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Communication

Applying the Behavioural Family Therapy Model in Complex Family Situations

Rubina Jhadray *, Gráinne Fadden, Martin Atchison, Paula Conneely, Julia Danks, Alison Lee and Chris Mansell

The Meriden Family Programme, Birmingham and Solihull Mental Health Foundation Trust, Tall Trees, The Uffculme Centre, Birmingham B13 8QY, UK; E-Mails: grainne.fadden@bsmhft.nhs.uk (G.F.); martin.atchison@bsmhft.nhs.uk (M.A.); paula.conneely@bsmhft.nhs.uk (P.C.); julia.danks@bsmhft.nhs.uk (J.D.); alison.lee3@bsmhft.nhs.uk (A.L.); chris.mansell@bsmhft.nhs.uk (C.M.)

* Author to whom correspondence should be addressed; E-Mail: Rubina.jhadray@bsmhft.nhs.uk; Tel.: +44-0121-301-2890; Fax: +44-0121-301-2891.

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Abstract: Behavioural Family Therapy (BFT) is a skills based intervention that aims to support families where a member is experiencing a mental health problem. The Meriden Family Programme has extensive experience in supporting families who have complex needs. The programme delivers training in the approach and works with families with the aim of providing information, education and reducing stress within the family environment. Training has recently taken place within various mental health services to equip staff with the skills to work collaboratively with families and to understand and support their needs.

Keywords: behavioural family therapy; family intervention; mental health; complex needs; family support

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1. Introduction

The Meriden Family Programme has been delivering training in Behavioural Family Therapy (BFT) and working with families since 1998. The programme has delivered training locally, nationally and internationally as there is a widespread need for training in the area of family interventions [1]. The aim of the programme is to ensure that families have access to family sensitive services and

evidence based interventions. The programme uses a cascade training system, in which individuals are trained in BFT and then go on to train as trainers and supervisors. This allows them to deliver BFT courses and supervise others within their own organisations and services. To date there are over 5000 people trained in BFT worldwide and just over 400 trainers and supervisors. The Meriden Programme offers ongoing supervision to organisations that are delivering family work to ensure that implementation within their services is supported. The programme offers an array of specialist training packages which are available to professionals, family members and service users.

When someone has a mental health problem, it does not only affect them individually but has an effect on the whole family: their daily lives, physical health and relationships [2]. The family is there as a support network for the individual and can be an integral part of the care and recovery process. The family can be seen as experts on their family member's disorder and the difficulties that they are facing, and so they can be a valuable source of support if services work collaboratively with them. Families may experience high levels of stress, burden and may be up against issues such as confidentiality when trying to be a part of the care that their loved one is receiving [3]. They may need information and skills to help them understand and cope better with the disorder and what their family is experiencing.

BFT is an approach aimed at supporting the family and the individual. It is a practical, skills based intervention that typically involves sharing information with the service user and their family about the service user's mental health issues, experience and treatment. The intervention consists of a number of components including engagement, assessment, formulation and early warning signs work in which the family develops a clear "staying well" plan. Each family member is also encouraged to set realistic and achievable personal goals for themselves. BFT promotes positive communication, problem solving skills and stress management within the family. When families are under pressure, whether it be because of a mental health issue, substance misuse or other reasons, communication can often deteriorate or become minimal. BFT aims to promote positive communication within families through skills training, and looks at skills such as "expressing pleasant feelings" and "active listening"; with the aim of creating a more supportive and stress-free environment for everyone involved. This type of evidence based family approach has been shown to reduce relapse rates, stress and hospitalisation, therefore improving the quality of life for individuals suffering from mental health difficulties and their families [4,5].

Family interventions have been shown to be effective where individuals are suffering from Schizophrenia and Psychosis [4,6,7] and Bipolar Disorder [8,9]. The Meriden Programme team has worked with families who are experiencing a range of difficulties and who may have complex needs.

The implementation of family interventions in clinical practice has been recommended by health guidelines and policies in the UK [10] and in the PORT Guidelines in the United States [11] encouraging professionals to take into account the needs of the family and to offer education and support. There has also recently been evidence showing the cost-effectiveness of family interventions highlighting the benefits for services as well as for families [12].

There are needs of families that are similar despite which service or specialism their family member is receiving care from. However, there may be some variation in their need for support and information depending on the nature of the problem and on what they are offered by services. It is important for professionals working in different settings to be aware and equipped to help families and keep them involved. This requirement impacts on the training provided to different services and the need to tailor it to the requirements of the team. With this is mind, we have recently delivered training on an eating

disorders unit, a mother and baby unit, within early intervention services and conducted a family work pilot project on an acute inpatient unit. BFT has also been utilised with families whose relatives are in secure settings. The detail of some of these is outlined below and highlights how family work can be beneficial in understanding and supporting families with complex needs in mental health services.

2. Case Examples of Supporting Families with Complex Needs

2.1. BFT in a Mother and Baby Unit

A pilot project looking at the implementation of a brief family intervention within a Mother and Baby unit was recently conducted. The unit was looking to involve families further within the care of service users. A brief intervention consisting of components of the BFT model including assessment, information sharing, recognising early warning signs and developing a staying well plan and problem solving was delivered to all staff on the unit. The training lasted a day and was repeated to ensure that all staff were able to attend. All sessions with the family were designed to last 20 minutes in order to increase the chance of ward staff being able to commit to this amount of time. The families were then interviewed using a short post intervention questionnaire looking at the impact of being involved in the service user's care in this way. The training team included a carer who had received the full BFT intervention along with his family who shared with the staff very clearly, how each of the components had been helpful to them as a family unit. As part of the training, for each component, staff were given time to practice the skills that they were learning. They had guided practice on delivering the sessions to families and received feedback from their peers and trainers in what they each did well and how they might do some things differently. Supervision sessions have been set up to support the staff beyond the training.

The staff on the mother and baby unit already have systems in place for working with partners, but working with the brief family intervention meant identifying a wider network of support. This initially created an increased workload as more people were offered individual meetings. What had been designed as 20 minute sessions were turning into 1.5–2 hour meetings as the staff familiarised themselves with the questions and also the process of engaging people using this particular method of assessment. It was identified through supervision that some staff, although highly motivated and enthusiastic to use the approach were anxious about delivering some of the components and have avoided doing so.

The delivery of the components and the engagement of the mothers and their families can be seen as key for the intervention to have maximum benefit. There could be potential difficulties in the initial engagement of mothers both as parents and people recovering from mental health problems. The focus on including families can be seen as important in meeting the needs of a mother suffering from a mental disorder [13]. However staff members also need to appreciate that some aspects of family relationships may be challenging. Some family relationships can be seen as potential stressors and can have a negative effect on the esteem and confidence of mothers [14]. So in situations such as these, the discussion of how engaging in the intervention can improve relationships and what the benefits of the intervention could be for the mother and the relationships she has with family members may be helpful. Discussions around ways in which the mother and family members may be able to communicate their needs and views better may take place in an attempt to overcome hesitancy towards family work.

Another potential barrier to engagement may be side-effects of medication. It has been seen that medication can have a negative impact on a mothers' ability to engage with her children [15] this could further have an effect on relationships with family members and their ability to engage with services. This should be considered when delivering family work and discussed sensitively and appropriately.

A complexity that frequently occurs in the process of engaging mothers in services is the fear of losing their children to authorities [15] which could make them reluctant to disclose their difficulties, as the child or children are seen as central to their lives and motherhood as a fulfilling and rewarding part of their lives. In the UK, babies of 48% of mothers with schizophrenia discharged from mother and baby units were under some form of supervision by social services after discharge [16]. So, this complexity of both suffering from a mental illness and being a caregiver may give rise to difficulties in engagement as there may not be an openness in sharing difficulties, experiences of coping and identifying extra support needs.

The mother may also encounter difficult relationships with family members or partners when there is judgment towards her or a lack of understanding of the mothers' experiences [17]. This could lead to reluctance to engage with the intervention as the mother may feel that her behavior may be evaluated in some way. The information sharing component of the BFT model addresses this and attempts to increase the understanding of the experiences that the mother has been through, the mental health problem and the impact of this on the family members involved. Information sharing would also allow family members to share their experiences and relay what would be of further help to them. As there can be issues with engagement, staff training and supervision are imperative to the implementation of family work within a mother and baby unit. Professionals should be well-equipped with the skills and confidence to deliver the sessions and this can be enhanced and developed through regular supervision.

On completing the outlined intervention, family members and service users felt there were a number of benefits. Family members were more involved in the care of their relative whilst on the ward; they had a greater understanding of symptoms and what to look for and felt like they had permission to talk to each other in a different way. Family members knew who to contact if things were to start deteriorating and were grateful for being signposted to support services. The benefits to the services are that if families are supported during an admission and thoroughly prepared for discharge, they can build capacity and resources to manage situations better and rely less on services. If the family are given the skills to help them cope better themselves, use their own resources, have a plan of what to do and who to contact, they will build better relationships with the people in the service user's support system.

2.2. BFT in an Eating Disorders Service

The training for the staff from an eating disorders service took place over three half day sessions. These sessions were repeated so that all staff could get the opportunity to attend.

The first training session looked at the experience of having someone in the family who is unwell, before some discussion about the experiences of family members who came into contact with the eating disorders service. The issue of confidentiality was then explored, focussing on the specific issues with confidentiality that related to people with eating disorders. The second session was spent looking at the concept of the Triangle of Care [18] , which led to discussion about how the team linked

with families, and then moved on the idea of involving families in developing staying well plans, and the benefits of doing so. An example of a brief family assessment interview schedule was also discussed. The final session included input from a carer, and a carer support worker. The structured process of problem solving was demonstrated and discussion took place about how this could be used with families.

One of the reoccurring themes from the training was that confidentiality played a significant part in how relationships developed with families. Following the discussion around confidentiality, some clinicians reported that they were starting to have more proactive conversations with service users about the benefits of families being involved in some aspects of their care, rather than feeling that they had to concur with the statement from service users that they didn't want their family involved at all.

Confidentiality can affect relationships between service users and their families and between the family and mental health professionals. It has been recognised that carers and families need certain information around the difficulty and guidance on how to deal with their family members problems, to enable them to care more safely and effectively for them [19]. Service users have the right to decide how information about them is shared and this can be seen as key in building trust between them and services. Alternatively, it can be seen that involving the service user's family can enable the family to provide more effective support as they would be better informed and more sensitive to the issues affecting their family member. Also, the family would be instrumental in supporting the service user outside of hospital and in their daily lives.

When a person suffers from anorexia nervosa, this often becomes a core value within their lives [20–22]. This can affect relationships within the family, as values that were previously core to the service user (such as family relationships) become secondary to the eating disorder. This may cause issues as the family may not understand the value placed on anorexia nervosa by the service user and why, and this can lead to conflict. Encouragement from services to involve and share information with the family can help ease situations such as these and aid in the recovery of the service user.

Sufferers of eating disorders can put themselves at high risk both physically and psychologically. Decisions that they make regarding their treatment and care can impact on the level of risk and their recovery. It has been argued that decision making abilities of people can be compromised as a result of their difficulties and value systems [20–22]. As mentioned previously, the eating disorder becomes the central value in a person's life, thus the decisions that they take may not be in the best interests of their recovery. Working collaboratively by including families in the treatment and decision making process may be helpful in making more effective decisions, and help family members be more supportive and understanding, as they are included in the process.

The issue of confidentiality can make it difficult to involve carers, as professionals may be unclear on what information they can and cannot share, so this may lead to reluctance by staff to share information. Staff may also lack confidence in being assertive in sharing information. Clinicians may be mindful of the need to develop a relationship with the service user so may be cautious about when and how to introduce the idea of sharing information with the family. They can find the whole situation challenging when there is a lot of stress in the family situation. It can sometimes take time and a number of discussions before an agreement can be reached to involve the family. A collaborative, team approach in giving a consistent message about the importance of involving the family may be helpful in increasing confidence in staff.

Families understand the idea of confidentiality and can be worried about expressing concerns in case the service user is unhappy with this. Even if they are told by professionals that they can talk to staff, some family members may be reluctant to do so in case this upsets the service user. Discussions at supervision indicate that sometimes, if the service user is upset about a decision made by the team, the family will be informed by the service user about this. The family will then argue the case on the service user's behalf, without having any understanding about the reasons for the clinical decision. Encouraging the involvement of family members and sharing information with them, still allows for client-centered and sensitive care, and may not be detrimental to relationships between professionals and service users.

Although the service consistently carried out carers' assessments and shared general information about anorexia nervosa with families, there was some acknowledgement that there were opportunities to increase the involvement with families. If the team were to carry out an assessment of the family which included questions, for example about their understanding of the eating disorder, the team could be clearer about what information would be beneficial for the family. This in turn could have a positive impact on the service user. Empowering the service user to have discussions with their family about what they do that is helpful or unhelpful (as part of developing a staying well plan) was thought to be really helpful and a more focused way of getting families involved in a practical way that benefitted everyone.

Currently there is discussion about having a 'workbook' for families in contact with the inpatient service. Service users will work their way through an 18 page manual during an admission to help them work on their ways of coping with their eating disorder. There may be a much shorter version for families in the near future which will include a brief assessment of their perspective on the eating disorder, information, involvement in the development of a staying well plan, and an introduction to the process of problem solving.

2.3. BFT and the Troubled Families Team

In December 2011, the UK Government committed to investing additional funding to "turn around the lives of the 120,000 most troubled families in England" [23] and issued a clear statement in terms of what needed to change for these families: getting children into school, cutting crime and anti-social behaviour and putting adults on the path to work. As such, the Troubled Families programme was established to work in partnership with local authorities to help change these families' lives and address issues at a local level.

The team provides a single point of contact for families facing a range of multiple problems in their daily lives. The team has workers from a variety of agencies, including Community Housing, the local Council, Youth Offending Services and Police Services.

Working with up to 500 families facing complex and multiple issues, 50 of which will require intensive direct support, the underlying principles of the approach are to:

- holistically address the needs of the family as a whole
- build trust with families resisting help
- share information and intelligence to understand family histories
- use resources flexibly and provide needs based access to services

- build family capacity and resilience through intensive support

Following involvement in an initial away-day, the Meriden Programme was invited to deliver family work training to nine members of the eleven strong team. Given the nature of the team and its varied membership, it was felt that having a "shared model" for working with families in a consistent and structured way may be of benefit.

The training was adapted slightly to meet the specific needs of the team and the complex nature of the families they work with. The most significant issue, initially, was that there was commonly no diagnosed mental health issue within the families supported by the team. However, team members generally felt there were significant levels of undiagnosed mental health issues and a high level of substance misuse. Supporting families where there are co-existing mental health issues and substance misuse can be challenging. Family interventions that consist of goal-setting, psychoeducation and communication and problem solving skills training can reduce the stress in families [24]. As a result, the training included "additional" sessions on common mental health issues, how stress affects us all, stress vulnerability, family stress and illness, mental health and cannabis use—together with the more traditional topics of the evidence for using BFT with families, information sharing, staying well planning, communication skills and problem solving.

The training was delivered over five days, two days one week and three the next. This allowed the team to process the learning, talk through as a team how the model might fit and to start talking to their families about working in this way. At the end of the training there was a real sense of optimism and hope that working more collaboratively, and in a more "proactive" way, would improve the outcomes for families.

During training it was noted that staff were motivated and enthusiastic with regard to changing their own practice—they were cautious as to how the families would receive the new intervention. The model had not been adapted to work with families experiencing complex problems such as these before, and there is a little research of the model being applied to families such as those in contact with the Troubled Families programme. In subsequent supervision sessions however, it emerged that a number of families (initially described as "abusive", "chaotic" and "constantly in crisis") welcomed the approach as a new and more positive way of dealing with their situation, helping with both family relationships and communication within the home.

The following is a report by one of the people who attended the training.

> My experience of completing the Meriden Training in Behavioural Family Therapy was positive and insightful. I felt that the training was accommodated to our needs in terms of relating the approach accordingly to the client group which we would be delivering the work to. The trainers took into consideration the difficult circumstances and dynamics which we would have to face throughout delivery of the work, and helped us to understand how the approach would be appropriate and helpful for some of our families as well as how to demonstrate these points to families and engaging them with family work sessions.
>
> I am in the process of delivering the sessions to two of my families, which has been challenging due to the additional difficulties which they present with, which often requires crisis intervention support. The main challenge which I have been faced with for delivering the work overall is maintaining the momentum of family work with the families in terms of

reminding them why adhering to the sessions is important and will be effective in the long term in relation to the current pressing issues and demands that they present with. However, due to the approach not being rigid and somewhat adaptable according to the family's needs, it does enable us to take this into account when delivering the work. Families, although initially expressing reluctance to engage with family work have expressed enthusiasm, interest and reflection throughout the sessions. They have all identified the need for better communication and how this could help improve their functioning as a family and relationships within the family.

Receiving supervision from the trainers has been helpful, particularly for reflection purposes as to how our delivery of the work may impact the response from families about family work. The trainers have offered advice and strategies around how to manage the challenges which we face on delivering the approach to the particular families which we work with. Supervision also assists with maintaining our confidence in and adherence to the model as well as identifying and reflecting on what has worked well [25].

3. Conclusions

The examples above demonstrate the range of complex situations where family work can be applied. The Behavioural Family Therapy model is flexible and is adapted to the needs of the individual family, whatever the setting. There are a number of components to the approach as can be seen below:

- Establishment of a positive, respectful, collaborative relationship between family and clinician.
- Agreement that service user and key family members will meet together with clinician.
- Information sharing and an agreement about issues relating to confidentiality.
- Time and space for discussion of emotional issues and personal reactions to mental health problem and its management.
- Support for family members in the achievement of personal goals.
- Focus on management of practical day to day issues.
- Enhancement of family problem-solving skills.
- Agreement on relapse prevention strategies.
- Development of effective communications patterns.
- Agreement on the ongoing nature of the relationship between family and mental health services.

As can be seen from theses components, the focus on day to day issues and the collaborative nature of the approach means that experienced workers can deliver it in a meaningful way in different contexts, ensuring that the needs of service users and their families in that setting can be met. Despite the flexibility of the approach, there is a lack of evidence supporting the use of the model in complex family situations that are unrelated to mental health, such as poverty or social disadvantage. Components of the model, such as problem solving training, may be helpful, as this may help families work together to find solutions to help their situations and decrease stress within the family home. However, the effectiveness of the model in these contexts is yet to be investigated. Working with families also gives rise to issues such as confidentiality and how it can be utilized in a positive way as well as complexities in the engagement of families.

Author Contributions

The Meriden Family Programme team applies the BFT model in different clinical settings. This article reflects the work of all members of the team.

Conflicts of Interest

The authors declare no conflict of interest.

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