

What systems must protect: relational care, uncertainty and recovery in early psychosis care

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ABSTRACT

Early psychosis services, including early intervention in psychosis programmes (EIP), are built on principles of timely access, continuity and recovery-oriented, evidence-based care. While these elements are well described at a model level, less attention has been paid to the relational work required to deliver them effectively. In this perspective paper, we argue that EIP care is fundamentally relational, characterised by sustained engagement, tolerance of uncertainty and the nurturing of hope. We describe key features of this work. These include entering the person's world, holding multiple perspectives and navigating differing explanatory models of illness, as well as the role of stigma in shaping help-seeking and engagement. We also explore the emotional and organisational tensions inherent in relationally flexible care. These include risks relating to burnout, boundaries and resource allocation. Finally, we argue that protecting relational capacity within teams through adequate resourcing, supervision and manageable caseloads may itself represent a fidelity issue for EIP systems. As EIP services expand, maintaining 'relational fidelity' while allowing flexibility in delivery poses a critical challenge for systems and leaders. Relational fidelity refers to preserving the conditions that allow sustained, trusting engagement and continuity over time.

INTRODUCTION

Early intervention in psychosis (EIP) has transformed expectations for the treatment and recovery of those experiencing first-episode psychosis.¹ Core components of the early psychosis service models, including rapid access, phase-specific care, continuity of therapeutic relationships and sustained engagement, are correlated with better clinical and functional outcomes.^{1–3} We argue that EIP practice is, at its core, relational before it is technical and uncertain before it is fully understood.

We define relational fidelity as the extent to which services preserve the relational conditions through which evidence-based interventions are effectively delivered. This includes continuity, sustained engagement, therapeutic trust, supervision, manageable caseloads and organisational support for relational work.

Existing fidelity scales prioritise structural and intervention components of EIP care but pay less attention to the relational context in which care occurs.^{4 5} The therapeutic relationship is not simply the context in which evidence-based interventions occur; it is itself one of the mechanisms through which change and recovery happen.

We propose that relational fidelity should be recognised and measured as a core domain within EIP care.

ENTERING THE PERSON'S WORLD

Early psychosis care asks clinicians to enter another person's reality while holding open the possibility that neither person yet fully understands what is happening.

Psychotic experiences frequently form internally coherent patterns that hold meaning for the individual. However, these patterns may appear fragmented and disparate to others.^{6 7} Time, patience and skill are required to help the individual and those around them to make sense of these patterns.

A stance that is too certain, too early, can undermine trust, while a position that is too remote risks disengagement. For example, when a young person says, 'I know people think I'm paranoid, but I can feel that others are watching me', a well-meaning but dismissive response ('don't worry, no one is watching you') may close down conversation, whereas 'That sounds frightening. Can you tell me more?' invites exploration and strengthens engagement. Over time, this kind of approach can help the person feel heard and understood, making it easier later to explore alternative explanations.

Engagement often requires flexibility in how and where care is delivered. Community-based meetings, informal interactions or engaging in shared activities such as walking or playing video games can act as conduits to engagement with other clinicians and therapeutic interventions over time.⁸

WORKING WITH UNCERTAINTY IN EARLY PSYCHOSIS

Uncertainty is a defining feature of early psychosis. Presentations are often evolving, information is incomplete, and trajectories are not yet established. Clinicians need to make decisions regarding care and risk, often in the context of limited understanding and information.⁹ This can create a tension between system demands for certainty and the slower relational work required in EIP.

Clinicians frequently use metaphor to help individuals, families and colleagues to tolerate uncertainty. An example might be a clinician describing recovery as 'crossing a river where the depth and current are not fully known, but where the team remains alongside the person'. Such imagery can help translate frightening experiences into more manageable, human terms.



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HOLDING MULTIPLE PERSPECTIVES

Early psychosis care frequently involves working with multiple perspectives. These often include those of the individual, their family, and the clinical team. Understandings of psychosis can be shaped by personal experience, culture, professional training and beliefs about aetiology. In the early stages of illness, these perspectives may differ significantly. Clinicians will often prioritise shared understanding over diagnostic agreement. For example, focusing on sleep difficulties may support engagement even when language like psychosis is resisted. Over time, trust develops, and other perspectives can more easily be considered. This type of approach is central to person-centred care and family-inclusive practice, both key EIP components.^{4 10}

Cultural context also influences how psychotic experiences are understood and discussed. Experiences that may be interpreted as symptoms in a clinical context may be understood through religious or cultural frameworks elsewhere. EIP clinicians must therefore demonstrate cultural humility and curiosity, engaging respectfully across differing explanatory frameworks while avoiding premature pathologisation.¹¹

EIP clinicians frequently act as translators, between psychotic experiences and shared reality, between families and services, between biomedical and personal understandings of distress and between recovery-oriented care and systems organised around diagnosis and risk. Much of this translational work is invisible within conventional descriptions of clinical expertise and carries real emotional labour, yet it is often central to engagement and recovery.

STIGMA

Stigma continues to shape whether individuals seek help and engage, and what their and their families' expectations are for recovery.^{12 13} Stigma may be especially heightened in some cultural or community contexts. EIP services, through how they engage and communicate and through the expectations they hold for recovery, are uniquely positioned to challenge this stigma.

CONTAINING DISTRESS AND SUSTAINING ENGAGEMENT

Clinicians frequently support individuals through intense distress. Early in engagement, services may be experienced as intrusive or even malign. Clinicians may need to tolerate being experienced as part of the problem before they are gradually experienced as part of the solution. In many respects, EIP functions as an attachment-informed model of care. Initially, the service provides a safe haven during acute psychosis, but as recovery progresses, it becomes a secure base from which autonomy and recovery can be re-established. This transition requires clinicians to remain attuned to changing relational needs.

HOPE AND RECOVERY IN EARLY PSYCHOSIS

Hope is a core therapeutic tool. Clinicians often hold hope when individuals and families are unable to do so and until they can hold hope for themselves, communicated through small but meaningful relational interactions; validation, warmth, humour and recognition of small achievements, which help to counter shame and isolation.

TENSIONS AND SAFEGUARDS

Without regular clinical supervision, reflective practice, and well-maintained professional boundaries, relational flexibility may contribute to burnout, boundary diffusion or inappropriate over-involvement with service users and families.^{14 15} The emotional labour of remaining therapeutically engaged with

Box 1 Potential indicators of relational fidelity in early psychosis services

Clinician-level

- ⇒ Quality of supervision.
- ⇒ Continuity of therapeutic relationships.
- ⇒ Staff-reported capacity to engage therapeutically under organisational pressure.

Team-level

- ⇒ Rates of patient disengagement.
- ⇒ Caseload instability.
- ⇒ Staff turnover.

Organisational

- ⇒ Stable funding.
- ⇒ Strong links between EIP and partner services (eg, inpatient, community and voluntary services).
- ⇒ Non-stigmatising care environments.

Patient-reported

- ⇒ Continuity of care.
- ⇒ Trust.
- ⇒ Feeling understood.
- ⇒ Therapeutic alliance.

individuals experiencing severe distress, trauma, paranoia or suicidal thinking over long periods can be considerable.

Relational dynamics present within early psychosis work may also emerge at team and organisational levels through parallel processes.^{16 17} Experiences of uncertainty, fragmentation or mistrust within the clinical context can become mirrored within clinical teams and organisational systems. These processes can impact communication, decision-making and risk tolerance. Reflective supervision and psychologically informed team cultures support clinician well-being and help teams think clearly, collaboratively and relationally under pressure.^{5 17 18}

IMPLICATIONS FOR SYSTEMS AND LEADERSHIP

Protecting relational fidelity requires organisations to provide clinicians with a secure base through stable funding, strong collaborative relationships across services, supervision and psychologically safe teams. Continuity, engagement and intensity of input depend on adequate resourcing, manageable caseloads, protected time for relational work and good clinical supervision. These relational aspects of early psychosis work are often less visible within existing service evaluation and fidelity measurements but are central to a healthy EIP culture.

We propose that measuring 'relational fidelity' within early psychosis services requires moving beyond structural indicators to capture the conditions that sustain therapeutic engagement over time (see [box 1](#)).

As EIP services scale, there is a risk that the more visible developments of new teams and expanded age ranges are prioritised over those less visible elements that underpin effectiveness. This reflects a broader tension between fidelity and flexibility. While adaptation to local context is necessary, in the context of constrained health systems, flexibility may drift into dilution, and unless we are attending to the relational aspects of EIP care, its erosion may go unnoticed. EIP leadership must therefore focus on maintaining core mechanisms of care while navigating these pressures.

CONCLUSION

EIP services have transformed outcomes in psychosis care. Their success depends not only on evidence-based interventions but also on the relational conditions that enable engagement, continuity and hope. These are not ‘soft’ aspects of care but are core mechanisms through which EIP achieves some of its most meaningful outcomes. Services that fail to protect these relational conditions risk retaining the outward appearance of fidelity while losing some of their most important therapeutic mechanisms. Variation in relational fidelity may explain why services that appear structurally similar often achieve markedly different levels of engagement and recovery. Future research should examine how domains of relational fidelity can be operationalised within existing fidelity scales and tested as predictors of clinical and functional outcomes in psychosis.

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REFERENCES

- Correll CU, Galling B, Pawar A, *et al.* Comparison of Early Intervention Services vs Treatment as Usual for Early-Phase Psychosis: A Systematic Review, Meta-analysis, and Meta-regression. *JAMA Psychiatry* 2018;75:555–65.
- Priebe S, Richardson M, Cooney M, *et al.* Does the therapeutic relationship predict outcomes of psychiatric treatment in patients with psychosis? A systematic review. *Psychother Psychosom* 2011;80:70–7.
- Addington DE, McKenzie E, Norman R, *et al.* Essential evidence-based components of first-episode psychosis services. *Psychiatr Serv* 2013;64:452–7.
- Addington D. The First Episode Psychosis Services Fidelity Scale 1.0: Review and Update. *Schizophrenia Bulletin Open* 2021;2:sgab007.
- Royal College of Psychiatrists. *Standards for early intervention in psychosis services*. 1st edn. London: Royal College of Psychiatrists, 2018.
- Freeman D. Understanding and treating persecutory delusions. *Schizophr Bull* 2024;50:233–43.
- Bentall RP. *Madness explained: psychosis and human nature*. London: Penguin Books, 2003.
- Tindall RM, Simmons MB, Allott K, *et al.* Essential ingredients of engagement when working alongside people after their first episode of psychosis: A qualitative meta-synthesis. *Early Interv Psychiatry* 2018;12:784–95.
- McGorry PD, Killackey E, Yung AR. Early intervention in psychosis: concepts, evidence and future directions. *World Psychiatry* 2008;7:148–56.
- Royal College of Psychiatrists. National clinical audit of psychosis (NCAP): state of the nation report 2024. Early intervention in psychosis services in England and Wales, 2022/23–2023/24. London Healthcare Quality Improvement Partnership; 2025.
- Kirmayer LJ, Guzder J, Rousseau C. *Cultural consultation: encountering the other in mental health care*. New York: Springer, 2014.
- Thorncroft G, Sunkel C, Alikhon Aliev A, *et al.* The Lancet Commission on ending stigma and discrimination in mental health. *Lancet* 2022;400:1438–80.
- Lamarca M, Espinosa V, Acuña V, *et al.* Reducing self-stigma in psychosis: A systematic review and meta-analysis of psychological interventions. *Psychiatry Res* 2024;342:116262.
- O’Connor K, Muller Neff D, Pitman S. Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *Eur Psychiatry* 2018;53:74–99.
- Berry K, Barrowclough C, Haddock G. The role of expressed emotion in relationships between psychiatric staff and people with a diagnosis of psychosis: a review of the literature. *Schizophr Bull* 2011;37:958–72.
- Bion WR. *Experiences in groups and other papers* (Originally published 1961). London: Routledge; 2001.
- Berry K, Barrowclough C, Wearden A. A Pilot Study Investigating the Use of Psychological Formulations to Modify Psychiatric Staff Perceptions of Service Users with Psychosis. *Behav Cogn Psychother* 2009;37:39–48.
- Man H, Wood L, Glover N. A systematic review and narrative synthesis of indirect psychological intervention in acute mental health inpatient settings. *Clin Psychol Psychother* 2023;30:24–37.