. This is due to the inherent power dynamics and professional authority associated with working in the MH system, further positioning me as an outsider. For some participants, my professional identity may have increased the legitimacy of the research and encouraged openness, particularly if they felt that their insights could lead to better service provision. At the same time, my association with the MH system may have inhibited disclosure, especially around more negative experiences of FW, clinicians, and MH services.

A further limitation of the study is the absence of PPI. Although attempts were made to engage experts by experience to pilot the interview schedule, no individuals came forward, meaning that the questions were developed solely from researcher and peer perspectives. As a result, the schedule may not fully reflect the priorities, language, or concerns of British Pakistani Muslim individuals who have lived experience of psychosis and FW. PPI input might have helped identify culturally specific issues, enhance the sensitivity of the questions, and ensure that areas of relevance to participants were not overlooked. The lack of experiential contribution therefore represents a constraint on the study's co-production, cultural validity, and overall rigour.

Clinical Implications and Recommendations

Improving Access to FW

Participants reflected that FW only became available to them after their referral to EIP, rather than through services that were often their first point of contact, such as GPs and perinatal services. Fundamentally, some participants felt that being offered FW earlier in their journeys may have prevented their MH

difficulties from worsening. This is particularly concerning for participants with siblings who have also experienced psychosis, given the growing body of research highlighting its impact on siblings. Notably, even when siblings had previously declined FW, FW was not offered to participants or the wider family by EIP. Participants therefore reported having minimal understanding of what psychosis or FW was until they encountered these issues themselves. These findings highlight the need for therapists and services to be more proactive in involving siblings in FW, as this could potentially serve a preventative function. Similarly, services should be more mindful of involving family members during periods when relationships may be especially vulnerable or significant e.g. following the birth of a child.

Furthermore, although NICE guidelines recommend that FW be offered to all individuals accessing EIP services in the UK, difficulties in recruitment highlighted that FW was still not being implemented at a level that meets these recommendations. This was a frequent reflection made by clinicians approached for the study, especially where FW was offered as a secondary intervention. Whilst the current findings offer valuable insights into how British Pakistani Muslims experience FW, the small and geographically limited sample subsequently restricts the generalisability of these clinical recommendations across services. Greater access to FW would subsequently contribute to a richer understanding of how FW is experienced, particularly in instances where this may be less positive than suggested. Thus, it is important that EIP services address the barriers to engagement and implementation of FW. This is to ensure that individuals experiencing psychosis receive a holistic package of care, and for experiences of FW to be further explored. One strategy may be to implement more general systemic approaches within EIP teams, such as Open Dialogue, which is currently being piloted and evaluated across several NHS Trusts. The integration of Open Dialogue across EIP services, beyond formal trials (e.g., Dawson et al., 2022), reflects the growing interest in a more relationally informed model of care that involves families and support networks. This approach allows for the active involvement of family members, whilst facilitating a less abrupt shift to more traditional forms of FW where indicated. The value of this approach was highlighted in one participant's account, who framed Open Dialogue network meetings as a demonstration of family support. This

appeared to be experienced as a less challenging format than SFT with a reflecting team involving multiple clinicians.

Greater curiosity around Family Involvement

With regards to family involvement, previous FW research has primarily focused on the perspectives of family and carers, as opposed to individuals experiencing psychosis. However, the findings of the current study provide crucial insight into how emotionally meaningful family involvement was for those experiencing psychosis. For many at the start of their psychosis journeys, the decision to involve certain family members appeared to be clouded with fear, due to uncertainty about psychosis and what FW would involve. Some participants also adopted a more passive position during this time, which may have reflected broader cultural and societal expectations of caregiving, such as the role of mothers. Also important to note is how the majority of participants eventually accepted family members' non-involvement, especially when they were experienced as supportive outside of FW. However, in the case of one participant whose family member withdrew from FW, there was a lasting sense of loss regarding their relationship. This underscores the need for therapists to adopt a more curious stance concerning who becomes involved in FW and the reasons for this. Furthermore, therapists should address the emotional impact of family members' involvement, absence or withdrawal from FW on individuals, especially as this may have long-term implications for their relationships.

Promoting Trust and Emotional Safety in FW

For some participants, a crucial aspect of feeling safe and accepting FW was therapists adopting a compassionate stance, not only towards them but also their families. While traditional FW approaches often emphasise neutrality, participants in this study described how therapists' expressions of warmth, empathy and compassion towards their family members invited trust and openness. This suggests that in contexts where family unity and collective wellbeing are central, neutrality may be experienced as emotionally distant or disengaged. In contrast, compassion may be experienced as a sense of care and respect from therapists.

In addition, participants perceived FW as consistent with their values and beliefs regarding family, which were shaped by Pakistani cultural norms and Islamic teachings. Clinicians may therefore find it helpful to openly acknowledge and explore how FW aligns with British Pakistani Muslim individuals' cultural and religious beliefs. Similarly, clinicians may benefit from exploring individuals' and family members' reservations about FW by acknowledging broader cultural narratives that often hinder or facilitate engagement. More broadly, efforts should be made to increase families' awareness of FW's congruence with cultural and religious principles.

Although participants perceived the challenging aspects of FW as necessary for positive change, this sense-making appeared to emerge through personal reflection rather than therapeutic dialogue, particularly once the benefits of FW became more apparent. Considering the barriers and concerns identified by individuals regarding the emotional impact of therapy, therapists may be more proactive in offering direct or indirect support around sessions to prevent early disengagement from FW.

Supporting Agency and Identity in FW

Though general psychoeducation around psychosis may be somewhat helpful, participants valued how FW allowed them and their family members to develop a more personalised understanding of their unique experiences, struggles, and support needs. Participants also appreciated how FW enhanced their sense of agency and identity within their families and broader society, whilst strengthening family relationships. These findings suggest that the effectiveness of FW may not depend on the strict adherence to a specific model, but rather on the extent to which it is experienced as individualised, relational, and recovery-oriented. Thus, going beyond symptom reduction alone. The findings reinforce the beneficial impact FW can have for individuals experiencing psychosis as well as their families, underscoring the importance of FW being shaped around each individual's personal experiences and family context. Clinicians may also find it helpful to highlight these potential benefits when discussing FW with individuals, particularly due to the ambivalence around what FW is and what it may involve.

Further Research

Experiences and Efficacy of Specific FW Approaches

Given the little research on FW for psychosis in this cultural context, future research may focus on exploring British Pakistani Muslims' experiences of specific FW approaches and their efficacy. This may help to understand the cultural applicability of specific FW techniques or components.

Negative Experiences or Reluctance

Individuals in the current study appeared to have relatively positive experiences of FW, which provides little understanding of those who had declined or had potentially harmful experiences. Further research may therefore focus on exploring the barriers to engaging in FW for British Pakistani individuals, or how FW may be experienced as less beneficial. Due to the persistent stigma and unhelpful cultural narratives surrounding MH and psychosis, this may be explored through more creative or safer methods, e.g. Service Evaluation Projects and surveys. Where significant ruptures have not occurred, these may be carried out by Care Coordinators, Psychologists or Family Therapists with the support of Assistant or Trainee Psychologists in the service. This is because clinicians embedded in the service may have already built trust with individuals or have the opportunity to do this over time.

Family Members' Experiences and Dyads

To date, very little research has been conducted to understand family members' experiences and understanding of FW, let alone those of British Pakistani Muslims. Further research could therefore help clarify the factors that influence family involvement in FW for psychosis, and how access and service provision may be improved. Moreover, research involving dyads could provide insight into the similarities and differences in expectations, experiences and sense-making between individuals experiencing psychosis and their family members.

Conclusion

Clinical guidelines recommend that FW is offered to all individuals experiencing early psychosis, which may be more prevalent for British Pakistani Muslims. There is a strong emphasis on preserving family ties in both the Pakistani community and the Islamic faith. Despite these factors, there is a notable lack of research exploring British Pakistani Muslim individuals' experiences and understanding of FW for psychosis, which the current IPA study sought to address.

For all participants, FW was either an unfamiliar concept or associated with negative pre-conceptions. While many desired family involvement, they initially felt anxious or apprehensive about disclosure in FW, which extended to therapists. This was attributed to perceived stigma surrounding MH and therapy, alongside fears of judgement and rejection, internalised shame, and discomfort, rooted in cultural and familial expectations. Over time, FW became a place of safety where personal transformation, relational healing, and spiritual reconnection could occur, despite being challenging at times. Family involvement was ultimately experienced and understood as emotionally and relationally meaningful, communicating loyalty, care, and a sense of being valued. At the same time, FW prompted reflection on personal responsibility and influence within the family, particularly in relation to collective healing. Significantly, participants' accounts outlined the central role of mothers in both facilitating and participating in FW sessions, reflecting the normalisation and implicit acceptance of limited paternal involvement in MH support.

By highlighting these experiences, the findings offer rich and nuanced insights into how individuals navigate cultural narratives, religious beliefs, and practical barriers surrounding family involvement in FW. This foundational knowledge may inform improved access to culturally sensitive FW interventions that are responsive to the specific needs of British Pakistani Muslims within their unique family, community, and religious contexts. This research resonates with the growing interest in bridging the gap between Muslim communities and MH services through community and family support avenues.

Overall, this study offers valuable contributions to FW for psychosis literature, where British Pakistani Muslim voices remain underrepresented. It also provides a promising response to longstanding critiques of the cultural applicability

and sensitivity of therapeutic approaches for British Pakistani Muslims. In doing so, it emphasises the commitment required from therapists, MH services, and researchers to move beyond tokenistic inclusion, towards genuinely attuned cultural practice.

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Appendix A
Ethics Approval Letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Ramsha Qureshi
[redacted]

Email: approvals@hra.nhs.uk

20 December 2023

Dear Miss Qureshi

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

Study title:	**Exploring how British Pakistani Muslim's experience and understand family involvement in family work for Psychosis.**
IRAS project ID:	**322397**
Protocol number:	**N/A**
REC reference:	**23/IEC08/0042**
Sponsor	**University of Leeds**

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.

Note. Project title amended for thesis submission

Appendix B
Participant Information Sheet Example

17/11/2023 V1.2; IRAS ID: 322397

UNIVERSITY OF LEEDS

PARTICIPANT INFORMATION SHEET

Exploring how British Pakistani Muslim's experience and understand family involvement in family work for 'Psychosis'.

My name is Ramsha Qureshi and I am a Trainee Clinical Psychologist studying at the University of Leeds. As part of my course, I am doing some research to find out about people's experiences and understanding of family involvement in family work for 'psychosis'. **You may not agree with the term psychosis to describe your experiences but may have received this as a diagnosis.** This is okay, I am interested to hear about your experiences and understanding.

You are being invited to take part in this study and it is entirely your choice whether you decide to do so. Please feel free to read through this information sheet and talk to others about the study if you wish.

What is the purpose of the study?

Some research has focused on people from a South Asian background and explored what it is like to have psychosis. Some studies have also explored whether certain psychological therapies for psychosis are effective for people from a South Asian background and what it is like to access treatment from an Early Intervention Service. However, very few studies have focused on British Pakistani people specifically and explored what it is like to take part in psychological interventions involving family members.

This study is about giving you the opportunity to share your own experiences and how you have made sense of them. You might find it helpful to think about things that have happened and share your story. You might also find it helpful to share things that have been difficult or gone really well. By learning about experiences of people from different cultural backgrounds, we may be able to improve our understanding of different people's needs and improve the services that are provided.

Why have I been approached for this study?

A member of your care team has given you this information sheet because you have taken part in family work for your experiences which may have been given the name psychosis. They think you may be interested in taking part in this study to share some of your experiences of the family work.

Do I have to take part in the study?

Taking part in this study is voluntary and will not affect the care you receive from the service. Please feel free to discuss taking part in this study with your family, friends and/or other people who are important to you before you decide.

What happens if I decide to take part?

If you are interested in taking part in the research, a member of your care team will ask you if they can share your phone number and/or email address with me (Ramsha) so I can contact you.

If you say yes, I will call or email you. I will ask if you are happy to come speak to me in person or over Microsoft Teams/Zoom, depending on what you prefer. This meeting will involve me asking you questions about your experience – this is called an 'interview' in research. The interview will be organised at a time that suits you.

You can choose not to share your contact details with me and still take part in an interview. You can ask a member of staff to contact me and arrange a time for us both to meet at the mental health service for the interview. You can also contact me yourself to arrange the interview using my contact details at the end of this information sheet.

If we meet in person, this will be where you usually meet your care team. We can have up to 90 minutes for the interview, and we will have regular breaks as needed or can stop the interview at any point if you no longer wish to continue.

Together, we will do the following things:

1. Discuss what the study involves, and I will answer any questions you may have.
2. If you wish to continue, I will ask you to provide consent (either written or verbal) which states that you agree to take part in the research.
3. I will talk to you about your experience of family members being involved in the family work you have taken part in and how you have made sense of this. This will be audio recorded. I have a number of questions to ask you, but I hope you are able to talk to me about whatever feels relevant and comfortable. There are no right or wrong answers, and more importantly, I would really like to hear about your individual experience.

After the interview, I will ask you and a member of your care team to give me some more information about you, with your consent. This will include:

1. Your age.
2. Month and year of first contact with mental health services.
3. Month and year of when family work started.
4. Number of family work sessions.
5. Current/most recent diagnosis.
6. Your country of birth and length of time living in the UK.

7. Country(s) of birth of family members who took part in the family work and length of living time in the UK.
8. Whether you are first generation/second generation/third generation.

After we have finished the interview, I will offer you the opportunity to have a second interview at a later date. You may choose to take part in this if you feel you need longer to share your experiences, or the interview has to be stopped early for any reason. You do not have to take part in this if you do not want to.

If I feel the interview needs to be stopped early for your wellbeing, I will discuss this with you first and then a member of your care team to make sure you are supported. The option of a second interview will also be discussed with the clinician.

If you choose to have a second interview to allow you additional time to share your experiences, this will last no longer than 30 minutes. If a second interview is offered because the first one had to be stopped, this will last up to 90 minutes.

What happens if I change my mind, do not wish to or cannot carry on with the interview?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. **If you decide to stop taking part, you will continue to receive your usual care.**

If you take part in an interview, you will have up to one week after to ask for your information to be withdrawn from the study. This can be done by contacting me or a member of the research team (contact details below). You can either do this yourself or by asking a member of your care team to do this on your behalf. Information that you have shared will be confidential which means that the information will be kept within the research team.

After one week, your interview(s) will be transcribed which means that the information will be typed up word for word and de-identified which means that your name will be removed. At this point, you will no longer be able to withdraw the information you have given me.

Are there any possible risks or disadvantages of taking part?

You may find it difficult or feel uncomfortable to talk about some of your experiences. However, you do not have to talk about anything that you do not wish to do so and can skip questions that you do not want to answer. If you do find anything that you have talked about upsetting, you might find it helpful to talk to me about this during the meeting to or a member of staff afterwards.

Are there any possible advantages of taking part?

There may not be any immediate or direct benefits to you of taking part in the study. However, you might find it beneficial to talk about your experiences, especially if you have not had many opportunities to share these before. The findings of this research will help us to think about how people from a British Pakistani Muslim background experience family work for psychosis, and your contribution can lead to better services for people in the future.

What happens to the information about me?

This study is sponsored by the University of Leeds. We will need to use information from you for this research project. This information will include your name and may include your contact details (telephone number and/or email address, if we carry out an online interview). People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. All information about you will be kept safe and secure. Once we have completed the study, some of the data will be kept so we can check the results. The reports will be written in a way that no-one will be able to work out that you took part in the study.

All personal information will be kept strictly confidential in accordance with the Data Protection Act 2018.

The interview will be audio recorded (on a password protected device) and will then be transcribed. The transcriber will agree to maintain strict confidentiality according to university policy. After transcription, the audio recording will be deleted and the transcription data will be de-identified with a participant number, to protect your confidentiality.

Your interview transcript will be held securely by the University of Leeds for three years, from the completion of the project and then destroyed securely. Quotes from your interview may be used as examples of what people have said but any potentially identifiable information will be removed to protect your identity. This information will only be used for purposes of the current study.

All information collected from you will remain confidential unless I become concerned about any risk to your safety or anyone else's. This will need to be shared with your care team and where possible, I will discuss this with you beforehand.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

The research team and I will follow privacy rules outlined by the University of Leeds (https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf) and the Health Research Authority (https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2020/08/My_data_and_research.pdf)

If you would like more information about how the University of Leeds protects your information you can:

- Email the data protection officer: dpo@leeds.ac.uk
- Ask a member of the research team (details below)

- Call us on: 01133432732

What will happen to the results of the study?

I am happy to share a summary of the results with you. If you would like to receive a copy, please let me know at the end of the interview or the staff member who approached you for the study. If you would like me to send you the results, I will keep your contact details and share the results with you directly. If you speak to a member of your care team, I will give them a copy of the results to give to you.

At the end of the study, the results will be written up as part of an educational qualification and may be published in a peer reviewed journal article or presented at conferences and team meetings. Published materials may include some of your quotes from the interview but this will not be identifiable. The results will also be available at the University of Leeds library once completed.

What if something goes wrong?

If you want to complain about how the research has been done or how your information has been handled, you should contact Dr Alastair Cardno, a.g.cardno@leeds.ac.uk.

If you are not happy after that, you can:

- Contact the University Sponsor Representative (governance-ethics@leeds.ac.uk)
- Email the data protection officer: dpo@leeds.ac.uk
- Contact your local Patient Advice and Liaison Service (0800 052 5790, pals.lypft@nhs.net).

If you feel very upset after your interview and need more support, you should:

- Discuss any issues with a member of your care team if you feel you can.
- Contact your GP and other services that you usually access.

Who has reviewed the study?

The study has been approved by the Social Care Research Ethics Committee (Ref: 23/IEC08/0042).

What if I have questions about the project? Contact details for further information:

If you require any further information then you can contact me or the rest of the research team using the details below:

Ramsha Qureshi (Trainee Clinical Psychologist)
Email address: umrq@leeds.ac.uk
Telephone: 01133432732
Clinical psychology Programme
Leeds Institute of Health Sciences
University of Leeds
Leeds, LS2 9NL

Dr Alastair Cardno (Senior Lecturer in Psychiatry)
Email address: a.g.cardno@leeds.ac.uk
Leeds Institute of Health Sciences
Faculty of Medicine and Health
University of Leeds
Level 10, Worsley Building
Leeds, LS2 9NL

Dr Gemma Clarke (Marie Curie Senior Research Fellow)
Email address: G.C.Clarke@leeds.ac.uk
Leeds Institute of Health Sciences
Faculty of Medicine and Health
University of Leeds
Level 10, Worsley Building
Leeds, LS2 9NL

Dr Carol Martin (Visiting Lecturer)
Email address: C.Martin@leeds.ac.uk
Leeds Institute of Health Sciences
Faculty of Medicine and Health
University of Leeds
Level 10, Worsley Building
Leeds, LS2 9NL

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

It is yours to keep.

Appendix C
Participant Consent Form

17/11/2023 V1.2

UNIVERSITY OF LEEDS

PARTICIPANT CONSENT FORM

Title of Project: Exploring how British Pakistani Muslim's experience and understand family involvement in family work for Psychosis.

Name of Researcher: Ramsha Qureshi

IRAS ID: 322397

Participant Identification Number:

Please initial boxes:

1. I confirm that I have read the information sheet dated 17/11/2023 (version 1.2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that the researcher may make the decision to stop the interview if I become significantly distressed or unwell. In this case, my contact details will be kept, and a second interview may be offered at a later date. ☐

1. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

2. I understand that the interview will be audio recorded, it will be transcribed by someone other than the person who interviewed me and that this will be kept confidential. ☐

3. I understand that I will have up to one week after each interview to withdraw my data. After this the information will be de-identified which means that my name will be removed, and I will not be identifiable. ☐

4. I understand that pseudonymised quotes from my interview may be used in the research write-up. ☐

5. I understand that if there are significant concerns regarding risk to myself or others, confidentiality will be breached and this information will be shared with appropriate ☐

When completed: 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.

individuals (such as, clinicians involved in my care).

6. I understand that individuals from the University of Leeds, regulatory authorities and the NHS Trust may look at the research study data to check it meets the standards required.

7. I consent for staff from the Early Intervention Service/Community Mental Health Team to be approached by the researcher to obtain some additional information about me, as described in the information sheet. ☐

8. I understand that the supervisors of the research may read my de-identified interview. ☐

9. I understand that my consent form, digital and transcript data will be held securely at the University of Leeds for 3 years from the completion of the research and then destroyed securely. ☐

10. I agree to take part in the interview. ☐

Name of Participant	**Date**	**Signature**
Name of Trainee Clinical Psychologist	**Date**	**Signature**

Email: umrq@leeds.ac.uk

Telephone: 01133432732

Ramsha Qureshi (Trainee Clinical Psychologist)
Clinical psychology Programme
Leeds Institute of Health Sciences
University of Leeds
Leeds, LS2 9NL

Appendix D
Interview Schedule

16/10/2023 – V1.1

Semi Structured Topic guide

Introductory questions:

1. **As I've mentioned, I am interested in your experience of family work for psychosis.**

a) Could you tell me a little bit about your experience of psychosis?
b) Different words are used to describe the experience you had with your family (e.g. family intervention, family therapy, family work, systemic therapy). What would you call the experience you had with your family? _____

1. **I'm interested to hear about your experience of family being involved in the [family work] you took part in. Can you tell me about your experience?**

Prompts:
a) When was [family work] first mentioned? Who by?
b) How was it described? Had you heard of [family work] before you took part in it?
c) First reactions/thoughts/feelings? What did you think it would involve?
d) How did you feel/think about the family work from a cultural/religious perspective? Did this fit with your religious and cultural beliefs? Was this different to your family members views?
e) How was the decision made about which family members would be involved? Did you want certain family members to be involved?
f) Who talked to family? How did family members react? Did you agree with them?
g) How long did it take for family members to agree? Did any family members not want to be involved? What were your thoughts/feelings about this?
h) Have family members been involved in other parts of your care? How is/was this different?
i) How do you understand the [family work] now? How would you describe the [family work] that you did? Did your initial thoughts/feelings about the [family work] change?

2. **Thinking about the experience of your family being involved in the [family work], are there any parts that really stand out?**

a) Can you describe what happened?
b) How were you feeling?
c) What were you thinking?

3. **Can you tell me what it was like to sit down with your family and talk about your difficulties/experiences of psychosis in this way?**

Prompts:
a) Is it usual to talk about your life experiences with your family? Did you talk about your experience of psychosis with your family before the [family work]?
b) How did it feel to talk about your experiences of psychosis with a clinician not part of your family whilst having family present?
c) How did you feel about family members coming to mental health buildings/clinics? Was this different to your family's thoughts/feelings/views?
d) Did you talk about the [family work] between sessions? How did your family members talk about the [family work]? Did you hold similar views?
e) Has the family work made it easier to talk about your experiences of psychosis?

4. **Has the experience of [family work] impacted on your relationships with your family members?**

Prompts:

a) How important is family to you? Are you close to certain family members? Has psychosis affected your relationships? Have any of these changed through the [family work]?
b) Has the experience of family work affected your role/position within your family? What was your role/position before? What's changed? How do you view your own role/position in your family now?
c) How was your family's role in your care talked about? How do you view your family's role in your care? Have these changed since the experience of [family work]?

5. **Can you tell me how your family's involvement in the [family work] has affected your understanding of your experiences of psychosis?**

Prompts:

a) How did you understand your experience of psychosis before you took part in the [family work]?
b) How did your family talk about your experiences of psychosis before you took part in the [family work]? What did you think/feel?
c) How did your family talk about your experiences of psychosis during sessions? What did you think/feel? Was this different to your understanding of your experiences?
d) How did your family talk about and understand your experiences of psychosis between sessions? Were you part of the conversations? Did you agree or hold a different view?
e) How do your family members talk about your experiences/difficulties related to psychosis now? Do you agree or do you hold a different view? Have these changed since family involvement?

6. **As you are aware, I am interested in how your cultural and religious background (being Pakistani and Muslim) might have affected your experience and understanding of involving family in the [family work]. Could you tell me how you think culture and/or religion affected your experience?**

Prompts:

a) How did you feel/think about family involvement from a cultural/religious perspective? Was this different to your family members views?

7. **Is there anything else you would like to share about your experience of family involvement in the [family work] for psychosis that we have not talked about?**

Appendix E
Annotated Transcript Example

Fears about the consequences of sharing personal life choices/MH experiences in front of family makes It harder to speak in the beginning Family involvement increases family members understanding which reduces fear and leads to more openness Opening up to family in FT makes it easier to open to other family members outside of FT FT strengthens relationships with family members due to more understanding and compassion	S: I: S: I: S: I:	At the start obviously it's scary because at first it was me and my mum... and it's obviously a bit scary because there's certain things you don't wanna say in front of your mum. But I think after a few sessions my mum became more understanding like now I could say anything to my mum, like I won't- like I'm not scared, like I can just tell her everything. Like I won't hide nowt from her. But I think it's just helped me open up a lot more like, and it made her like understand a lot better. Yeah, yeah. Tell me a little bit more about that, like that experience of opening up to your mum and things feeling easier. Yeah, it does feel easier because I feel like umm, once I opened up to my mum it was easier to open to everyone else like my sisters, my brother, my dad. Like, my mum made it a lot easier for everyone else, but I just think, some like, I feel like, family therapy like helps you open up more and helps you bond. I think me and my mum bonded a lot more... through it. Okay yeah, yeah. What did you notice in terms of the bonding like, what made you feel like you were bonding more? Because she'd understand like if I was acting a certain way at home she would understand she'd be like, less like... like normally before she'd be quick to be like oh my God what are you doing like, what the hell? Or like she'll snap easy but like, and that was my fault as well like if I didn't like get up, to like, if I didn't wake up on time, if I didn't like get up to wash the dishes on time, or like clean or whatever, she used to be like really snappy like what's wrong with you? But like when we did like therapy and that, she kind of understood. So she was more like she gives me time... because it's just about motivation I think [I: Yeah] And like, she'd just understand a bit more. Yeah yeah. So it seems like there might have been like more patience from her. [S: Yeah.] In terms of umm, like day-to-day things. [S: yeah]. Is that how it felt, yeah. Okay and umm, you know the family therapy then, who was it umm, like first mentioned by, like who did- did [therapist name] mention it or did somebody else mention it that you'd have this? Or did it naturally just happen, like how much-	"scary" to open up in front of mum (fear of rejection?) but quickly felt easier as mum understood her – increased feelings of trust? Opening up to mum helped to open up to other family members – feeling more confident? "bond": increased connection and understanding between her and mum "she gives me time" More compassion & patience from mum in day-to-day life after family therapy – greater sense of support?

Appendix F
PET Table Example

PERSONAL EXPERIENTIAL THEME, Subtheme, Experiential statements, *"quotes"*

1. EXPERIENCING LIBERATION AND CONNECTION THROUGH FT

FT contextualises issues/MH difficulties

Shift from a) individual to family interactions/issues/patterns and b) current issues to past/generational issues and future possibilities as a family

"At first, we were just talking about like individual issues... And then it built up into more like, issues from the past and like talking about... tryna stop that generational trauma in our generation and... move on from that and help our children and our children's children, to break free from that" (page 1).

FT different to individual therapy as it offers multiple perspectives and connections between family members issues/traumas

"... instead of just one perspective, one person's issues... it (FT) combined issues and different traumas and different things that have happened" (page 5).

FT helps to deconstruct various cultural beliefs and expectations around stoicism, perfectionism and success

Breaking free from unhelpful deep rooted internal beliefs and expectations around perfectionism and success

"I've put a lot of pressure on me as a kid... to get really high grades and like perform... it caused a lot of trauma... family therapy helped a lot with that because it showed that my family... and the family therapists were there to help guide me through it... and we came up with the term... breaking idols... in your head that tell me what to do and like, say to be perfect" (page 2).

FT helps to deconstruct cultural and societal beliefs around stoicism and vulnerability as a British Pakistani Muslim man

"British Pakistani Muslim males... they have this idea of like being hard and gangster and... be as tough as possible and you can't be vulnerable. You can't talk about these things because it's seen as a weakness... that hardwiring from a young age, it was quite difficult to overcome. But I think umm through sustained efforts, I think I overcame that" (Page 5).

FT is liberating as H no longer felt restricted to hide his emotions

"In Pakistani Muslim culture... men aren't supposed to show their emotions like that and cry and, really let out everything. And I think that I did. I feel quite happy about it because it was quite cathartic when I felt like that was a realisation moment that it was okay to do that" (Page 19).

Separate "safe space" outside of daily life

FT is a different space to talk about experiences of psychosis and have emotional conversations as a family, which are usually avoided

"We talk differently, more openly in family therapy and about different topics that we don't really talk about at home where I guess the emotional shields are up." (page 13).

Appendix G
GET Coding Example

F PET labels	Subthemes
Navigating different attitudes towards MH support	-Appreciation for parent's efforts to understand MH difficulties and encouragement to seek mainstream MH support, despite cultural taboos/stigma -Appreciation for husband's support, despite personal reservations -Encouragement to seek secular services and advocacy for therapy in Muslim community is validating
Wrestling with duty and abandonment	-Gratitude and guilt that long term carer's feel they have to stay involved long-term - Disappointment, hurt and empathy towards SIL's withdrawal from FT
Managing conflicting feelings towards openness	-Initial discomfort due to cultural and familial norms -Fear of judgement when feeling low and experiencing "paranoia" -Frustration towards husband's initial hesitation
Building mutual understanding and confidence through challenging conversations	-Understanding family's unspoken feelings and emotions related to MH experiences/difficulties -Feeling more confident to express MH struggles - Feeling heard, supported and accepted by family - Addressing marital and family issues is challenging but strengthens relationships
FT through the NHS is valuable	-Free access outweighs cons of medication -FT tailored to practical needs, facilitating family involvement

H PET labels	Subthemes
Managing the *"struggle"* between optimism and family members' initial reluctance	-Wanting family members to experience benefits of therapy -Initial refusal of family members is disappointing and frustrating due to therapy being considered taboo and undervalued in Pakistani community
Admiring family members' loyalty and sacrifice	- Appreciation for family members' willingness to participate as involvement is easier when focus is not on them -Admiring mum's willingness to show vulnerability in FT, despite emphasis on stoicism
Overcoming discomfort and adjusting to FT	-More confidence to open up about deeper issues over time -Learning how FT differs from individual therapy and other MH appointments