

**DUBLIN BUSINESS SCHOOL**

**ELIZABETH CARDUS (1396369)**

**AN EXPLORATION OF THE PLACE OF PSYCHOTHERAPY IN THE  
TREATMENT OF SCHIZOPHRENIA IN IRELAND**

**THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS  
OF THE BA COUNSELLING AND PSYCHOTHERAPY**

**SUPERVISOR: DR GRAÍNNE DONOHUE**

**19 APRIL 2013**

## CONTENTS

Acknowledgements .....	5
List of Tables .....	6
Abstract.....	7
<b>CHAPTER 1: INTRODUCTION.....</b>	<b>8</b>
<b>1.1 Background .....</b>	<b>8</b>
<b>1.2 Ireland's Response.....</b>	<b>9</b>
<b>1.3 Aims and Objectives .....</b>	<b>10</b>
<b>CHAPTER 2: LITERATURE REVIEW.....</b>	<b>11</b>
<b>2.1 Does it Work?.....</b>	<b>11</b>
2.1.1 Early Psychotherapeutic Treatments .....	11
2.1.2 Early Empirical Findings.....	15
<b>2.2 Where does it Fit? The Question of Integration .....</b>	<b>18</b>
<b>2.3 The Irish Context.....</b>	<b>23</b>
<b>2.4 Conclusion .....</b>	<b>25</b>
<b>CHAPTER 3: METHODOLOGY.....</b>	<b>26</b>
<b>3.1 Research Design .....</b>	<b>26</b>
<b>3.2 The Sample .....</b>	<b>26</b>
<b>3.3 Recruitment of the Sample .....</b>	<b>27</b>
<b>3.4 Data Collection Methods.....</b>	<b>28</b>
<b>3.5 Reliability and Validity .....</b>	<b>28</b>
<b>3.6 Data Analysis.....</b>	<b>29</b>

3.7 Ethical Considerations .....	30
<b>CHAPTER 4: FINDINGS .....</b>	<b>32</b>
4.1 <b>THEME 1: What is Psychotherapy?.....</b>	<b>32</b>
4.1.1 Differences in knowledge .....	32
4.1.2 The potential for harm .....	34
4.2 <b>THEME 2: The Gap in the Jigsaw of Recovery.....</b>	<b>35</b>
4.2.1 The missing intervention .....	35
4.2.2 Exploration of experience.....	37
4.2 <b>THEME 3: Change in Ireland .....</b>	<b>39</b>
4.3.1 Culture change – or not?.....	39
4.3.2 External pressures on the services .....	40
<b>CHAPTER 5: DISCUSSION .....</b>	<b>42</b>
5.1 <b>Introduction.....</b>	<b>42</b>
5.2 <b>What is psychotherapy? .....</b>	<b>42</b>
5.3 <b>The Missing Piece in the Jigsaw of Recovery .....</b>	<b>44</b>
5.4 <b>Change in Ireland .....</b>	<b>46</b>
<b>SECTION 6: CONCLUSION AND RECOMMENDATIONS.....</b>	<b>48</b>
6.1 <b>Recommendations: .....</b>	<b>48</b>
6.2 <b>Areas for Future Research.....</b>	<b>48</b>
6.3 <b>Strengths and Weaknesses .....</b>	<b>49</b>
<b>REFERENCES.....</b>	<b>50</b>

**APPENDICES .....57**

**Appendix 1: Information Letter .....57**

**Appendix 2: Question List.....58**

**Appendix 3: Informed Consent Form.....59**

**Appendix 4: DSM-IV-TR Criteria for the Diagnosis of Schizophrenia.....60**

## **Acknowledgements**

To my mum and dad, for their endless support and kindness throughout my journey over the past four years.

To my fellow peers, who have trundled along beside me into the unknown.

And finally, I would like to thank my research supervisor, Dr. Gráinne Donohue, for helping me to give birth to this piece of work.

**List of Tables**

Table 1	Demographics of Sample of Participants.....	17
Table 2	Superordinate Themes & Subordinate Themes.....	20
Table 3	Participant Codes.....	20

## **Abstract**

*The purpose of this research was to explore the place, if any, that psychotherapy could have within the treatment of schizophrenia in Ireland, with a focus on community rehabilitation teams in the mental health service which were established in order to provide comprehensive multi-disciplinary care. The study firstly explored the opinions of professionals working with mental health service users in the use of psychotherapy as a treatment method for schizophrenia. Secondly this study explored the reasons why psychotherapy may not be considered to be an appropriate intervention with schizophrenia. Finally this study sought to understand any reasons behind progression or lack of progression of the use of psychotherapy within mental health services in Ireland. The study was carried out by way of a qualitative design. The sample consisted of four female participants from two separate teams based in Dublin. Semi-structured interviews were used to carry out the data collection, following which the data was analysed using thematic analysis. The findings provided insight into the research subject from an Irish perspective and broadly supported the existing literature. The findings highlighted that psychotherapy as a discipline is largely missing within multi-disciplinary mental health care in Ireland. Evident throughout the findings was the different levels of knowledge regarding the different approaches of psychotherapy. Finally influences both internally and from a national perspective were found to exert a pressure upon the service. Three recommendations were made, firstly that all mental health staff working on multi-disciplinary teams should be provided with education and assessment training regarding the differing approaches within psychotherapy to ensure appropriate matching to intervention. Secondly, guidelines informing service users to access any current psychotherapeutic services should be made available. Finally, further consideration is to be paid to the current Irish context and the role of psychotherapy with regard to the economical pressures of a condition such as schizophrenia.*

## **CHAPTER 1: INTRODUCTION**

Schizophrenia is a complex mental health condition characterised by a variety of psychological symptoms. It is one of the most common mental conditions, occurring in all cultures, and it is thought that approximately 1 in 100 people will experience it during their lifetime (NHS Choices, 2012).

### **1.1 Background**

Up until the 1950's, people diagnosed with schizophrenia tended to be housed in overcrowded hospitals, facing an array of often barbaric treatment options and a bleak prognosis for recovery (Deutsch, 1948, p. 45). Improvement came in the shape of pharmacotherapy, with the development of anti-psychotic medication which reduced the more debilitating symptoms, facilitating improved functioning and in many cases the possibility of re-entering society. During this period, however, people with schizophrenia continued to be placed in large institutions, with both acute and long-term facilities being the primary means of treatment and care (World Health Organization, 2001).

In 2001 the World Health Organisation (WHO) called upon governments globally to update policies within their mental health sector (Kelly, 2004). Their report outlined the need for care to move away from the large psychiatric hospitals to become community based services, integrated with the primary health service and put forth within a holistic model of care, providing psychosocial education and rehabilitation services alongside the supply of medication (World Health Organization, 2001).



## 1.2 Ireland's Response

With the last major health policy revision made in 1984, The Department of Health and Children (DOHC) in Ireland commissioned and published 'A Vision for Change' in 2006, which aimed to provide over a ten year period a comprehensive modernisation of the Irish mental health service based on the needs of the population within "a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness" (Department of Health and Children [DOHC], 2006, p. 8). The policy promoted a person-centered approach, focussing heavily on the biopsychosocial model of care and proposed a number of recommendations for change to the service relevant to this study, a brief summary of which follows:

- To establish Community Mental Health Teams (CMHT) in the area of general adult mental health which should combine a diverse range of skills as required, including the delivery of individual and group psychotherapies;
- To establish specific Community Rehabilitation Teams (CRT) whose role is to support and rehabilitate people with severe and enduring mental illness back into society through the appropriate use of medication, psychological and psychosocial care
- The requirement of three main categories of psychotherapy is anticipated within the service, either individually or as a combination during the course of recovery, ranging from informal counselling to specialist therapeutic programmes (Department of Health and Children [DOHC], 2006).

In addition, as a further justification of the rationale behind this study, A Vision for Change recommends that further research is carried out, owing to a perceived gap regarding

“efficacy and effectiveness of a range of pharmacological, psychological and psychosocial interventions” (Department of Health and Children [DOHC], 2006, p. 211)

### **1.3 Aims and Objectives**

With the above recommendations proposed by A Vision for Change in mind and seven years following its publication, the primary aim of this research is to explore the place, if any, that psychotherapy could have within the mental health sector, with a focus on the CRT’s which were established in order to provide comprehensive multi-disciplinary care. Opinions were therefore sought within three areas of exploration:

1. The use of psychotherapy as a treatment method for schizophrenia, both in conjunction with other psychosocial interventions and as a separate form of treatment;
2. Reasons why psychotherapeutic interventions may not be considered to be an appropriate intervention with schizophrenia; and
3. Reasons behind any progression or lack of progression of the use of psychotherapy within mental health services in Ireland.

## **CHAPTER 2: LITERATURE REVIEW**

Since the classification of dementia praecox as a discrete mental condition by Kraepelin in 1887 and further defined to be schizophrenia by Bleuler in 1911 (Butcher, Mineka, Hooley, & Carson, 2004), the medical world has struggled to shape a coherent definition of the etiology behind this complex condition. It has been the focus of many different areas of research, with the repeated swinging from one focal point to another described as the “bandwagon of hopefulness” (Silver, 2003, p. 325). Psychotherapy too has repeatedly tried to find a foothold within the treatment model, yet two questions in particular have plagued the discipline throughout its rocky relationship with the condition; firstly, the overarching question of ‘does it work?’ and secondly, assuming the answer to the first to be affirmative, the question of ‘where does it fit?’ within the medical world today.

Within these themes, the author will examine the historical development of the early psychotherapeutic treatments of schizophrenia, with a discussion of the factors which may have served as a barrier for the inclusion of psychotherapy as a respected form of treatment. Following this an inquiry is made into the debate concerning the integration of psychotherapy in the treatment of the condition. Finally to conclude, the current position within Ireland is briefly outlined.

### **2.1 Does it Work?**

#### **2.1.1 Early Psychotherapeutic Treatments**

During the early twentieth century the most advanced form of psychotherapy was the psychoanalytic approach. Amongst others, key concepts within this approach include the engagement in a transference process between analyst and patient, which facilitates

regression of the patient through dependency upon the analyst (Kohut & Seitz, 1963). Early investigations into the etiology of schizophrenia include those by Freud himself, who, within his theory of ego psychology, conceptualised the primary process within schizophrenia to be the ‘decathexis of objects’, otherwise understood to form the emotional or libidinous withdrawal from either intrapsychic internalised object representations or real people, in response to intense frustration and internal conflict (Freud, 1911, 1914b, 1924a, 1924b). The symptom of psychosis therefore manifests due to a conflict between the ego and the perceived external world in which reality is reconstructed as a defence (Gabbard, 2005, p. 184). The nature of libidinous decathexis and the resulting psychosis therefore led Freud to assert that psychoanalysis was not a suitable intervention for schizophrenia owing to the patient’s apparent inability to engage in free association or the deep transference relationship required for recovery. For a period of time, this assertion served to discourage the application of psychoanalytic methods with schizophrenia (Fromm-Reichmann, 1948). Undeterred, however, many of Freud’s successors disagreed with his assertion, with Federn, Jung and Abraham finding the opposite (Stone, 1999). Bleuler recorded that he applied psychoanalytic techniques to patients at the Burgholzli Clinic, a psychiatric asylum based in Switzerland, to find that not only could patients engage in the transference process, but that discharges subsequently tripled (Silver, 2003, p. 325). Further anecdotal reports of success in establishing a meaningful therapeutic bond through psychoanalytic techniques were reported by Fromm-Reichmann (1954); Knight (1946); Searles (1965) and Sullivan (1962).

Jung, working as a student under Bleuler, was interested in the experience of the psychotic patient, believing the more incomprehensible symptoms such as delusions and hallucinations could be linked back to life history or self concept. Viewing a person to be constructed from many autonomous selves, he wondered if the mind could be similarly

structured, with psychosis occurring following a trauma which threatened the foundations of a person (Lysaker, Glenn, Wilkniss, & Silverstein, 2010). The focus on experience gathered momentum during 1940-1970, particularly surrounding the early years of development. Harry Stack Sullivan (1962) studied the impact of early interpersonal experience, attributing the development of schizophrenia to 'faulty mothering' resulting in an intensely anxious self, and stated that recovery could only occur during a long-term interpersonal psychoanalytic process (Gabbard, 2005, p. 184). Fromm-Reichmann (1950) added that a person with schizophrenia was full of fear and distrust which could not be surmounted alone due to these early interrelated family experiences (p.110). The concept of the impact of interpersonal relations thus began to generate a significant amount of interest in psychoanalytic circles (Fleck, 1960; Frazee, 1960; Lidz, Parker & Cornelisn, 1956; Wolman, 1968).

From 1950, alternative approaches began to enter the field with the rise of the humanistic, systemic, and behavioural approaches, none of which emphasised the need for regression for recovery. The humanistic approach again focused on the experience of the person but this time within the context of the therapeutic alliance, acknowledging the influence the therapist may have in affecting the outcome of treatment by communicating through a strong use of immediacy and integrity (Gendlin, 1962). Indeed, Rogers detailed a number of successful cases of working with the humanistic, person-centered approach in treatment schizophrenia (Seeman, Rogers & Dymond, 1954; Rogers, Gendlin Kiesler & Truax, 1967), however, as most were overseen by Rogers, there were questions raised regarding their validity (Gabbard, 2005). Meanwhile, the systemic approach focused primarily on family interactions, exploring patterns and dynamics present within the whole family. The first study detailing use of the systemic approach, more commonly known as family therapy, with schizophrenia was carried out by Bateson in 1956. Through an

examination of patterns of communication and behaviour, Bateson believed that conflicting 'double bind' messages from different family members created an intense level of emotional distress, playing a vital role in the onset of psychosis (Bateson, Jackson, Haley, & Weakland, 1956). Recovery could therefore occur through the disruption of dysfunctional patterns of communication and interaction by the therapist. Finally, Beck, pioneer of cognitive-behavioural based therapies, described working successfully with an individual with symptoms of schizophrenia as early as 1952. Beck primarily used psychoanalytic techniques but with a focus on the person's rational cognitive functioning, which would later be developed into cognitive therapy and subsequently Cognitive Behavioural Therapy (CBT). At this time Beck believed that cognitive therapy would not be suitable as a treatment for schizophrenia due to the lack of evidence it could work with this population (Beck, Rector, Stolar, & Grant, 2009).

Significantly for the future of psychoanalysis and its offshoot approach, psychodynamics, both the theory that family dynamics were to blame for the onset of schizophrenia and the concept that recovery could only occur through regression within a transference process proved to be deeply unpopular (Eeche, 2003). Concerns were raised regarding the harm these both may inflict on the person with the condition, particularly when favoured over biological factors (Brenner & Pfammer, 2000; Lehman & Steinwachs, 1998). Indeed, the notion of potential harm was not unheard of in psychoanalytic circles. Jung himself had included a caveat to psychoanalytic treatment declaring it must be used with caution in certain conditions owing to the possibility of increasing symptoms in a psychotic patient (Lysaker et al. 2010, p.78). A further nail in the coffin for psychoanalysis occurred through the rather arrogant claim that psychoanalysis alone could alleviate the symptoms of

schizophrenia together with the refusal to consider any alternative disciplines (Karon & Van Denbos, 1981).

### 2.1.2 Early Empirical Findings

As research into alternative treatments for schizophrenia developed, particularly in the areas of neurobiology and pharmacotherapy, pressure to prove the efficacy of psychotherapeutic techniques through empirical research via the use of controlled trials increased. Largely, this period of research did not have the desired outcome for either the psychoanalytic, psychodynamic, family or humanistic approaches, resulting in many conflicting or inconclusive findings. In contrast, the cognitive-behavioural approaches are considered to be effective interventions in the treatment of the condition. The reasons behind this split in the approaches are outlined below.

One of the earliest and most well-known randomised controlled clinical studies was the Camarillo State Hospital Study (1968) which compared outcomes of schizophrenia patients who were treated with psychodynamic psychotherapy and/or antipsychotic medication. The findings showed that those receiving antipsychotic medication improved significantly more than those who did not receive it, and interestingly, nor was any increased interactive effect shown between psychotherapy and the medication found (May, 1968). Furthermore, significant studies carried out in both humanistic and psychodynamic approaches during the period of 1960-1984 by Fairweather et al. (1960); Grinspoon, Ewalt, and Shader (1972); Karon and O'Grady (1969) and Karon and VandenBos (1970, 1972, 1981) and Rogers et al. (1967) all provided either little or questionable evidence of overall effectiveness, or were subsequently heavily criticised for a variety of methodological problems (Gabbard, 2005).

One study of particular note during this period, owing to the attention paid to the training of therapists and methodological sophistication, was the Boston Psychotherapy Study (Stanton et al. 1984) which comprised a two year multi-hospital study of the effects of psychotherapy on patients with non-chronic schizophrenia. The study included two methods of psychotherapy, the first exploratory, insight-orientated (EIO) and the second reality-adaptive supportive (RAS) with pharmacologically stabilised patients and reviews conducted at six month and two year periods. By the end of the study, positive findings showed that those who has received the RAS therapy showed less recidivism and better role performance, while those who had received the EIO therapy exhibited better cognitive and ego functioning, but with little difference in overall efficacy between the two. Less positively was the drop rate, which, after six months stood at 40%, and at 70% after two years highlighting that a substantial amount of people with schizophrenia were likely to not be interested in continuing in long-term psychotherapy (Lysaker et al. 2010).

A further decisive blow was dealt to the psychoanalytic, psychodynamic and family approaches in the release of the Schizophrenia Patient Outcomes Research Team (PORT) report (Lehman & Steinwachs, 1998) which provided a comprehensive study of a range of treatments for the condition. Within this, it stated that “individual and group psychotherapies adhering to a psychodynamic model” (p. 7) and promoting regression through transferences should not be used (Recommendation 22) and in Recommendation 26 “family therapies based on the premise that family dysfunction is the etiology of the patient's schizophrenic disorder should *not* be used” (p. 8). Supportive therapies incorporating “educational, behavioural and cognitive skills training” fared slightly better in Recommendation 23, which stated that some benefit had been found in conjunction with pharmacotherapy, however as yet the most effective of these was unknown (Lehman & Steinwachs, 1998, p. 8),



The reason behind the exclusion of family therapies is complex and believed to have arisen due to the predominantly psychoanalytic theory that psychosis can arise as a result of interactions between family members (Bateson et al. 1956). This claim was believed to create unwarranted guilt within a family, which in turn fuelled distrust in the relationship between the clinician and the family (Eecke, 2003, p. 12). There are, however, a number of significant studies which highlight the role of the family in the onset of schizophrenia. As an example, a well known study is the Finnish Adoption study (Tienari, 1991). In this study, carried out between 1960-1979, adoptive families to children of women with schizophrenia were studied and categorised according to their psychological health. Out of 144 adopted children only 13 developed schizophrenia, and most significantly, no child adopted into a 'healthy' adoptive family developed the condition (p.460). Additional studies confirming the significance of family interactions were carried out by Myhrman, Ranakallio, Isohanni, Jones & Partanen (1996) and Vaughn & Leff (1976).

In summary, this period of empirical research in the psychoanalytic, psychodynamic, family and humanistic approaches did not provide satisfactory evidence in order to establish their efficacy to secure their place in the treatment of schizophrenia, and as such, were mostly discredited and isolated to be either inappropriate or ineffective forms of treatment for schizophrenia.

In contrast, research in the field of cognitive-behavioural therapies such as CBT, has proved to be extremely reliable due to the structure of the therapy. The use of goal setting and exploring outcomes and targets means it can be assessed more accurately for effectiveness using quantitative research methods. There have been many studies in the effectiveness of CBT with particular focus on providing behavioural treatment strategies with the aim of helping a person manage the symptoms of schizophrenia in order to function more

effectively in society. Examples of this can be found in studies including Cathera et al. (2005) and Sensky et al. (2000). Cognitive therapies have since gone from strength to strength in the area of rehabilitation in the mental health sector, with newer models being formulated regularly to coexist alongside other disciplines in rehabilitation owing to its 'easy to package' nature, short term duration and adaptability to the specific needs of schizophrenia.

Increasingly, however, the other approaches are not content with this exclusion from treatment of schizophrenia. As our understanding of schizophrenia develops, these approaches are adapting their techniques to offer treatment into areas where behavioural approaches may not reach (Fonagy, 2000). This struggle is still apparent today as these approaches strive to prove their efficacy in the areas of psychotic disorders and are worthy of inclusion alongside the biological and psychosocial models.

## **2.2 Where does it Fit? The Question of Integration**

Throughout the history of schizophrenia, there has been a tendency to seek the answer to recovery within individual disciplines as new findings are published. Decisive moves to unite disciplines to work together have been made only since the promotion of the biopsychosocial model of care in the WHO annual report in 2001, over a hundred years after the classification of the condition. Even following this change, in reality rarely are the terms psychiatry and psychotherapy linked together when considering a treatment plan for schizophrenia today. Although it is known that both ultimately wish for the same outcome, traditionally their paths divide in the approach to reaching this goal of recovery (Lysaker et al. 2012). Strauss (2000) observed that psychiatry has been keen to distance itself from the 'outdated' psychoanalytic concepts of recovery and that psychiatry still hopes to join the

more acceptable forms of medicine to promote its respectability. Strass also observed that psychiatry as a discipline is not open to trying new concepts, preferring to stick to current tried and tested methods (p. 21).

Read and Ross (2003) stress the importance of providing psychological treatments to people with schizophrenia owing to the high levels of psychological trauma found in people with psychosis. Although the current accepted 'diathesis-stress' model of schizophrenia (Walker and DiForio, 1997) is considered to integrate biopsychosocial aspects, the understanding of diathesis to be a genetic predisposition has led to all environmental factors to be encased within the overall term of 'stress' and thus excludes an exploration of specific factors such as poverty, trauma, and abuse in the onset of the condition (p. 668). This does not marry up well with the original 'vulnerability-stress' model proposed by Zubin and Spring (1977) in which 'acquired' vulnerabilities included a wide range of possible environmental factors (p. 109). Indeed, understanding that part of the etiology of schizophrenia lies in biology does not minimise the need for people to explore and make sense of their experience (Lysaker, Roe & Kukla, 2012, p. 348). Indeed, there is a prevailing view that the field of psychiatry may do well to begin to learn to observe rather than dismiss phenomena because it cannot be defined within the established medical model (Strauss 2000).

Regarding integration of specific approaches, disagreement still remains regarding the integration of the psychoanalytic and psychodynamic approaches. Neither concept of looking backwards forwards faulty family dynamics nor the need for regression to enable recovery have aligned well with the current positive focus upon the future and enablement of a person to move forward (Lysaker et al. 2012). Willick (2001) states one obstacle lies in the many

analysts who fundamentally believe the above concepts form the etiology of schizophrenia and that neurobiology and medication have no place in the treatment of the condition (p. 27). In a study by the Cochrane Schizophrenia Group, the effects of psychodynamic psychotherapy were reviewed in the treatment of people hospitalised with schizophrenia, in which the findings did not support the use of this approach. Based on this, a further recommendation was made, stating “if psychoanalytic therapy is being used for people with schizophrenia there is an urgent need for trials.” (Malmberg, Fenton, & Rathbone, 2001). In contrast however, in a meta-analysis study by Mojtabai et al. (1998) of 106 studies of interventions with schizophrenia, findings showed that programmes which combined both psychological and pharmacological interventions had a success rate of 60%. The same study further stated “therapies based on various psycho-dynamic principles were not significantly less effective than verbal treatments based on other theoretical rationales. Thus, our review provides no evidence that psychodynamic therapies are harmful” (p. 583).

Family therapies have fared considerably better owing to the adaptability and diversity of the approach today, with most practitioners modifying their approach to meet the needs of the individual (Asen, 2002, p. 232). In particular family therapy interventions have found their place within the multi-disciplinary approach. Carr (2008) advocates the use of family therapies within ‘multimodal’ programmes when treating schizophrenia through integrating medication with psychological interventions (p.25). The efficacy of combining medication with psychotherapy has been established in a number of studies. (Pfammatter, Junghan, & Brenner, 2006) conducted a review of 21 meta-analyses and considered to be one of the most “methodically robust randomised controlled therapies for schizophrenia” (Carr, 2008, p. 23) which combined four different forms of intervention with medication: psycho-educational family therapy; CBT; social skills training; and cognitive rehabilitation. Each form of

intervention was found to have a positive impact on different areas of functioning. Again it was found that combining medication with each of the psychological interventions improved functioning, either in fewer relapses, fewer positive symptoms, social skills or cognitive functioning. Recurrent relapse is a feature of schizophrenia and often attributed to non-compliance with medication. In a study by Zygmunt et al. (2002) it was found that out of the 39 interventions tested, only 13 showed any improvement in the compliance rate. Most significantly it was found that psycho-education of the service user and involving family members proved the most effective.

Currently there is a difficulty in obtaining an absolute definition of the broad range of humanistic approaches currently available to gain an accurate understanding of their integration with schizophrenia. Often referred to as 'supportive' counselling, all tend to draw heavily on Roger's person-centered therapy, with a focus on enhancing progression towards independence (Bachmann et al. (2003). The concepts of the therapeutic relationship and 'person-centeredness' as a way of being have originated from Rogers, both of which underpin the holistic model of care. Furthermore, most supportive approaches provide an exploration of the experience of psychosis from the entirely subjective self and are seen as non-harmful owing to the focus on empowerment and maintaining wellbeing (Burne Lynch, 2008).

Mixed messages, however, continue to prevail in treatment recommendations, as is evident in the National Institute for Health and Clinical Excellence (NICE) guidelines of interventions in the treatment and management of schizophrenia. Updated in 2010, the guidelines are acknowledged to promote the multi-disciplinary, holistic approach. In summary, although this comprehensive breakdown makes recommendations that CBT, family interventions, arts therapies and educational/ employment programmes should be

offered to all service users, 'counselling and supportive psychotherapy' was actively discouraged along with the surprising addition of social skills training. (p. 370), thus contracting elements of earlier studies.

As psychotherapy continues to struggle to find a foothold within the treatment of schizophrenia, Lysaker et al. (2012) suggest that there are three issues that still prevent integration of psychotherapy into the rehabilitation model: "1) a lack of clarity regarding the optimal form of the relationship between mental health service users and professionals; 2) uncertainty about relative effects of therapeutic conversation and rehabilitative action on a person's wellbeing and subjective sense of self; and 3) a lack of manualised, recovery orientated psychotherapeutic interventions" (p. 344). To address these, Lysaker and Roe (2012) suggest that there is a need for the development of an integrative psychotherapy which brings together "a range of interventions under an internally consistent framework, rather than merely a multitude of highly specific or isolated approaches" (p.287). An integrative approach would therefore compass insights from a range of psychotherapeutic approaches, specifically tailored to encompass the needs of both the condition and the individual, yet further clarification needs to be carried out in this area.

There is a focus upon the requirement for a psychotherapist to possess a strong skillset and to be experienced in working with schizophrenia. Fenton (2000) stresses that treatment should be provided by highly skilled, flexible and well-supervised practitioners whose ultimate goal to help a person accept and manage their condition (p. 63). Kraft Goin (2000) goes further, stating practitioners require a 'skilled supportive psychotherapy stance, with an understanding of transference and countertransference, cognitive development, learning theory, psychodynamic principles and the ability to empathise with both implicit and explicit

nuances (p. 1380). Asen (2002) states that the need for adaptability will in particular pose a challenge for practitioners who remain exclusive to one approach, regardless of the needs of service and the potential outcomes of therapy (p. 232). O'Brien (2001) expands these requirements to a wider body in the mental health sector, confirming the importance of ensuring mental health team members are equipped with knowledge of psychotherapeutic concepts and dynamics, which should be addressed through education and clinical supervision, in order to provide people with the appropriate levels of care (p.184).

### **2.3 The Irish Context**

Described as being 'hospital prone', in 1961 it was believed that Ireland had the highest number of hospital beds per 1,000 people worldwide, housing people with all manner of illness and difficulty. Prior to the restructuring proposed in A Vision for Change, this situation remained largely unchanged (Department of Health and Children [DOHC], 2006, p.52). The release of A Vision for Change encompassed a valiant effort to include all possible aspects of holistic recovery, stating that in order to foster well-being "the goal of mental health promotion is the enhancement of potential, i.e. building psychological strengths and resilience, rather than focusing on reducing disorders" (p.44). From the perspective of psychotherapy, it made the recommendation that access to 'talk' therapies was required and acknowledged that many service users and providers alike have found this to be missing.

During the period since its release, Ireland has made attempts to implement the framework as outlined in A Vision for Change. This has included commencing the closure of the larger institutions and relocation to community based services. Owing, however, to the recent enormous decline in economic prosperity, the current challenge facing the mental health service is maintaining this momentum against difficulties with human resources and

annual budgets. Today, the planned changes for the entire service have been reduced to individual mental health sectors across the nation implementing change on a specific need basis. This has varied from region to region, with some progressing on to developing a comprehensive community based system whilst some remain relatively unchanged (HSE National Vision for Change Working Group, 2012). The HSE and DOHC, however, state their continued commitment in progressing the framework. It remains to be seen how this will develop, as in November 2012 the DOHC released “Future Health: A Strategic Framework for Reform of the Health Service 2012 – 2015”, announcing a new plan for reform of the entire health care system. This publication specifically states the intention to maintain the progress of A Vision for Change, including the integration of mental health services wholly into the new health care system. Within this new system every person will be insured for primary and acute hospital services, which will also include acute mental health services (Department of Health and Children [DOHC], 2012 p.4).

A final point specific to schizophrenia is the twofold concern relating to the current unstable economic situation in Ireland. The first concern is the economic cost of treating the condition. Behan et al., (2008) completed a study which investigated the cost of providing treatment upon society, taking into account care, indirect costs and informal care made by families. The estimated figure came to €160.6 million. In addition, a further €77 million was estimated for lost productivity. The second concern relates to the understanding that socioeconomic factors have been found to be instrumental in the onset of the condition, which over time may mean even more strain on the nation if the economy continues to worsen (Saraceno, Levay, & Koh, 2005, p. 181). Cullitan (2009), states that in light of these costs, further consideration needs to be given to investing in psychological treatments with the specific long term aim of relieving the cost on the nation through providing service users



the possibility to return to a productive status, which, as Ireland enters a further period of change in the health care system, the Department of Health would do well to deeply consider.

## **2.4 Conclusion**

In summary, and with the primary aim of this research in mind, this literature review has explored the historical reasons why some psychotherapeutic approaches have largely been excluded from the treatment of schizophrenia. These have largely focused on two factors, the potential for harm, and the difficulties in establishing efficacy in a discipline which is largely based on an exploration of subjective experiencing. It also highlights that change is around the corner, with more and more calls for the integration of psychiatry and psychotherapy occurring as awareness that service users are currently denied an expression of their experience grows. Finally, it discusses the current economical issues Ireland is experiencing and the further potential implications of delaying the inclusion of psychotherapy into CRT's may have upon the economy.

## **CHAPTER 3: METHODOLOGY**

### **3.1 Research Design**

Qualitative research has proven to be effective for the in-depth exploration of human experience in a wide range of subjects, generating a rich knowledge base and providing understanding within areas where there may be little focus or observation (Mintz, 2010). The rationale for adopting a qualitative approach in the execution of this research lies in the requirement for an open-ended investigation of the viewpoints of professionals who are currently working within the Irish mental health and education sectors, facilitating an exploration of their experience of current day-to-day practice against proposed recommendations in government policies.

### **3.2 The Sample**

The sampling for this research focused upon professionals working with people with a diagnosis of schizophrenia within Ireland. The original inclusion criteria stated that the sample must meet one of the following criteria to be eligible for inclusion for this research:

- a) engage professionally with a person(s) meeting the criteria for schizophrenia as per the DSM-IV-TR; or
- b) have a direct involvement in the setting up and/or implementation of a rehabilitation programme in Ireland; or
- c) has had or currently has direct involvement in the formulating of the mental health policy framework as outlined in A Vision for Change (2006).

At the outset, the researcher had hoped to interview six participants from a range of organisations covering each aspect of the inclusion criteria, however, owing to restrictions in

availability and access, it was deemed that two participants from a community rehabilitation team and two participants from an educational and training team would be approached to fulfil the sample. All participants met the inclusion requirements of engaging professionally with people with a diagnosis of schizophrenia and having direct involvement in the setting up and/or implementation of a rehabilitation programme in Ireland. The respondents were all female, ranging in age between 25-56. Individual interviews were conducted with each participant to ensure the opinions were of the participant and not subject to external influence.

<b>Role</b>	<b>Team</b>	<b>Age</b>	<b>Gender</b>	<b>Qualification</b>	<b>Experience</b>
Social Worker	Community Rehabilitation Team	32	F	National Qualification in Social Work MA in Social Work BSc in Social Science	15 months
Occupational Therapist	Community Rehabilitation Team	25	F	Bsc (Hons) in Occupational Therapy	13 months
Rehabilitation Facilitator	Education & Training Team	56	F	HDip in Rehabilitation Management MA in Anthropology (current)	9 years
Clinical Psychologist (part time)	Education & Training Team	42	F	Counselling Psychologist	3 years

Table 1: Demographics of Sample

### 3.3 Recruitment of the Sample

Initial contact with the sample was made through via the snowball method of sampling (McLeod, 2003, p. 30), whereby access was gained through one individual working within psychiatric rehabilitation for a non-government educational team offering training and employment services to people who may find it difficult to obtain employment, including those with schizophrenia. Referral was made on to additional participants working within both this team and a Health Service Executive (HSE) community rehabilitation team. Verbal permission was obtained for the researcher to make contact, upon which an email was issued

containing a request for an interview together with a copy of the information letter (Appendix 1) outlining the details of the study, which required signature once the participant agreed to partake in the study.

### **3.4 Data Collection Methods**

A narrative approach was used to collect the data regarding a healthcare professional's opinions on the potential use of psychotherapy as an intervention in the treatment of schizophrenia. This took the form of semi-structured, in-depth interviews, lasting between 40-60 minutes within a private room at each participant's place of work. A list of questions (Appendix 2) inviting an open-ended discussion of the specific objectives relating to the research question was formulated and approved by the research supervisor prior to the commencement of the interviews (McLeod, 2003). The researcher anticipated that additional relevant information may arise during the course of the interview and provision was made for this in terms of the flexibility, thus increasing the qualitative process. Each interview was recorded using a digital voice recorder from which a transcript was produced for in-depth analysis.

### **3.5 Reliability and Validity**

As the use of qualitative methods in research has become more popular in the study of human experience, meanings, perspectives and understandings, so has the requirement to determine appropriate methods of assessment of this often descriptive and complex exploration. The differing nature of qualitative research compared to the 'gold standard' that quantitative research provides requires a separate set of standards for judging the reliability and validity of a study. It has been proposed that trustworthiness is a central feature of qualitative research, incorporating credibility, transferability, dependability and

confirmability in order to provide a framework for assessment of similar weight to that applied to quantitative studies (McLeod, 2003, p. 93). In this research, owing to the understanding any data this study yields will be local and heavily contextualised indicates an additional exploration of these factors would be necessary. A further aspect of qualitative research is the emphasis placed on the contribution the researcher plays in facilitating the interview and thus influencing the quality of the data.

### **3.6 Data Analysis**

Owing to the non-standardised nature of the raw data gathered, it was decided that to facilitate a thorough exploration of the relationships between emerging themes and patterns within the data, the method of data analysis would be a thorough and in-depth thematic analysis (McLeod, 2003, p. 65). Thematic analysis is particularly suitable for this research subject as it allows a flexible approach to analysing the data arising from the interviews and an exploration into human subjectivity. From this analysis a selection of the key themes which relate most significantly to the objectives will be reported in the findings of this research.

In conducting the process of a thematic analysis for this research, a thorough exploration of the raw data was conducted. This involved listening to each interview a minimum of three times, upon which a transcript for each was created. A systematic, manual examination of each transcript was undertaken, during which coding categories were assigned to the text according to the both the explicit and implicit themes materialising and the descriptive language and nuances of speech used by each participant. McLeod describes the main tool a qualitative researcher has is the capacity to enter the lived experience of the participant, and to internalise and own as much of it as possible, allowing the felt sense of the

data to emerge (p. 85). From this initial categorisation, a process of phenomenological reduction was applied, in order to ensure that all consideration had been made to eliminate the researcher's assumptions regarding the research question. The use of phenomenological reduction allows new perspectives or meanings within the object of inquiry to emerge, and again following this process, a further stage of coding was applied to the data (McLeod, 2003, p.85).

In order to further refine the themes, the researcher undertook a method of cross-referencing themes and identifying the points where themes converge by compiling a listing of all the interviews. From this, it was possible to see where themes predominantly overlapped, producing further core themes. From this process, three core, or superordinate themes were identified, and within each of these were found two subordinate themes (McLeod, 2003).

### **3.7 Ethical Considerations**

Every effort has been made to preserve the anonymity of each participant owing to the sensitive nature of this research. At the start of the interview, participants were asked to carefully read and sign an informed consent form (Appendix 3) and the information letter. Both were counter-signed by the researcher and the participant was provided with a copy of each to retain for their own records. Confidentiality and anonymity concerns were briefly discussed before the interview commenced and each participant was reassured that appropriate measures would be undertaken to preserve anonymity through a process of coding each participant for the purposes of this research, and the exclusion of any information which may compromise the identity of a participant. Each participant was advised that they would be able to withdraw from the study should they so wish, without fear of reprisals. It was not considered that the safety of the participants would be compromised,

however reassurance was provided that all due care and attention would be made in this regard to all ethical and confidentiality aspects of the study. Interviews were recorded using a digital voice recorder, once the verbal and signed agreement of this has been obtained from each representative (McLeod, 2003).

## CHAPTER 4: FINDINGS

Participants for this study were interviewed regarding their current role in the area of mental health and their experience and opinions regarding the use of psychological interventions with schizophrenia with a focus on psychotherapy. Following extensive data analysis, three superordinate themes were identified, within which were two subordinate themes. These are outlined in Table 2 below:

<b>Theme 1: What is Psychotherapy?</b>	<ul style="list-style-type: none"><li>• Differences in knowledge</li><li>• The potential for harm</li></ul>
<b>Theme 2: The missing piece in the jigsaw of recovery</b>	<ul style="list-style-type: none"><li>• A much needed intervention</li><li>• Exploration of experience</li></ul>
<b>Theme 3: Change in Ireland</b>	<ul style="list-style-type: none"><li>• Culture change - or not?</li><li>• External pressures</li></ul>

Table 2: Superordinate and subordinate themes

Each theme is presented separately below together with relevant extracts of data to support and demonstrate the rationale behind each finding. Each participant can be identified by their unique code:

<b>Participant</b>	<b>Code</b>
Social Worker	SW
Occupational Therapist	OT
Rehabilitation Trainer	RT
Clinical Psychologist	PSY

Table 3: Participant Coding

### 4.1 THEME 1: What is Psychotherapy?

#### 4.1.1 Differences in knowledge

Upon examination of the data it was apparent that although there was a familiarity with CBT, knowledge of other mainstream approaches of psychotherapy was rudimentary at best



in three of the participants. “I don’t really know that I would advocate anything or have strong opinions about, er, CBT or not, or any type of intervention of psychoanalysis” (RT). Primarily distinctions were identified by the SW, OT and RT in terms of depth, risk or duration, such as “delving”; “too deep”; “dismantling”; “supportive” and “ongoing”. The OT made references to more specialist therapies including Cognitive Analytical Therapy (CAT) and Dialectical Behaviour Therapy (DBT) but did not elaborate upon her understanding of these approaches.

Also persistent was a noticeable difference in the clarity of articulation when the same participants were speaking about psychological interventions in comparison to speaking about their professional role. This was apparent in the hesitations in the flow of speech, the struggle to organise thoughts and use appropriately descriptive language:

SW: *Yeah. Well yeah exactly, er, exactly it’s not a, er, like a, er, cognitive kind of psychological assessment, do you know, it’s more, it’s got more specific, er.*

RT: *My opinions aren’t very, you know, you know, you know what I’m trying to say, I don’t have a lot of knowledge in what therapies are, or interventions or anything like that.*

OT: *Um, it’s just counselling, more like psychotherapy counselling, er, ongoing counselling, like psychotherapy counselling.*

By contrast, the PSY was able to articulate clearly her understanding of some of the fundamental concepts of psychotherapy, looking past the question of ‘what is psychotherapy’ and focusing upon identifying what would be required in order to structure psychotherapeutic treatment with schizophrenia into mental health services:

PSY: *A therapist needs to be aware. Usually if somebody comes for counselling or psychotherapy, that boundary of ‘this is confidential and this is your space’, is very important. And it creates that safe space. I think that when you’re dealing with somebody, perhaps with a serious mental illness, those boundaries need to be a little bit looser. For example . . . if you’re counselling somebody with schizophrenia and they are telling you that they’re non-compliant with their*

*medication, then that kind of information can't stay confidential, it needs an action.*

#### 4.1.2 The potential for harm

Differing levels of knowledge concerning any potential risks involved in the use of psychotherapy with schizophrenia also became apparent when identifying participants' knowledge of the approaches. As previously detailed, there is evidence to support that this is not unsubstantiated; however, not all participants indicated an awareness of the need for caution. There were clear distinctions found between the two teams. For example, when the two members of the CRT team were asked if they would have any cause for concern regarding the use of psychological interventions with schizophrenia, the SW responded with "nothing that would come to mind right now". "Not at all" stated the OT, but later added that a consideration of the symptoms might be useful.

In contrast the two members of the training and educational team responded with more detailed cautionary responses, indicating a deeper level of knowledge. The subject of appropriate training arose: "Just that. . .the person would be trained and. . .wouldn't be too enthusiastic about solving all their problems." (RT), and a high level of focus was placed on the need for knowledge of the condition of schizophrenia and the potential risks:

RT: *You are not aware how, how the person has needed these behaviours and these ideas to cope, so you're not going to go dismantling. Any type of psychotherapies aren't going to go dismantling whatever the person, however the person is surviving, or be too enthusiastic about curing everybody.*

PSY: *I think that, um, if a counsellor, a psychotherapist was to take on a client with schizophrenia, then they need to have a knowledge of the illness. Um, so that they're aware you can unravel somebody, depending on the kind of therapy you are giving them. So for example, if somebody has schizophrenia, or a serious mental illness, sometimes some therapies are contraindicated.*

Furthermore, the risks of insufficient knowledge of the condition were also referenced in relation to the psychotherapist: "suddenly you're dealing with somebody who is perhaps

paranoid. . .hallucinating. . .I think that the counsellor puts themselves in a very risky position.” (PSY).

Anecdotal evidence of a deeper concern running through psychiatry regarding potential risks was further outlined by the RT:

RT: *It's evident that psychiatrists, er, fear, fear I think wouldn't be too strong a word, psychotherapy, and I think it's because. . .it's that it's hard to know what psychotherapy would be offered . . . But they fear...the psychotherapist's skills at being able to judge what is best for the client . . . I'm sure you would agree that you don't always go delving into everything, but it seems that psychiatrists fear that psychotherapists would do that.*

## **4.2 THEME 2: The Gap in the Jigsaw of Recovery**

### **4.2.1 The missing intervention**

All participants referred to recovery in mental health as a ‘jigsaw’, with each discipline addressing a separate aspect of the service user’s wellbeing. All participants considered psychological interventions to be useful as a further intervention within the biopsychosocial model of care. Conclusive views were expressed by all by asked the need for its inclusion; “absolutely, yeah absolutely” (SW), “there is a huge need for it” (PSY), “an awful gaping lack” (RT) and “definitely needed” (OT).

The lack of a psychologist on the CRT was experienced to be a “huge loss” by three participants. Reference was made by the SW of more specialist services being available by referral, such forensic psychological services, but believed that this would be used only due to a specific need. The PSY could think of only two psychologists in Dublin who had any sort of psychotherapy training, and who were only available for an assessment or on a short term contracted basis. The RT had experience of an assessment made by a psychologist but

was disappointed to find the intervention ended after only three meetings with the service user.

Three participants confirmed their experience that there were either none or very few psychotherapeutic services available:

RT: *There are none and they're just not available.*

PSY: *I don't see them from where I sit, and like I say I'm not in mental health services, we source that outside, but I don't see many psychological interventions. I can't see them being done.*

OT: *I feel like currently in Dublin and in this service, in comparison to working in England, there's not so much readily available.*

In contrast there was inconclusive evidence by both participants from the CRT as to whether external psychological services were available by referral or not. The OT stated that she would regularly recommend or refer on for counselling in community centres or may provide leaflets to service users so they could contact the services directly, whereas the SW had never referred on to psychotherapeutic services during her time in the role. In addition, there was some ambiguity evident regarding the process of referral to psychological services “I actually, to be honest I'm not entirely sure how it works” (SW).

There was evidence of disbelief that psychotherapeutic services are not accessible in the mental health service. The SW found it “unbelievable” that in her experience, psychotherapeutic supports are not easily accessible to people in the mental health system. The PSY was of the opinion that the only route to access psychotherapy would be via a GP referral in primary care. Furthermore, the PSY stated she felt it was “aspirational” when asked about the recommendations for the provision of psychotherapy in mental health services as per A Vision for Change.

All participants felt their role offered some level of therapeutic support to service users and again this varied by team. Participants from the CRT considered therapeutic interventions to be a part of their role; the SW referred to her “therapeutic work” both with service users and their families, whilst the OT enthused about the value of establishing a therapeutic relationship: “you can touch them so much more than maybe what you’ve even been referred for”, as well as her use of CBT-type interventions in group work.

In contrast, participants from the education and training team agreed that if required, they could offer some level of therapeutic support, however both described the boundaries of their roles. The RT stated the importance of ‘kindness’ as a tool for motivation, yet emphasised the limitations of this: “We don’t get into...a process of dealing with issues”. The PSY agreed her role was to support learners but stated: “We are not a medical centre, and we are very clear on the boundary. We are a training organisation.”

#### 4.2.2 Exploration of experience

Three participants expressed the requirement for a service which facilitated a person to talk about their experiences. Compassion for service users with schizophrenia was also identified in the attempt to understand the experience of having this condition. The RT and PSY stressed the importance of being able to talk about the experience of being given a diagnosis of schizophrenia and living with the condition “for somebody who’s hearing voices or hallucinating...where’s the support to find out how to manage that?” (PSY). Described by the PSY to be a “life changing diagnosis”, the RT stressed the importance of a space to process this:

RT: *What must it be like, to have this serious, really serious condition, where your mind doesn't work very well, you kind of can't trust your mind, you're not sure what's going on, and you, you're not supposed to talk about it.*

The PSY drew attention to the high levels of non-compliance with medication in schizophrenia “If somebody hasn't come to terms with having this illness and been empowered to manage it, of course they're going to be non-compliant”.

There was, however, some evidence of exploration of the subjective experience of a person in the CRT within the area of occupational therapy. The OT described person-centeredness to be at the root of her role, which facilitated her in assessment of service users “really getting what their goals are . . . If it's not meaningful for them it's not going to work.”

There was considerable frustration expressed by the RT in the need for a service which facilitated a person to talk. “Talk to the staff”, she said with evident disdain, “And that means whoever happens to be in the house at the time, without any even effort at building up a relationship.”

Anecdotal evidence was provided by the RT in her observation of a psychiatrist conducting an assessment with a service user and the lack of any other intervention between assessment, diagnosis and pharmacological treatment:

RT: *The doctor was fantastic, he was just so skilled at being able to talk and make the person feel really comfortable. . . I thought there was a lot of trust there and the guy kept saying “I'm just so glad I'm saying this all, I'm delighted, I'm delighted I'm saying this”. But, the doctor then, once he was really happy. . .he started to explain about this medication and so that was the end of the conversation then, that just became the detail . . . So from a medical perspective, that was the right thing to do, and I'm not saying that it isn't, but there's no other, there's nothing in between, there's nothing else.*

## 4.2 THEME 3: Change in Ireland

### 4.3.1 Culture change – or not?

There were opposing findings regarding the proposed shift towards multi-disciplinary approach in Ireland as outlined in A Vision for Change. The two participants from the CRT both confirmed that their team adopted this approach, and expressed significant enthusiasm at being involved in a system which is now aimed at focusing on a spectrum of individual's needs. "Holistic assessments of needs" (SW) and "holistic kind of social model" (OT) was the terminology used to describe their approach, and: "back to the basics of looking at what people are doing. . . how people are occupied, what is meaningful to someone. I believe it has a huge impact on recovery" (OT).

The OT emphasised her role in the CRT as facilitate a "much bigger picture than medication and their diagnosis" for service users, yet also acknowledged that the change in Ireland may not be as comprehensive as in other countries:

OT: *I think there's a huge change in culture at the moment . . . I think it's coming along, but it's still probably a bit behind compared to other countries and things, and sometimes that can be a real challenge.*

By contrast the two participants from the education and training team painted a different picture: "I think it's getting worse. I think that the medical model is getting stronger. And the notion about treating people as patients is getting stronger" (RT) "I don't see any psychological, I see medical. I see prescriptions, we'll up your medication, we'll change your medication" (OT).

Evidence of difficulty in changing attitudes in staff who had been in the health care system for a long time was also evident:

OT: *It's kind of been 'doing for' rather than 'doing with', and that's a huge challenge . . . It's making sure they know what you're about and that you're not threatening and you're not threatening their job . . . A huge, huge part of my role, I guess, is educating people.*

This difficult was further expanded through experience in the role that psychiatrists may play in blocking the integration of psychotherapy:

RT: *It's as if they are trying to maintain that position, that they don't want to be thrown across into something that will threaten the fact that medicalisation is not as strong as they are trying to keep it . . . there is some sort of holding of power there you know.*

This was further clarified through an observation of how psychiatrists who do buck the trend are alienated within the discipline of psychiatry: “Psychiatrists are alienated from their peers if they take that view you know” (RT).

#### 4.3.2 External pressures on the services

All participants experienced pressure exerted upon either their roles or the service from external sources. The two participants from the CRT experienced severe time pressures, which impacted on visits or programmes offered to service users. The SW described her role as “very busy” and expressed her wish for a second social worker on the team: “I’m spread quite thinly”. The OT also discussed the pressure of the many service users requiring support against her available time “our catchment is so large . . . you need to be pragmatic about the resources you have, and the time”. The impact of this was she would only visit service users on a referral basis.

Two participants described funding as exerting a pressure. In the case of the SW, she stated that the lack of the second social worker was most likely to be due to insufficient funding, as the recommendation in A Vision for Change is for more than one, per capita. The



RT expressed the pressure of obtaining funding for a training course which addresses both the requirements set by the funder and also meets the needs of the service users:

RT: *There's a standard protocol to get funding from the training division. . .we design a training programme specification to be able to achieve that funding. But it's all about work, it's all to get people back to work . . . Even though, in truth that is a very large ask for people who either live in institutions or are very heavily medicated, and you know, coming here is an enormous achievement.*

Further evidence of funding pressure upon another training course run by the same organisation, for service users unlikely to ever return to work also arose in the discussion: "It is the only programme that's funded directly from hospital funds, which also makes it very precarious since the hospital is closing. And it's been chipped away at." (RT).

There was evidence that communication between the educational and training team and the CRT had begun to be affected due to stress, meaning updates on patient's wellbeing was not being communicated effectively:

RT: *The communication's always been good. Now it's less, its less good. Staff are so stressed in the houses and there's this constant turnaround of staff. . .so while we know some people very well, there are a lot of new people.*

Three participants felt it unlikely that complete recovery or rehabilitation would occur for the majority of service users, meaning an ever increasing volume of users. "It wouldn't happen that often that people would move on. It's more of an ongoing rehabilitation service" (SW). The RT concurred, stating "They would require...that somebody should go on to Level 4 or 5, minimally, or to a job, or to a community employment scheme. . .but very few people actually do that". The SW confirmed the impact of this upon waiting lists "There is. . .a backlog on the waiting list . . . I don't actually know how long the waiting list is to be honest, but you would be waiting a while I suppose."

## **CHAPTER 5: DISCUSSION**

### **5.1 Introduction**

The primary aim of this research was to explore the place, if any, that psychotherapy could have within the treatment of schizophrenia in Ireland, with a focus on CRT's in the mental health service which were established in order to provide comprehensive multi-disciplinary care. To achieve this, members of a CRT team and a training and education organisation who work to rehabilitate service users were interviewed to elicit opinions on the use of psychotherapy. A thematic analysis was applied to the narratives of the four participants, from which emerged three distinct superordinate themes which will now be subjected to a critical evaluation.

### **5.2 What is psychotherapy?**

Like anything else, knowledge varies in accordance to exposure to the subject matter.

Following this principle, the findings suggest that there are none or very few psychological interventions currently occurring within the Irish mental health service. This should not come as a surprise; A Vision for Change itself stated the need to include talk therapies and subsequent publications continue to list it as an objective, rather than achieved. Particularly notable was that neither participant in the CRT team, a facility set up and funded through the HSE with the specific aim of providing multi-discipline, holistic care, could clearly articulate thoughts to define “psychotherapy” and consequently neither expressed an awareness of the unsuitability of some approaches for a person with schizophrenia owing to the potential for harm as initially highlighted by Jung (Willick, 2001).

Furthermore, the loose language used to describe the discipline made some distinction between exploratory and supportive, which may possibly refer to characteristics of the psychodynamic and humanistic approaches. It is difficult, however, to be confident that should psychotherapy become available within the service, that these participants would be able to ensure referrals were made to an appropriate approach. Ensuring the suitability of an approach to meet the individual needs of a service user is especially significant for those with schizophrenia as identified by Asen (2002) and Lysaker and Roe (2012). Short term therapies fared slightly better; however the OT's exposure to CBT could be just as likely to stem from previous experience of working in the NHS in the UK as in Ireland, and other references to CAT and DBT therapies within the Irish service were fleeting and not expanded upon in any meaningful way. As outlined by O'Brien (2001) there is a need for mental health staff to be educated in at least the basic concepts and skills of the approaches within psychotherapy to ensure the responsibility of providing accurate continuity of care is achieved (p.184).

There seems a small irony that more knowledge of individual service users' psychological needs can found within a non-government run training and educational team. Yes, the team provides services to mental health service users, but both participants had awareness of the potential for harm in applying psychoanalytic and psychodynamic techniques to people with schizophrenia and the need for training and awareness. This is to be expected in terms of the PSY, whose knowledge will originate from her own educational training. In terms of the RT, perhaps this can be accounted for by the length of her experience in her role, meaning greater exposure to opinions in the mental health sector. The anecdotal evidence provided of psychiatrics 'fear' provides insight into her experience of what may be occurring at the very top, confirming that psychiatrists may still be keen to

avoid being associated with the ‘outdated’ psychoanalytic techniques, and confirming the view that they would rather remain with the security of the current tried and tested psychiatric model, as highlighted by Strass (2000).

These findings highlight that educational training in the at least the different mainstream approaches within the discipline of psychotherapy is required within the mental health service before the integration of psychotherapy is established, to ensure referrals are made to appropriate treatments, particularly with schizophrenia. Some reference was made to this is A Vision for Change in its recommendation that three different types of psychotherapy should be offered to suit a range of service users’ needs, however, without the prior educating of the team, there seems little point providing these. Information regarding any plans in place for this education at present was not identified.

### **5.3 The Missing Piece in the Jigsaw of Recovery**

Psychotherapy is currently a missing component in the multi-disciplinary approach in Ireland. These findings confirm the statement in A Vision for Change which expresses that service users and staff alike have expressed a need for it alongside other disciplines. Also confirmed is the opinion that a multi-disciplinary approach is believed to be the most effective method of treatment for people with severe mental health conditions, including schizophrenia, as outlined in the publications by WHO (2001) and NICE (2010). All participants believed from their own experience of working with service users that psychotherapy could offer some value, contradicting the historical need for evidence of a measurable change as the ‘gold standard’ to provide justification, and confirming that a comprehensive holistic model of care is required, of which psychotherapy is a part (Carr, 2008; Pfammatter et al. 2006 ). Equally, all participants experienced the value of the

therapeutic relationship with service users and in the case of the SW, working with families too. This confirms not only that care should be person-centered but also that the involvement of a service user's family as an integral part of treatment can aid recovery and wellbeing (Burne Lynch, 2008; Zygmunt et al. 2002).

Differences again arose between participants in relation to whether there were any psychological interventions available at all to service users. The term "aspirational", used by the PSY to describe the recommendations in a Vision for Change created an image of something ideal; promised but not yet realised. Likewise, the SW had no experience of either working with or referring on to any sort of psychological intervention and her lack of awareness of any referral process would suggest there is no easily accessible path. In contrast, the OT expressed that she regularly recommended, referred or provided information for service users to access counselling in community centres where she believed that 'ongoing' psychotherapy would be provided. This contrasts with the detail provided in HSE National Vision for Change Working Group (2012) publication which outlines psychotherapeutic treatments are still to be realised. There appear to be two possibilities here. Either counselling is being accessed in primary care via GP referral as identified by the PSY, or there is the possibility that some individual HSE mental health sectors have set up their own counselling services in the struggle to meet the needs of service users as outlined in the above publication.

All participants believed in the value of a person exploring their experience and that, with appropriate precautions, this could only be a positive step, confirming views by Burne Lynch (2008); Lysaker et al. (2010); Read and Ross (2003) and Strass (2000) that exploring the service user's subjective experience of both living with schizophrenia and previous

psychological traumas is a necessary and important part of recovery. The lack of an appropriate facility for such exploration fuelled frustration mixed with compassion for service users who have such a condition as schizophrenia and who are advised to “speak to the nurses” or merely placed straight onto medication. Furthermore, and possibly more significantly in terms of maintaining wellbeing, there is a view that the lack of this service could impact directly upon the relapse rate in schizophrenia, although this finding is not supported by Zygmunt et al. (2002) who states that the provision of psycho-education and family support are key to maintaining compliance.

#### **5.4 Change in Ireland**

Some of the biggest obstacles to the implementation of psychotherapy in Ireland were found to exist in factors both internally and externally to the service. For example, the anticipated culture change within the service was experienced from two polar opposite viewpoints within the two teams. Members of the CRT firmly believed in a movement towards a complete culture change, with their roles operating within a model of holistic care which provided a big shift away from the previous medical model. The training and education team, however, experienced a shift away from this, with an increased focus on the ‘assess-diagnose-treat’ model of care. Reasons for this division may possibly be linked firstly to a change the Irish education of mental health care occupations, and certainly through the gradual implementation of A Vision for Change within Ireland, as a part of the overall global shift towards holistic care. Participants from the training and education team, however, were able to provide an external perspective backed up by greater experience when making their assessment of the culture change. Certainly, both the OT and RT experienced that obstacles to a complete culture often lay in mental health professionals’ personal biases, confirming the views of Strass (2000) and Willick (2001) that psychiatry does not favour the

application of new concepts within its discipline or wish to commence integration with psychotherapy.

Finally, the economy in Ireland currently poses the biggest problem to the integration of psychotherapy in the mental health service. A Vision for Change was published at a time when both national prosperity and resources were high. Less than two years later, the economy fell in to a depression which has yet to be stabilised, affecting the annual funding into the service. As a result of this the proposed implementation of A Vision for Change has not progressed as hoped. This has led to enormous disruption in the service manifesting in a lack of unity in sectors across the nation and ad-hoc changes being made when absolutely necessary (HSE National Vision for Change Working Group, 2012). Findings confirmed this disruption within the service. Both participants from the CRT team described their struggle to manage their time to meet the needs of each service user, due to the size of the catchment area. There is a backlog of people waiting to use the service and an accumulating number of service users who never leave the service. Communication breakdown is occurring between teams due to 'stressed' nursing staff who do not have the time to pick up the telephone to provide updates on the wellbeing of service users. This echoes the warnings of Cullion (2009), painting a picture of a system under strain which may well continue to deteriorate as the socioeconomic status of the population worsens, triggering a cycle of decline in which more people are diagnosed with schizophrenia which in turn places further strain on the Irish economy,

## **SECTION 6: CONCLUSION AND RECOMMENDATIONS**

In conclusion, this study has found evidence that mental health professionals perceive that the inclusion of psychotherapy within the holistic, multi-discipline treatment of care would primarily be of benefit to the service user. The application of this would provide service users with an avenue for self-exploration of their unique life experience, should they wish to pursue this, broadening the current model of care into one which is truly holistic. Overall, this study has reflected much of the literature on the integration of the approaches and provides an important consideration of this within the current Irish context.

### **6.1 Recommendations:**

Recommendations are made as follows:

- Education and assessment training in differing approaches in psychotherapy should be offered to all mental health rehabilitation professionals, with a focus on accurate assessment of service users' needs to ensure these are matched to an appropriate intervention
- Access to any existing psychotherapy services to be made more transparent, with clear guidelines as to whether these are available through primary care or alternative services
- Access to either individual psychotherapy or as part of a multi-disciplinary approach should be provided for the rehabilitation of service users with schizophrenia, particularly in this time of economic uncertainty

### **6.2 Areas for Future Research**

Further research should continue in the following areas:



- Adaptation of the psychodynamic and psychoanalytic approaches to an integrative model in the treatment of schizophrenia. Currently there is a significant amount of conflicting evidence in the efficacy of these approaches which is inadequate to facilitate their promotion in their traditional, pure form.

### **6.3 Strengths and Weaknesses**

One major limitation of this study lies in the sample. Although two separate teams working in rehabilitation services were interviewed, both were located in Dublin and so therefore are not representative of the other mental health regions within Ireland owing to differences in population and services available in catchment areas. It would therefore be difficult to generalise these findings across the nation. The study does however provide a solid base for understanding the current economical difficulties Ireland is facing which are largely concentrated in Dublin. Furthermore, a consideration of the possible influence of the author's biases upon the data is necessary, as outlined by McLeod (2003).

## REFERENCES

- Asen, E. (2002). Outcome research in family therapy. *Advances in Psychiatric Treatment* , 8, 230-238.
- Bachmann, S., Resch, F., & Mundt, C. (2003). Psychological Treatments for Psychosis: History and Overview. , 31(1), 155-176. *Journal Of The American Academy Of Psychoanalysis* , 31 (1), 155-176.
- Bateson, G., Jackson, D., Haley, J., & Weakland, J. (1956). Toward a theory of schizophrenia. *Behavioural Science* , 1, 251-264.
- Beck, A. T., Rector, N. A., Stolar, N., & Grant, P. (2009). Beck comes full circle: A review of schizophrenia: cognitive theory, research, and therapy. *Cognitive Behavioral Therapy Book Reviews* , 5 (4), 1-4.
- Behan, C., Kennelly, B., & O'Callaghan, E. (2008). The economic cost of schizophrenia in Ireland: a cost of illness study. *Irish Journal of Psychological Medicine* , 25, 80-87.
- Brenner, H. D., & Pfammatter, M. (2000). Psychological therapy in schizophrenia: what is the evidence? *Acta Psychiatrica Scandinavica* , 102, 74-77.
- Burne Lynch, A. (2008). Talking about Talking Therapies: Psychotherapy & Psychosis. *Schizophrenia Ireland* , 5-8.
- Butcher, J. N., Mineka, S., Hooley, J. M., & Carson, R. C. (2004). *Abnormal Psychology*. Boston: Allyn and Bacon.
- Carr, A. (2008). Psychotherapy: Evidence for its value in recovery from schizophrenia. *Talking about Talking Therapies: Psychotherapy & Psychosis* , 22-26.
- Cathera, C., Pennb, D., Ottoa, M. W., Yovela, I., Mueserc, K. T., & Goffa, D. C. (2005). A pilot study of functional Cognitive Behavioral Therapy (fCBT) for schizophrenia. *Schizophrenia Research* , 74, 201-209.

- Culliton, G. ( 2009, April 21). *The economic costs of mental illness in Ireland*. Retrieved April 21, 2012, from Irish Medical Times:  
<http://www.imt.ie/opinion/guests/2009/04/the-economic-costs-of-mental-illness-in-ireland.html>
- Department of Health and Children. (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: The Stationary Office.
- Department of Health and Children. (2012). *Future health: A strategic framework for reform of the health service 2012-2015*. Dublin : Department of Health.
- Deutsch, A. (1948). *The Shame of the States*. New York: Harcourt, Brace.
- Eecke, W. (2003). The Role of Psychoanalytic Theory and Practice in Understanding and Treating Schizophrenia: A Rejoinder to the PORT Report's Condemnation of Psychoanalysis. *Journal Of The American Academy Of Psychoanalysis* , 31 (1), 11-29.
- Fairweather, G. W., Simon, R., Gebhard, M. E., Weingarten, E., Holland, J. L., Sanders, R. ..., et al. (1960). Relative effectiveness of psychotherapeutic programs: A multicriteria comparison of four programs for three different patient groups. ,74(5, Whole. *Psychological Monographs: General and Applied* , 74 (5), 1-26.
- Fenton, W. S. (2000). Evolving Perspectives on Individual Initiatives for Schizophrenia. *Schizophrenia Bulletin* , 26 (1), 47-68.
- Fleck, S. (1960). Family dynamics and origin of schizophrenia. *Psychosomatic Medicine* , 22 (5), 333-344.
- Fonagy, P. (2000). The outcome of psychoanalysis: The hope of a future. *The Psychologist* , 13 (12), 620-623.
- Frazee, H. E. (1953). Children who later became schizophrenic. *Smith College Studies in Social Work* , 23, 125-149.
- Freud, S. (1924). Neurosis and psychosis. *Standard Edition* , 19, 149-153.

- Freud, S. (1914). On narcissism: An introduction. *Standard Edition* , 14 (67), 102.
- Freud, S. (1911). Psycho-analytic notes on an autobiographical account of a case of paranoia (dementia paranoides). *Standard edition* , 12 (1).
- Freud, S. (1924). The loss of reality in neurosis and psychosis. *Standard Edition* , 19, 183-187.
- Fromm-Reichmann, F. (1948). Notes on the development of treatment of schizophrenics by psychoanalytic psychotherapy. *Psychiatry* , 11 (3), 263-273.
- Fromm-Reichmann, F. (1950). *Principles of Intensive Psychotherapy*. Chicago: University of Chicago Press.
- Fromm-Reichmann, F. (1954). Psychotherapy of schizophrenia. *American Journal of Psychiatry* , 111, 410-419.
- Gabbard, G. O. (2005). *Psychodynamic Psychiatry in Clinical Practice*. Arlington: American Psychiatric Publishing.
- Gendlin, E. T. (1962). Client-centered developments and work with schizophrenics. *Journal of Counseling Psychology* , 9 (3), 205-212.
- Grinspoon, L., Ewalt, J. R., & Shader, R. I. (1972). *Schizophrenia: Pharmacotherapy and Psychotherapy*. Baltimore: Williams & Wilkins Company.
- HSE National Vision for Change Working Group. (2012). *Advancing community mental health services in Ireland: Guidance papers*. Dublin : Heath Service Executive.
- Karon, B. P., & VandenBos, G. R. (1970). Experience, medication, and the effectiveness of psychotherapy with schizophrenics: A note on Drs. May and Tuma's conclusions. *British Journal of Psychiatry* , 116, 427-428.
- Karon, B. P., & VandenBos, G. R. (1981). *Psychotherapy of schizophrenia: The treatment of choice*. New York: Jason Aronson.

- Karon, B. P., & VandenBos, G. R. (1981). *Psychotherapy of Schizophrenia: The Treatment of Choice*. New York: Jaxon Aronson.
- Karon, B. P., & VandenBos, G. R. (1972). The consequences of psychotherapy for schizophrenic patients. *Psychotherapy: Theory, Research, and Practice* , 9, 111-120.
- Karon, B., & O'Grady, B. (1969). Intellectual test changes in schizophrenic patients in the first six months of treatment. 6:88-96. *Psychotherapy: Theory, Research and Practice* , 6, 88-96.
- Kelly, B. D. (2004). Mental Health Policy in Ireland 1984-2004 : theory, overview and future directions. *The Irish Journal of Psychological Medicine* , 21 (2), 61-68.
- Knight, R. P. (1946). Psychotherapy of an adolescent catatonic schizophrenic with mutism. *Psychiatry* , 9, 323-339.
- Kohut, H., & Seitz, P. F. (1963). Concepts and theories of psychoanalysis. *Concepts of personality* , 113-141.
- Lehman, A. F., & Steinwachs, D. M. (1998). Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations.1998. *Schizophrenia Bulletin* , 24 (1), 1-10.
- Lewis, S., TARRIER, N., & Haddock, G. (2002). Randomised controlled trial of cognitive-behavioural therapy in early schizophrenia: acute-phase outcomes. *British Journal of Psychiatry Supplement* , 43, 91-97.
- Lidz, T., Parker, B., & Cornelison, A. (1956). The role of the father in the family environment of the schizophrenic patient. *The American Journal of Psychiatry* , 113, 129-132.
- Lysaker, P. H., & Roe, D. (2012). The processes of recovery from schizophrenia: The emergent role of integrative psychotherapy, recent developments and new directions. *Journal of Psychotherapy Intergration* , 22 (4), 287-279.

- Lysaker, P. H., Glenn, S. M., Wilkniss, S. M., & Silverstein, S. M. (2010). Psychotherapy and recovery from schizophrenia: A review of potential applications and need for future study. *Psychological Services* , 7 (2), 75-91.
- Lysaker, P. H., Roe, D., & Kukla, M. (2012). Psychotherapy and rehabilitation for schizophrenia: Thoughts about their parallel development and potential integration. *Journal of Psychotherapy Integration* , 22 (4), 344-355.
- Malmberg, L., Fenton, M., & Rathbone, J. (2001). Individual psychodynamic psychotherapy and psychoanalysis for schizophrenia and severe mental illness. *Cochrane Database of Systematic Reviews* (3).
- May, P. R. (1968). *Treatment of schizophrenia: A comparative study of five treatment methods*. New York: Science House.
- McLeod, J. (2003). *Doing Counselling in Research*. London: SAGE Publications Ltd.
- Mintz, R. (2010, April). *Introduction to conducting qualitative research*. Retrieved April 21, 2013, from British Association for Counselling and Psychotherapy: [www.bacp.co.uk](http://www.bacp.co.uk)
- Myrman, A., Rantakallio, P., Isohanni, M., Jones, P., & Partanen, U. (1996). Unwantedness of a pregnancy and schizophrenia in the child. *British Journal of Psychiatry* , 637-640.
- National Institute for Health and Clinical Excellence (NICE). (2010). *The NICE guidelines on core interventions in the treatment and management of schizophrenia in adults in primary and secondary care*. Leicester: The British Psychological Society.
- NHS Choices. (2012, September 17). Retrieved April 16, 2013, from NHS: <http://www.nhs.uk/Conditions/Schizophrenia/Pages/Introduction.aspx>
- O'Brien, L. (2001). The relationship between community psychiatric nurses and clients with severe and persistent mental illness: The client's experience. *Australian and New Zealand Journal of Mental Health Nursing* , 10, 176-186.

- Pfammatter, M., Junghan, U., & Brenner, H. (2006). Efficacy of psychological therapy in schizophrenia: Conclusions from meta-analyses. *Schizophrenia Bulletin* , 32, 564-580.
- Read, J., & Ross, C. A. (2003). Psychological Trauma and Psychosis: Another Reason why People Diagnosed Schizophrenic must be Offered Psychological Therapies. *Journal of the American Academy of Psychoanalysis* , 31 (1), 247.
- Rogers, C. R., Gendlin, E. G., Kiesler, D. J., & Truax, C. B. (1967). *The therapeutic relationship and its impact: Study of psychotherapy with schizophrenics*. Madison: The University of Wisconsin Press.
- Saraceno, B., Levav, I., & Koh, R. (2005). The public mental health significance of research on socio-economic factors in schizophrenia and major depression. *World Psychiatry* , 4 (3), 181-185.
- Searles, H. (1965). *Collected papers of schizophrenia and related subjects*. New York: International Universities Press.
- Seeman, J., Rogers, C., & Dymond, R. F. (1954). Counselor judgments of therapeutic process and outcome. *Psychotherapy and personality change* , 99-108.
- Sensky, T., Turkington, D., & Kingdon, D. (2000). A randomized controlled trial of cognitive-behavioral therapy for persistent symptoms in schizophrenia resistant to medication. *Arch Gen Psychiatry* , 57, 165-172.
- Silver, A.-L. S. (2003). The Psychotherapy of Schizophrenia: Its Place in the Modern World. *Journal of the American Academy of Psychoanalysis* , 31 (2), 325.
- Stanton, A. H., Gunderson, J. G., Knapp, P. H., Frank, A. F., Vannicelli, M. L., Schnitzer, R., et al. (1984). Effects of psychotherapy in schizophrenia: I. Design and implementation of a controlled study. *Schizophrenia Bulletin* , 10, 520-563.
- Stone, M. H. (1999). The history of the psychoanalytic treatment of schizophrenia. *Journal of The American Academy of Psychoanalysis* , 27, 583-601.

- Strass, J. (2000). The interactive model revisited. *Acta Psychiatrica Scandinavica (Suppl.407)* , 102, 19-25.
- Sullivan, H. S. (1962). *Schizophrenia as a human process*. New York: Norton.
- Tienari, P. (1991). Interaction between genetic vulnerability and family environment; the Finnish adoptive family study of schizophrenia. *Acta Psychiatrica Scandinavica* , 84 (5), 460–465.
- Vaughn, C., & Leff, J. (1976). The Measurement of Expressed Emotion in the Families of Psychiatric Patients. *British Journal of Social and Clinical Psychology* , 15 (2), 157–165.
- Walker, E., & Diforio, D. (1997). Schizophrenia: A neural diathesis-stress model. *Psychoanalytic Review* , 104, 667-685.
- Willick, M. S. (2001). Psychoanalysis and schizophrenia: A cautionary tale. *Journal of the American Psychoanalytic Association* , 49 (1), 27-30.
- Wolman, B. B. (1965). Family dynamics and schizophrenia. *Journal of health and human behavior* , 6 (3), 139-169.
- World Health Organization. (2001). *The World Health Report 2001: Mental Health: New Understanding, New Hope* . Geneva: World Health Organization.
- Zubin, J., & Spring, B. (1977). Vulnerability—A new view of schizophrenia,. *Journal of Abnormal Psychology* , 86, 103-126.
- Zygmunt, A., Olfson, M., & Boyer, C. A. (2002). Interventions to improve medication adherence in schizophrenia. *American Journal of Psychiatry* , 159, 1653-1664.



## APPENDICES

### Appendix 1: Information Letter



#### INFORMATION FORM

My name is Elizabeth Cardus and I am currently undertaking a BA in Counselling and Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is concerned with the rehabilitation of people diagnosed with Schizophrenia and the type of interventions and supports that are available for them. I will be exploring the views of people like yourself who work directly with individuals diagnosed with Schizophrenia and those involved in setting up and running rehabilitation care plans in the use of interventions as a treatment method

#### What is Involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, being a member of a community rehabilitation team and/or involved in rehabilitative training. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience which should take no longer than an hour to complete. During this I will ask you a series of 10-15 questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

#### Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

#### DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research. I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) \_\_\_\_\_

Signature \_\_\_\_\_

Date    /    /

If you have questions regarding your rights as a participant in this research, please contact Siobáin O'Donnell, Academic Co-ordinator, BACAP, School of Arts, Dublin Business School.

## Appendix 2: Question List

Elizabeth Cardus  
BA in Counselling and Psychotherapy  
Dublin Business School

### Research questions:

1. Can you tell me a little about your role in the rehabilitation team:
  - a. What are your key tasks/responsibilities?
  - b. What was your experience like previous to this job - has it always been within mental health?
2. What happens when someone diagnosed with Schizophrenia presents to the services - could you talk me through the steps involved.
  - a. At what stage do you get involved?
3. Could you describe the process involved in deciding upon a care plan or intervention for a patient diagnosed with Schizophrenia
  - a. what is your role in this?
4. What are the factors involved in deciding upon an intervention?
5. How are these interventions monitored or is there ever a decision made to alter or change them?
  - a. What influences these decisions?
6. Could you describe some of the psychological supports that are in place for patients diagnosed with Schizophrenia in the service?
  - a. How do patients access these?
7. A Vision for Change makes recommendations for the inclusion of psychotherapy when seeking to work with mental illness – is this something that is evident in your experience when working with Schizophrenia?
  - a. If no, then does this have an impact upon patients?
8. In your opinion, what is the efficacy of psychological interventions being used to treat patients diagnosed with Schizophrenia?
9. Would you have any causes for concern regarding the use of psychological interventions diagnosed with Schizophrenia?
10. Do you deliver WRAP and how effective do you find it as a tool?
11. If you could make any changes to your role or the service that is provided to these patients what would it be?
12. On a personal level, are there any particular difficulties you experience with this type of work?
  - a. How do you manage these?
13. Is there anything else you feel is relevant to tell me?

## Appendix 3: Informed Consent Form



### CONSENT FORM

**Protocol Title:**

AN EXPLORATION OF THE PLACE OF PSYCHOTHERAPY IN THE TREATMENT OF SCHIZOPHRENIA IN IRELAND

**Please tick the appropriate answer.**

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

Yes No

I understand that my participation in this study is entirely voluntary and that I may withdraw at any time, without giving reason.

Yes No

I understand that my identity will remain confidential at all times.

Yes No

I am aware of the potential risks of this research study.

Yes No

I am aware that audio recordings will be made of sessions.

Yes No

I have been given a copy of the Information Leaflet and this Consent form for my records.

Yes No

Participant \_\_\_\_\_  
Signature and dated

\_\_\_\_\_  
Name in block capitals

**To be completed by the Principal Investigator or his nominee.**

I the undersigned, have taken the time to fully explained to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/hers to ask questions on any aspect of the study that concerned them.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name in Block Capitals

\_\_\_\_\_  
Date

## Appendix 4: DSM-IV-TR Criteria for the Diagnosis of Schizophrenia

- A. *Characteristic symptoms:* Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
1. delusions
  2. hallucinations
  3. disorganized speech (e.g., frequent derailment or incoherence)
  4. grossly disorganized or catatonic behavior
  5. negative symptoms, i.e., affective flattening, alogia [little speech, or little substance of ideas contained in speech], or avolition [deficient or absence of “will”]

*Note:* Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

- B. *Social/occupational dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).
- C. *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
- D. *Schizoaffective and Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.
- E. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiologic effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
- F. *Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

*Source:* Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. Copyright 1994 American Psychiatric Association.

(Butcher, Mineka, Hooley, & Carson, 2004)