

A Psychotherapeutic Exploration of the Treatment of Schizophrenia in Ireland.

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ABSTRACT

The purpose of this research is to explore the place if any, of psychotherapy in the treatment of schizophrenia within the mental health services. Firstly, this study aims to understand the participant's perspective of their role in the assessment and process of treating schizophrenia. This study will attempt to explore the professional's opinion of psychotherapy as a form of treatment of schizophrenia. The health professionals understanding of the experience of schizophrenia from their patient's perspective will be examined. Finally, this study endeavours to understand the reasons behind the advancement or lack of advancement in the use of psychotherapy in the process of treating a diagnosis of schizophrenia. The main sources of experience and opinion will be gathered from six mental health professionals actively working within the mental health services. The aims of this study requires a research strategy within the qualitative paradigm. Semi-structured interviews will be used to carry out data collection, followed by the use of thematic analysis to analyse the data. The findings will provide an insight into this area of research from an Irish context. This research endeavours to gain greater insight into the reasons behind the mental health services hesitation to fully embrace psychotherapy as a form of treatment in the patient's recovery. It is hoped that the mental health professional's perspectives will provide in-depth insight into the process of treatment thus far and the future psychotherapy may have in the process of recovery.

CHAPTER ONE: INTRODUCTION

Schizophrenia is a disorder of thinking where a person's ability to recognise reality, his or her emotional responses, thinking processes, judgment and ability to communicate deteriorates so much that his or her functioning is seriously impaired. Symptoms such as hallucinations and delusions are common (Warner, 1994, p.4). The World Health Organisation defines health as a "state of complete, physical, mental, and social wellbeing and not merely an absence of disease and infirmity" (WHO, 1995 as cited in World Federation for Mental Health, 2014, P.12). This statement emphasizes the point that mental health is an inseparable part of a person's holistic well-being. This concern is grounded by the fact that psychiatry has focused on illness as opposed to well-being and good functioning (Cooke, 2014). Despite the fact the people with Schizophrenia are all around us (One in one hundred are affected worldwide) the illness is often misunderstood and people with schizophrenia are often stigmatised by both the medical profession and the public (Andreasen, 1999, P. 645).

In a short paper, "*Fear of Insanity*", Roger Money-Kyrle (1969), called attention to the significant fact that "most people fear contact with the insane" (p.434). He believes that this is the underlying reason, to why there has always been a tendency, among both ordinary people and mental health professionals to keep insanity out of mind and out of sight. Money-Kyrle (1969), also suggests that the suffering patient, too, cannot bear much contact with his state, a state whose transformations are mostly in the zones of hatred and destruction (Evans, 2016, p.xxi). This parallel distancing of the patient and staff from contact with madness serves the objectifying and rigid principles of the medical approach to diagnosis and treatment. To an extent the Irish mental health services collude with the patient in taking up the position of the master discourse via the medical model and through the consultant psychiatrist and other members of the multi-disciplinary team. The mental health professionals are placed in the position of 'subject supposed to know' and to give into the patient's desires relinquishes the

important content of the unconscious. Services operating from a fixed general knowledge base, opt to manage symptoms instead of relationships. The master discourse has many consequences with it; the notion of a “service” brings with it an expectation that it comes with a guarantee and that there is no limit to the responsibility of the consultant psychiatrist. Psychiatry is frequently very acute, and more often than not it is easier to give in to the desire of the patient to be lead, and the utilisation by professionals of the University and Master discourses further strengthens the medical approach to treatment. This suggests that the mental health services as a whole or as Campbell (2006), refers to it as the ‘enterprise’, becomes dangerously close to functioning at an entirely imaginary level, answering only demand.

It seems that the closure of the institutions across Ireland have put more emphasis on the importance of the relationship between the staff and patient. The mental health professionals in their various capacities in the community, have replaced the concrete container of the asylum walls. In his book *“Making Room for Madness in Mental Health”*, Evans (2016), suggests that staff and patients would benefit not from psychoanalysis as a treatment but, from having a psychoanalytic understanding of psychotic communication. Evans (2016), postulates that the influence of the institute has developed an overly defensive organisational structure to avoid anxiety rather than allow both staff and patients the space to think and feel (p.10). Medication plays a pivotal role in the treatment process of the schizophrenic patient, however, it is the ‘tool’ which maintains the distance between the patient and staff and also disavows the patients experience or ability to find truth in their symptoms. Through these claims it seems sufficient to suggest that there is inevitably a place for psychotherapy as a treatment intervention for schizophrenia.

The overall aim of this research primarily, is to distinguish if psychotherapy holds a position in the treatment process of a diagnosis of schizophrenia. This will be deciphered from the

perceptions and opinions of individuals working within the mental health services in Ireland focusing on the following areas:

- Exploring the nature of the participant's experience of working with schizophrenia through the lenses of their respective professions.
- Investigating the participant's opinion of the diagnostic and treatment process of schizophrenia, and their role within this context.
- Examining what specific psychological interventions are in place for the treatment of schizophrenia.
- Exploring the participant's perceptions of the use and efficacy of psychological interventions in the treatment of schizophrenia.

CHAPTER TWO: LITERATURE REVIEW

2.1 Schizophrenia

2.1.1 Prevalence and Symptoms

Throughout history, there has been incidence of schizophrenia, roughly one percent of the population, consistently, in every culture (Peuskens, et al, 2001; McWilliam, 2002). Schizophrenia is currently conceptualised as a recurrent episodic psychotic disorder characterised by positive and negative symptoms and disorganisation (American Psychiatric Association, 2000; World Health Organization, 1992). Delusions and hallucinations are the main positive symptoms of schizophrenia and negative symptoms include poverty of speech, flat affect, and passivity. While genetic and neurodevelopmental factors associated with pre- and perinatal adversity play a central role in the aetiology of schizophrenia, its course is affected by exposure to intra- and extra-familial support and stress, individual and family coping strategies, and medication adherence (Kuipers et al., 2006; Walker, 2004). A high proportion of research around understanding schizophrenia is both biologically and genetically informed (Gottesmann 1991). Tsuang et al. (2001) argues that there is a substantial genetic component in schizophrenia. There is a wide acceptance of the idea that a diagnosis such as schizophrenia being referred to as biological illnesses has led to people often assuming that the experience of hearing voices always arises from problems with brain function. As a consequence of this belief the majority of mental health professionals have often not tried to understand the experience in the context of the person's life. This belief has also contributed to a climate in which the main, or only treatment is medication (Cooke, 2014, P. 41).

2.1.2 What is schizophrenia?

Schizophrenia is derived from two words: '*schizo*'; which means to tear or to split and '*phren*' which signifies; 'intellect' or 'the mind'. Thus the word schizophrenia literally means the splitting or tearing of the patient's mind and emotional stability, by its selection Bleuler was highlighting the obvious associated fragmentation. (Madux and Winstead, 2009, p.200). Emil Kraepelin (1856-1926) is best known for his description of what we now regard as schizophrenia; Kraepelin used the Latin version of Morel's term "dementia praecox" to refer to a group of conditions that seemed to feature mental deterioration beginning early in life. Kraepelin stated that the disorder was characterised by hallucinations, apathy and indifference, withdrawn behaviour, and an incapacity for regular work (Butcher, et al., 2015, P.315). Unlike Kraepelin, Bleuler was an 'empathetic and workaholic clinician' who 'spent many hours getting to know his patients, and struggled to understand their inner life (Bentall, 2009, p.93). Bleuler used the term schizophrenia because he believed that the condition was characterised primarily by disorganisation of thought process, a lack of coherence between thought and emotion, and an inward orientation away (spilt off) from reality. Bleuler also contested that in schizophrenia there is a split within the intellect, between the intellect and emotion, and between the intellect and external reality (Butcher et al., 2015).

A crucial question posed in both Bleuler and Kraepelin's time and currently, is whether treatments for schizophrenia are best determined as attempts to 'cure' an illness or attempts to suppress socially unacceptable behaviour. Kraepelin (1913; 1919) devotes less than five pages of his three hundred pages on '*How to combat it*'. "*The patients do not remain in the bath, but always jump out again, perform neck breaking gymnastics, roll about on the floor.*" "*The next thing now to be tried is to quiet the patients so far by a sedative, Nyoscine, Sulphonal, Trional, Veronal, that he may remain some hours in the bath.*" (Kraepelin, 1913; 1919: 257; as cited in Read & Dillon, 2013, p.31). At that point in the history of schizophrenia the use of drugs was

not viewed as a medical treatment. It was acknowledged by both Bleuler and Kraepelin that the drugs were to tranquillise or to get patients to do as they were told. Bleuler claimed that a cure for schizophrenia did not exist and the use of drugs was for sedation as oppose to treatment (Read & Dillion, 2013, p.32).

2.1.3 Pharmacological Treatment

The primary initial treatment for a diagnosis of schizophrenia is pharmacological. The common property that all anti-psychotic medications share is their ability to block dopamine D2 receptors in the brain (Seeman, 2011, cited in Butcher et al., 2015, P. 346). Typical anti-psychotic medications such as chlorpromazine and haloperidol were among the first to be used to treat psychotic disorders in the 1950's. The typical antipsychotics are effective in targeting the positive symptoms (quietening voices and diminishing delusional beliefs) of schizophrenia providing patients with clinical improvements (Tandon et al., 2010). However, common side effects of these medications include drowsiness, dry mouth, weight gain and extrapyramidal side effects (EPS) such as involuntary movement abnormalities that resemble Parkinson's disease (Butcher et al., 2015, P.346). In the 1980's, second generation antipsychotic medications were developed, the first of these being Clozapine, which is now widely used. These atypical antipsychotics cause fewer extrapyramidal symptoms, despite this drowsiness and considerable weight gain are still common side effects, also in rare cases Clozapine has been linked with causing a drop in white blood cells known as agranulocytosis (Butcher et al., 2015, P.347). Computed Tomography (CT) revealed that patients with a diagnosis of schizophrenia on average had a larger intracranial cerebrospinal fluid (CSF) volumes, including larger lateral ventricles (Johnston et al, 1976 & Reveley et al. 1982) and cortical sulci (Weinberger et al, 1979 & Pfefferbaum et al, 1988, cited in Zipursky et al, 2012, P.1365).

Longitudinal MRI studies have shown that brain tissue volumes decrease and CSF volumes increase over time to a greater degree in patients with schizophrenia than control subjects (Chan et al. 2002; Olabi et al, 2011; Ho et al, 2003, cited in Zipursky, 2012, P.1366). However, compelling evidence now suggests that anti-psychotic medications also play a significant role in relation to “progressive” brain changes. Lieberman et al. (2005), suggests that patients treated with haloperidol for a first episode psychosis (FEP) for two years had worsening deficits in grey matter volume. Ho et al. (2011), have also demonstrated an association between antipsychotic treatment and brain volume reductions in patients ascertained with a first-episode schizophrenia who were scanned longitudinally over an average of 7.2 years. Anti-psychotics were associated with decreases in grey-and white matter volumes with higher doses resulting in greater decreases (Ho et al., 2011). It is crucial to point out that the rejection of schizophrenia as a progressive brain disease does not negate the seriousness and the debilitating problems that many patients with schizophrenia experience. It is important for patients, family members, clinicians and the public more broadly to recognise that the deterioration that many patients experience over the long-term is not an inevitable part of the illness course (Zipursky et al., 2012, P.1368).

2.1.4 Psychoanalytic Theories of Schizophrenia

One of the most traditional methods of classifying mental illness is by dividing it into either neurosis or psychosis (Birchwood & Jackson, 2001). According to Freud one of the features which differentiates a neurosis from psychosis is the fact that in neurosis the ego, in its dependency on reality, suppresses a piece of the id (of instinctual life), whereas in psychosis, this same ego, in the service of the id, withdraws from a piece of reality (Freud, 1924, p.183). From a psychoanalytic perspective the ego, a psychic structure made up of internalised

relationships, comes into existence at the very beginning of life. The ego may be more or less robust, depending on how these relationships are internalised, and this is determined by both constitutional and environmental factors. The term “Psychotic breakdown” is used to describe the traumatic loss of an important internal structure, that of the ego, which either leaves the individual feeling overwhelmed by psychotic anxieties about fragmentation or leads to psychological collapse in the ego’s functioning. The psychotic anxiety resulting from the loss threatens to overwhelm the individual’s ego, and there is a collapse in the ego’s capacity to manage the relationship between internal and external reality (Evans, 2016, p.3). Freud in his paper ‘*On Narcissism*’ (1914), describing the functioning of the ego and focusing on the notion of primary narcissism, identified a distinction between ‘ego-libido’ and ‘object-libido’. He considered schizophrenia through the lens of the libido theory, which identified two primary characteristics; that of megalomania and a withdrawal of the libido from the external world, people and objects, are directed instead towards the ego. (Freud, 1914, p.76-77). Freud suggested that schizophrenia occurs when an individual relinquishes all emotional input in the world and instead internalizes this energy therefore sinking into radical narcissism. (Lysaker, 2008, p. 27).

In psychosis, just as the imaginary is not overwritten by the symbolic, so the drives are never hierarchized in the body except by imitation. Lacan asserts that the body in neurosis, is essentially dead, it is overwritten with signifiers by the symbolic. The body as a biological organism is what Lacan calls the “real”, and it is progressively socialised to such an extent that libido retreats from all but the erogenous zones. Only in these zones is the body still alive, in some sense, or real. It is here that jouissance is channelled and contained. To a degree certain people derive a great deal of pleasure from torturing themselves, from subjecting themselves to painful experiences. This kind of pleasure in pain is referred to as jouissance. This is not the case for the psychotic; the hierarchy of drives achieved imaginarily can collapse when the

imaginary order that supports it falters. The body which has been for the most part rid of jouissance, is suddenly inundated with it and the psychotic may experience it as an attack, an invasion, or forcible entry (Fink, 1999, p. 97). In psychosis according to Lacan, there is no recognition of the father as the one who bears the “phallus”, is the “Law”, and gives meaning to the dynamic instinctual sexual relations that take place within the family setting. When there is foreclosure of “*The-Name-Of-The-Father*”, there is a break in the signifying chain of the symbolic order, and this produces a “gap” or “hole” which the psychotic attempts to fill with delusional formations. He is immersed in the imaginary world of relations with those around him, particularly in relation to sexual desires which are not regulated or restrained by “*The-Name-Of-The-Father*”. The subject has not undergone signification and there is an absence of meaning in their lives (Fink, 1999). According to Lacan there was a completely different structure at play in psychosis, where foreclosure of “*The-Name-of-the-Father*” meant that repression did not take place as it did in neurosis, but rather there was a defiance as to the paternal role (Fink, 1999). Lacan therefore viewed schizophrenia as a foreclosure of this key signifier. (Steinman, 2009, p.201).

Bion (1957) describes the way a split can develop between a psychotic and a non-psychotic part of the mind. The psychotic part hates any knowledge of psychological pain, vulnerability, damage, or weakness and attempts to solve complex emotional problems through concrete physical actions, attacking the non-psychotic part of the mind that is capable of experiencing psychological pain and conflict. The ego’s capacity to perceive and think is attacked, fragmented and projected into the external world. Hence, the patient may feel that the external world contains fragmented elements of their own mind that threatens to violently re-enter their personality (Evans, 2016, p.35). The schizophrenic is governed by terror and a persistent fear of being consumed not only by others, but even by himself (Steinman, 2009, p.200).

From Freud, Lacan and Bion's interpretations of the psychotic experience, it seems that the schizophrenic patient's experience is a relevant piece that is missing in the treatment process. In a sense it seems that if psychiatrists and mental health professionals alike were to delve into the patient's experience and gain a level of understanding of what the patient's concrete actions and thinking is attempting to communicate there may be a possibility of giving meaning to what is perceived as meaningless. The author may suggest that a particular form of psychological treatment and a deeper understanding is needed to meet the therapeutic needs of the schizophrenic patient.

2.1.5 Efficacy of Psychotherapy

In the early twentieth century debates around the treatment of schizophrenia were unfolding in the psychoanalytic world. Due to the nature of libidinous decaathexis and the resulting psychosis Freud asserted that psychoanalysis was not a suitable intervention for schizophrenia owing to the patient's inability to engage in free association or the deep transference relationship required for recovery (Fromm-Reichmann, 1948). In contrast Bleuler recorded his application of psychoanalytic techniques to the patients at the Burgholzli clinic, a psychiatric asylum in Switzerland, to find that not only could patients engage in the transference process, but that discharges subsequently tripled (Silver, 2003, P. 325). Asay (1999) asserts that there has been extensive empirical investigation on outcome arising from counselling and psychotherapy and these findings have broadly identified counselling and psychotherapy to be effective.

Alternative approaches to psychotherapy began to enter the field with the rise of humanistic, systemic and behavioural approaches, none of which focused on a need for regression for recovery. The pioneer of cognitive-behavioural based therapies Aaron Beck primarily used

psychoanalytic techniques but with a focus on the person's rational cognitive functioning, which would be later developed into cognitive therapy and subsequently Cognitive Behavioural Therapy (CBT) (Beck, Rector, Stolar, & Grant, 2009).

The efficacy of traditional psychoanalysis and psychodynamic psychotherapy in the treatment of schizophrenia remains questionable. A comparative study between reality-adaptive supportive (RAS) therapy and exploratory-insight orientated (EIO) therapy found that the psychodynamic approach was inferior in comparison to the reality-adaptive therapy in three out of four outcome criteria; rehospitalisation, vocational outcome, social adjustment and neither approach differed in their impact on symptoms (Gunderson et al., 1984). Strupp et al. (1977), argues that psychotherapy can sometimes lead to deleterious rather than beneficial effects. According to Kernberg (1973), most individuals with a diagnosis of schizophrenia would match the following description of the type of patient who was found to respond poorly to psychoanalysis in the Menninger Foundation Psychotherapy Research Project: "Patients with low initial quality of interpersonal relationships, low initial anxiety tolerance, and low initial motivation" (Kernberg, 1973, P.66). Mueser (1990), suggests that it is possible that therapy that is too emotionally intense and may be harmful for at least some of those diagnosed with schizophrenia (Mueser, 1990, P. 259). Research testing the efficacy of psychotherapy, particularly psychodynamic psychotherapy concludes with conflicting, ambiguous, and inconclusive findings. Lysaker and Roe (2012) suggest that integrative psychotherapy, utilising approaches from psychoanalysis and CBT together, with established practices (i.e. Medication) can improve treatment outcome with a diagnosis of schizophrenia. Zarbo et al. (2016), also advocate for the use of integrative psychotherapy in the treatment of several psychiatric disorders.

2.2 Mental Health Services: The Irish Context

Public health services in Ireland are delivered by the Health Service Executive (HSE) under legislation that is provided in the *Mental Health Act* (Government of Ireland, 2001). The Mental Health Act outlines a structure for the organisation, and management and delivery of services by consultant led mental health teams. Person's presenting to the mental health service are initially assessed over a period of time, followed by diagnosis and treatment under a dominantly medicalised model that commenced with Tuke's work and that became firmly established to the extent that its end is impossible to determine (Foucault, 2006, p.490).

The Irish policy on mental health reform "*A Vision for Change*" acknowledges the shortcomings of the current mental health system during that period, within this document an innovative plan of action was proposed. The report of the expert group reiterates the views expressed in the consultation process with service users, carers and providers as well as proposing 'a person-centred treatment approach' (Government of Ireland, 2006, p.8). Adopting this policy adds to confusion about service philosophy as it contributes to a paradoxical and contradictory approach between the Mental Health Act (Government of Ireland, 2001) and the policy document '*A Vision for Change*', with the former promoting a mainly medicalised approach and largely pharmacological means to addressing treatment and the latter suggesting a person-centred holistic approach. It seems that both the Mental Health Act (2001) and the policy *A Vision for Change* (2006) operate to support social fantasy and ignore social reality.

2.2.1 Medical Model as Master Discourse

Discourse prevents the annihilation of the subject, by fostering desire and keeping jouissance at bay. The desire of the Other, which is unknown, creates anxiety in the subject. Discourse operates as a way of negotiating with the Other, it is an attempt to orientate to the Other's unknown desire. In this manner desire is translated into demand which is negotiable (Loose, 2002). The Master discourse is a desire to master knowledge. The other as slave has to work for the master and produce something for the master to enjoy. In reality the master has no great interest in what the slave produces. His interest is confined to the slave working for the master. However, this appears to be contradictory and, Loose (2002) suggests this 'not wanting to know' is not incommensurable with wanting to master knowledge (p.243). Knowledge is important to the master as it gives him a status allowing him to remain in the master position. *"Not wanting to know is not incommensurable with wanting to master knowledge. What is important to the master is that he possess knowledge so that he can maintain his position in order to master the situation"* (Loose, 2002, p.243).

Through the application of the master discourse to the services via the medical model the mental health professionals can conceptualise the patients' symptoms as a product that fuels and justifies the medicalised approach to diagnosis and treatment within the mental health service. The medicalised approach places the psychiatrist in the position of the master discourse, the 'subject supposed to know'. It may also be argued that in order to augment its status the Master discourse utilises the University discourse (Knowledge), and also holds firmly its place as the discourse of law. In a sense the Mental Health Act (2001a), also informed by the medical model operates as the law and possess the ability to castrate with its statutory power to detain and physically treat patients, this power ultimately displayed in the position of the consultant psychiatrist. The master discourse is structural to the role of the doctor, and is the discourse which shapes the mental health services. The idea that someone is responsible for

alleviating the suffering of others is basic to the whole enterprise (Campbell, 2006) The mental health professional's resistance to relinquishing the position of subject supposed to know is exhibited in the mental health's conscious ego to ego dialogue. It is maintained by the desire in the patient to be lead and the utilisation by professionals of the University and Master discourses which results in scant motivation to change. Campbell suggests that the master discourse is pervasive in Irish society and is paired with a maternalistic attempt to control the actions of every citizen without reference to any symbolic; the very existence of the unconscious is written out of this discourse (2006). This further suggests that the mental health service becomes dangerously close to functioning at an entirely imaginary level, answering only demand.

In a sense Evans (2016) suggests that the application of the medical model and the influence it has on diagnosis and how mental health professionals rigidly observe patients' symptoms creates a distance in the relationship between the patient and the professional to an extent that the illness is the focus and not the subject that experiences it. Symptoms function as attempts at a solution and carry displaced meaning rooted in the formation of the unconscious that requires uncovering and understanding. Psychoanalysis differs from psychiatry as it does not initially seek to remove symptoms. To effect change in symptom formation psychoanalysis enables; "replacement of what is unconscious by what is conscious, the translation of what is unconscious into conscious" (Freud, 1917b, p.435). This occurs through transference management via the discourse of the analyst; a master discourse inhibits this process.

2.3 The institution within the Community

Even though the physical structure of mental health service delivery has changed the mind-set of the institute remains through the guise of the medical model. In a sense the solid walls of

the institutions provided a concrete container for the patient's fragmented minds, keeping their 'out of the ordinary' behaviour out of sight and to a degree out of mind via the use of anti-psychotics (Steiner & Harland, 2011; cited in Evans, 2016 p.4). *"The dynamic processes that go on in institutions at both conscious and unconscious levels of particular significance are the defences developed to deal with anxiety - provoking content and the difficulties in collaborating to accomplish the common task."* *"These defences appear in the structure of the institution itself and permeate its whole way of functioning"* (Menzies Lyth, 1989, p.28).

According to Evans (2016), what appears to have happened and has gone unaddressed is that the relationships between patients and mental health professionals to some extent has changed. Mental health care is delivered through a relationship between a clinician and a patient. Although this therapeutic relationship is of central importance for mental health care, it appears to be relatively neglected in the psychiatric services. The mental health professionals in their various capacities have replaced the asylum and now act as the container of the subjective experiences of the schizophrenic patient. There is a greater level of dependency on the professionals, however this relationship is defined by observational task and ensuring adherence to the medicalised approach to treatment. Hinshelwood (2004) suggests that together staff and patients avoid their fear of madness. This avoidance is based on the attitude that madness comes from intimate emotional contact with others, if anything comes to life in the interaction between people, it will bring madness to life as well (Hinshelwood, 2004, p. 122). Evans (2016) urges that the medication, although central in the treatment of schizophrenia in the acute phase, it does not address the underlying causes of the mental illness and patients need other forms of therapeutic work as part of their treatment.

Freud believed that the unconscious was timeless; although symptoms may seem to disappear, they remain in the unconscious part of the mind and may return from the repressed state at any moment- particularly when the individual is feeling stressed or vulnerable (Evans, 2016, p.59).

Freud (1912) asserts that a service that does not recognise and work with the unconscious generates negative and hostile transference. Transference emerges around something that is repressed and the patient will resist the exposure of the repressed. Freud (1917), construes a system of analysis that enables the patient to reach a point “...where there is nothing we would rather bring about than that the patient should make a decision for himself” (Freud, 1917, p.433). There is a struggle between the staff and the patient which is a reflection of a psychological struggle, between the intellect and the instinct, between understanding and attempting to take action (Freud, 1912, p.108). The mental health services are built on an illusion and operate in the imaginary realm, consequently its staff, to avoid anxiety and psychological vulnerability keep the truth at bay by whatever means. It is through analysis the transference is used to allow truth and recognition of reality to emerge, the opposite of what is applied in current service delivery. In a sense the mental health professionals resist the subject of the unconscious, by remaining in the position of knowing, supporting this with the illusion of treatment that cures, prompted through their University discourse, a manualised understanding of the psyche outlined in the DSM-5 (American Psychiatric Association, 2013). Symptoms have meaning and serve a function for patients; equally the medicalised approach has meaning, giving staff a degree of certainty; however, this sense of certainty in the medical model destroys any sense of meaning;

If the analyst believes in the symptom in the conscious story or narrative or transference to the subject supposed to know, then the analyst will collude with the resistance of the analysand. This is what Lacan called resistance, Lacan believed that ‘there is no other resistance to analysis than that of the analyst himself’.

(Lacan, 1997; cited in Fink, 2007, p.132).

It seems what is being suggested in these texts is that their needs to be a shift from focusing on the symptom from an observational, classifying stance to a greater focus on the patient, the person experiencing the symptom. Lucas (2009a) described psychotic patients as needing an

exoskeleton around them that would help pull them out of their withdrawn, negativistic state and into contact with external reality (Evans, 2016, p.18). It seems that the missing piece in relation to encouraging such a task is the psychotherapeutic encounter the missing block that could bridge the gap for the patient in relation to reading between the lines of their concrete actions and thoughts to find meaning.

The lack of connection between the psychological and medical models continues to distance the space between the patient the mental health professionals. There is a greater demand on mental health professionals outside the walls of the institute and to answer that demand in the position of subject supposed to know further enmeshes the medical and university discourse both within the service but more importantly it relinquishes all responsibility from the patient in an attempt to bypass the failure of the pleasure principle resulting in much *puissance*. It is evident from the literature reviewed that the mental health services lack insight into the experience of the schizophrenic patient and continue to be seduced by the symptom offering concrete medical solutions to suppress not only the patient's anxiety and fear of madness but also to further suppress their own.

CHAPTER THREE: METHODODOLOGY

3.1 Introduction

This chapter introduces the research methodology used for this study and how it has guided data collection, analysis and development of theory. This chapter also looks at the purpose of the research and the sample population used. The reasons for selecting this sample population and the challenges in the recruitment phase will also be discussed.

3.2 Aims and Objectives

This study aims to explore and interpret mental health professional's opinions of the use of psychological interventions such as psychotherapy in the treatment of schizophrenia. The research explicitly explored each health professionals' perception of diagnosis and treatment of schizophrenia in their respective roles within the mental health services. The following list outlines the objectives of the research:

- To explore the nature of the participant's experience of working with schizophrenia through the lenses of their respective professions.
- To investigate the participant's opinion of the diagnostic and treatment process of schizophrenia, and their role within this context.
- To examine what specific psychological interventions are in place for the treatment of schizophrenia.
- To explore the participant's perceptions of the use and efficacy of psychological interventions in the treatment of schizophrenia.
- To identify the place, if any of psychotherapy in the treatment of schizophrenia.

3.3 Research Design

For the purpose of this study qualitative methodology has been selected. Qualitative research is a systematic, subjective approach used to describe experiences and give them meaning (Burns & Grove, 2001, p.61). Two research paradigms that inform qualitative research methodologies, namely the interpretive and critical research paradigms, place emphasis on seeking to understanding of the meaning of human actions and experiences, and on generating accounts of their meaning from the viewpoints of those involved. Interpretive methodologies focus primarily on understanding and accounting for the meaning of human experiences and actions. Those enjoying the most prominence in social research are ethnography, phenomenology and narrative approaches, each of which addresses the issue of meaning from a differing standpoint (Fossey, et al., 2002). Qualitative research does not aim to test hypotheses or assess the validity of existing theories, instead this approach aims to develop understanding. The concept of understanding refers to a state of knowing in which the person already possesses some degree of understanding and seeks to ‘deepen’ this understanding (McLeod, 2015, P.96). Qualitative research is subjective, it is proposed that there is no single social reality and that social reality, based on the perception of the individual will change and evolve over time. The qualitative researcher identifies and describes the meaning of experiences, exploring the speech and actions of the subject in the context of their social and cultural setting (Burns & Grove, 2001).

The aims of this research require a research strategy within the qualitative paradigm as this study seeks to explore the place of psychotherapy in the treatment of schizophrenia from the perspective of the mental health professionals. This current research utilised semi-structured interviews and qualitative thematic analysis to identify emerging patterns and themes that will inform the data and research findings. Thematic analysis further permits consideration of any drawbacks or limitations, and recognises the emergence of themes from the early descriptive

and categorical stages of analysis through to the identification of superordinate constructs (Langdridge, 2004). The qualitative research interview attempts to understand the world from the subjects' point of view, to unfold the meaning of people's experiences and to unfold their lived world prior to scientific explanations (Kvale, 1996).

3.4 The Sample

After great consideration the sample population that was selected were professionals that work and have experience of people with a diagnosis of schizophrenia. The original sample was specified to five psychiatrists working in an inpatient and outpatient capacity. However, the recruitment of such a sample proved to be a difficult task. Due to time constraints the alternative solution to this impasse was to alter the sample population to include other members from the mental health services multi-disciplinary teams. The criteria for this sample was the following:

- Engage at a professional level with individuals' diagnosed with schizophrenia as per the DSM-5.
- Have direct involvement in the provision and implementation of care plans and treatment interventions for individuals' diagnosed with schizophrenia.

The researcher had hoped to interview at least five professionals; two psychiatrists, two clinical nurse specialists and one community mental health nurse. However, a sixth interviewee came forward and offered his experiences in his capacity as a chief nursing officer. All participants are employees of the Health Service Executive at various locations in the west, midlands and east of the country. A profile of each participant is offered in the diagram below (Table: 1). From the outset, participants were informed of the research question, that a semi-structured interview would be conducted face to face, and that the interview would be recorded, for later

transcription. All interviews took place at a location convenient to participants and each interview was no longer than one hour in duration. It is also important to note that the participants' true identities have been protected using fictitious names. Two of the respondents were female and the remaining four were male. The age profile of the participants ranged from the age of 33-55.

Table: 1

Profession	Age	Gender	Years of experience	Area
Psychiatrist	38	Male	4	Galway
Psychiatrist	39	Male	4	Galway
Clinical nurse specialist	54	Male	35	Galway
Clinical nurse specialist	33	Female	11	Midlands
Community mental health nurse	54	Female	34	Galway
Chief nursing officer	55	Male	35	North Kildare

3.5 Recruitment of Sample

Initial contact with the sample was made via the snowball method of sampling (McLeod, 2003, p. 30), whereby access was gained through one individual working within psychiatric services. The researcher approached potential interviewees through an associate who work within the mental health services. Once the researcher had verbal permission to contact the potential participants' further contact was made through email and telephone conversations inviting these professionals to take part in this study. Each participant received an email with an attachment of the information sheet (Appendix 1) and the consent form (Appendix 2).

3.6 Data Collection Method

Prior to the commencement of data collection, the research questions regarding the aims and objectives relating to the research topic were formulated and approved by the research supervisor (Appendix 3). The researcher had also considered the possibility of additional information arising during the interview process that may not have been considered and flexibility in regards to the structure and process of the interview was applied adding to the richness of the qualitative approach. Upon approval each participant took part in a semi-structured interview, at their convenience in private meeting rooms at their respective work place. Each interview lasted between 30 to 55 minutes from start to finish. Each interview was recorded using a digital voice recorder. Upon completion the interviews were transcribed and finally, the researcher analysed the data using the technique of thematic analysis.

3.7 Data Analysis

Thematic analysis (TA) is a method for identifying and analysing patterns of meaning in a data set (Braun & Clarke, 2006). It illustrates which themes are important in the description of the phenomenon under study (Daly et al., 1997 as cited in Harper & Thompson, 2012, P. 209). Thematic analysis refers to the notion of a theme which must be examined more closely. A theme refers to a specific pattern of meaning found in data. It can contain manifest content, which is something that is directly observable across a series of interview transcripts. It can also contain more latent content such as references in the transcripts. Themes are thus patterns of explicit and implicit content (Harper & Thomson, 2012, P.209). In order to formulate the themes that inform the results of the research the researcher must devise a coding frame to guide the thematic analysis. For each code, its name appears in the first column, a definition of what should be classified with this code appears in the second column and an example of material that should be coded with this code appears in the third column (Harper & Thompson,

2012, P.215). Initially four themes were taken into consideration, however after closer inspection these emerged into three themes. After all data was coded and themes had emerged, it was organised into different categories that reflected what had been reviewed in the literature (Harper & Thompson, 2012).

3.8 Ethical Issues

The participants were informed of the purpose of this research and again were reminded about the voluntary nature of the study, their right to choose what to disclose during the interview as well as the right to withdraw from the study at any stage. Confidentiality and anonymity concerns were briefly discussed prior to the interview and reassurance was given regarding the appropriate measures that would be taken to preserve their anonymity through a process of excluding any identifying information, which included changing the name of the participant. Ethical consideration was also given to the safe storage and maintenance of both the audio material and the analysed transcripts.

CHAPTER FOUR: RESEARCH FINDINGS

4.1 Introduction

The participant's interpretation of their role and their experience of working with a diagnosis of schizophrenia in the mental health services has been analysed. The most pivotal element of this piece of research, the position of psychological interventions such as psychotherapy in the treatment of schizophrenia was also explored. Following extensive data analysis, three themes have evolved from the research. These themes have emerged from the responses of the participants and have not been pre-determined. The results of this study will be articulated under the following three themes:

- Subject Versus Symptom
- The Master Discourse
- The Relationship.

Each theme will be further discussed and analysed in the next chapter. Extracts from the participants' interviews will be presented to support the analysis.

4.2 Theme 1: Subject vs. Symptom

All six participants give their own interpretation of the diagnostic process, the provision of care plans and their perception of their own role individually within the multidisciplinary teams. Their perception of the patient's role in this process as well as their perception of the place of psychological interventions in the treatment of schizophrenia was also considered.

In all interviews there seemed to be a focus on either the symptom or the subject. To be more precise, two of the interviewees exhibited a greater consideration for the subject, the person diagnosed with schizophrenia. Both female participants (the community mental health nurse and the clinical nurse specialist) identified the limitations in their respective roles and in the mental health services as a whole in relation to the treatment experience of the patient. Both Ciara and Mary for example, identified that medication is an important aspect in the treatment of schizophrenia, but also felt that the psychological effects of experiencing schizophrenia and the psychological impact of receiving a diagnosis of schizophrenia have been given limited consideration in regards to the biopsychosocial approach to treatment.

Ciara (clinical nurse specialist):

“Am, I would also take into account, their cognitive and emotional awareness, their ability to link in with that kind of stuff. Am, I find that with CBT, that is one of the limitations, you will get so far with a client, and if they just don't have that ability to verbalise their emotions or their cognitions your kind of at a bit of a sticky point with CBT.”

And with Mary,

“We just haven't got the information that we should or the training either. ...” “I mean sometimes as a nurse I don't know what to say or have I the knowledge or a right to say it.”

As the community mental health nurse reflected upon her earlier experiences of the treatment of schizophrenia, her voice took a deeper, shaken tone as she described what she was involved in. Through Mary's reflection upon the past the researcher sensed a real loss of autonomy for

the patients, but there was also a sense of a loss of autonomy for Mary in her role as a psychiatric nurse. There was a real felt sense of fear and anxiety as she discussed her past experiences:

“What my experience was that, first of all it was very frightening, I didn’t understand their symptoms and going back to the early seventies it was just where, if a lot of them, they had an outburst, they were kind of just taken away and medicated and am, (pause) I felt, (pause) I used to feel sad about this, (pause) I just, I just used to think it was so, so sad...”

Ciara (CNS) identified the need to listen and advocate for the patient, there was a sense of firmness in her belief. She felt that the process of identifying the symptomology of a client was important as a way to work with the illness but felt that helping the patient gain autonomy in this uncertain process had a greater impact on whether the patient would continue to engage in the treatment process.

“At the end of the day the client will decide, will dictate the pace and decide what they are going to do and services are having to come into line with this. Once you start telling the people what to do you have lost your client.”

In contrast, the remaining four male participants shared a greater focus on treating the symptom and the issue of stabilisation. Gerry (CNS) identified a need for services to focus more on the person towards the end of the interview. John (psychiatrist) felt that the patient would benefit from talking to someone but there was a sense of trepidation in his response and medication adherence and the reduction of the symptom were viewed as the most important aspect in the diagnostic assessment and the treatment process.

“I think that it is very helpful that the patient can see that we are trying to approach this on a multi-factorial basis and that it isn’t just medication, that they are getting that support.” “...but certainly, my faith would be more so in the medication model.”

John seemed to place himself in the position of the patients' experience and felt that if he was in that situation he would rather mediate. John seemed to have a fear of the symptoms of schizophrenia from his experience of working in the area, there was an urgency in his response in relation to defending the medical approach to treatment.

“As for efficacy [of psychological interventions], to be perfectly honest, if it was myself and I had a choice between the two I think I would choose medication first then I would see that at a later date.”

Gerry (clinical nurse specialist), in a matter of fact fashion, stated that stabilisation was the most paramount part of the treatment process in order for every other aspect of the care interventions to be successful:

“...But I suppose the most important thing is stabilisation, it comes first because until that is achieved everything else is kind of not achievable in my mind anyways...”

When Gerry was asked about how he manages any identified difficulties in relation to treating schizophrenia, he paused and shifted in his chair as he reflected upon the question. The tone of Gerry's voice was somewhat softer and had an air of sadness to it in his response,

“I have an external supervisor that I go to and talk to...all I am sorry for is that some patients don't have or aren't given the opportunity of that safe environment.”

It seemed that in the final few questions in relation to the treatment of and his sense of schizophrenia Gerry removed himself from the “we” approach and experience of the Multidisciplinary team to the “I” experience in his profession. Gerry became more reflective and empathic in his knowledge and understanding and shifted his focus on to the experience of the subject, and in doing so his demeanour completely changed:

“...realistically it is about being open minded to the different therapies and not to be afraid of them...I would encourage consultants to be more mindful of psychotherapy and its benefits...it might cost a little more initially, in the long term it might also save money, but also give a better quality of life to people who are entitled to a better quality of life.”

When discussing the steps involved in the diagnostic process, John, the psychiatrist felt that medication initially is the only and primary form of treatment in relation to schizophrenia.

“I suppose we do have a reliance upon medication initially, am, quite often people could be agitated or distressed, based upon their delusions, or their hallucinations or perceptual changes...we have our statistics to show the reduction of relapse rates, people are maintained on maintenance treatments for as long as necessary depending on the number of episodes.”

Joe, the chief nursing officer, shared his concerns around the closer of institutions. Throughout the interview there was a sense that his knowledge of the current provision of assessment and treatment was somewhat hazy. Joe identified that in his role as chief nursing officer he has little to no involvement in the assessment and treatment process of patients. There was a sense of hopelessness in his response to the treatment process and recovery from schizophrenia. This is evident in his response to changes he would like to see in the services. He felt that there will always be a need for this type of service, particularly in relation to patients with schizophrenia;

“I think ah, am there is always going to be a need to have a high support, I think maybe we might rush too fast to close down every institution in the country.”

When discussing the process of an individual being diagnosed with schizophrenia there was a view of “no return” for the patient in towards the end of his answer, a sense that the patient will in time relapse and need more medication or a review of their dose;

“...and we give them the prescribed medications the delusions will disappear, but sometime in the future course the delusions will come back and they will think what am I taking tablets for I don't need them....” “So that is where the depo. comes in.”

Michael (psychiatrist) discussed his process in weighing up the diagnosis with what he referred to as the biopsychosocial model. There was an air of profound knowledge and confidence in his discussion of the biological aspects (medication, symptomology) and the social aspects (disadvantaged background, destructive environment). In discussing the social aspects Michael identified the social worker as the most prominent figure in treating this issue;

“...like if they got any, a destructive home environment say, we would be linking in with the social workers ah, then with the biological, the medical side of things, I suppose depending on their symptoms really I suppose we might be looking at ah... anti-psychotic medication.”

However, when Michael arrived at the psychological aspect of this model he was less hesitant to answer and there was a sense of uncertainty;

“...then from the psychological point of view, am, (pause), I suppose the psychological point of view is a little bit harder to answer that side of things, it's a little more vague.”

Upon reviewing the data, it is evident that when the focus was on the symptoms of schizophrenia Michael, John and Joe mostly discussed assessment, treatment and their experiences of schizophrenia in a plural and detached sense, “we”. However, when the subject became the focus for Ciara, Mary and eventually Gerry, they entered into a more relational realm as they paused to reflect upon their own level of insight into the assessment and treatment of patients diagnosed with schizophrenia. The level of insight of the patient was an issue for all interviewees, particularly in relation to the patients' capacity and capability in engaging in the treatment process. It seems that with little insight the only hope for the patient is a sense

of containing the symptoms. However, it also seems from the analysis of the data as a whole, that the insight of the service providers is as equally an influencing factor. Both the clinical nurse specialists and the community mental health nurse at some level had a greater insight into the experience of the patient and also a greater awareness of the limitations that still exist in a treatment approach that places most emphasis on the medical approach. Both Mary and Ciara seemed to have a greater sense of understanding and empathy when identifying the needs and challenges of working with people who are diagnosed with schizophrenia.

4.3 Theme Two: Master Discourse

The Master Discourse is structural to both the role of the Doctor and the mental health services as a whole. It can also be argued that the medical model, the true master discourse is structural to the role of the doctor and also shapes the mental health system. It is clear that the majority of the decisions around diagnosis, provision of care plans, and treatment interventions are dictated and informed by the psychiatrist and the system within which they work. Evidently, the obvious identifier in the role of the master discourse was the doctor, consequently the doctors' role is given significant power, "*...the doctor decides...*" (Gerry), "*...you report all this back to the consultant...*" (Mary). However, it is evident throughout the data that the master discourse is also identified if not more so in all participants placing their sense of security in their knowledge of the medical model and their ignorance towards the experience of the patient. This became more palpable when the psychiatrists and the chief nursing officer struggled to offer their opinion on the use of psychological interventions such as psychotherapy. There was a sense of discomfort and hesitation when discussing treatment interventions outside of the realm of the medical model. Joe sniggered a little when discussing the psychological supports that are in place;

“...schizophrenia is obviously it’s a psychotic am, disease and psychological supports wouldn’t jump off the page as the first way of dealing with it...” “... so you wouldn’t say obviously let’s leave all the neuroleptic drugs aside and just go with this, so it is secondary to that [medication].”

It seemed that once the patient does not adhere to the needs and desires of the system that is currently in place the doctor is exalted into the role of the master and called upon to deal with the defiant patient. In these instances, the participants that are referred to as being non-compliant are said to be lacking insight into their illness. Michael in his role as a psychiatrist felt that a patient’s level of insight heavily influences the level of involvement they have in their care interventions.

“In the ideal situation where the patients’ have a degree of insight and they realise that they are having experiences whether it is a voice they are hearing...if they are aware of that and it is causing a lot of stress, ah, in, in that case their vision and my vision would be on the same page and they want to elevate that and then it is a case of reviewing medication weekly...”

It seems that there is little room for attempting to understand the presenting symptoms. In Michael’s answer there is a sense of security in having a potion to evaporate and dampen down the symptoms that create fear in the system if the patient lacks insight and a willingness to comply, and there is also a sense of being a saviour when the patient comes to realise through the eyes of the system that they are outside of the realm of acceptable human behaviour. There is also a sense of anxiety in Michael’s response regarding the use of psychological interventions. This further strengthens the idea of the doctor being exalted to the position of the master, ‘the subject supposed to know’ and the anxiety experienced by the doctor in relation to his lack of knowledge around therapeutic interventions.

“...if the patient doesn’t have insight or they have acute paranoia...I suppose it [psychotherapy] might make them more agitated about the mental health sector as a whole, there may be a certain amount of problems with it [psychotherapy], that they can’t trust their doctor, so you have to trust that they will take their medications you

need that little bit of good will, it could cause them more distress you'd worry would they stop taking their medication and go cold turkey. I think that would be my biggest concern."

There is a sense that the master has no interest in this knowledge and his or her concern is that the system and the subjects in it works. This statement is too black and white as it seems that the professionals that are in a position of authority had little knowledge of psychological interventions and to some degree struggled with the idea of psychological interventions being part of the treatment process for individuals with schizophrenia because it does not fit the medicalised approach or the protocols that the system has in place for decades. John identified the fact that as a psychiatrist in making decisions around treatment interventions he is influenced by the medical model and in a sense seems secure in this position because of the research evidence supporting the medical stance to treatment.

"I suppose we do have a reliance upon medication initially... we are I suppose quite ingrained in the medical model as we depend a lot on (pause), we have our statistics to show the reduction of relapse rates..."

However, when John discussed the treatment of patients in an involuntary capacity he identified a possible niche for psychological interventions in relation to dealing with the trauma of initial loss of autonomy during this phase. However, John also holds firmly the need for medication in the acute phase but seemed curious about the possibilities of psychotherapy as part of the treatment process.

"...when you have issues of perhaps traumas with involuntary admission am, loss of capacity, that, the trauma of these episodes can be very debilitating and certainly I think that psychologists are very useful in that case, but I think in the acute case medication is probably more important." "But certainly I see a role for the development of psychotherapy to focus therapy on dealing with those issues that medication can't solve in the long term."

Even though the nursing professionals in their different capacities seemed to have a greater level of insight and acceptance regarding the use of psychological interventions there was still

a sense of reliance on medication compliance and the patients level of insight. Gerry, Ciara and Mary identified that there was a need for more psychological approaches accessible on a frequent and flexible basis. There was also an urge for more educational opportunities particularly in relation to psychological intervention. There was a sense of urgency in Ciara's voice regarding the need for a change in service provision.

“Well, across the board, greater access to talking therapies, definitely. I mean the medical approach on its own just doesn't work. Am, and I think that there should be more and more people trained with, you know, psychotherapy, CBT, DBT different approaches like that so I do think that is where it is going to go, but it is going to take a massive shift in thinking not just from the doctors but from the nurses as well.”

When discussing the challenges faced when treating individuals with a diagnosis of schizophrenia, in a matter of fact way Gerry identified patient compliance as one of the failures in the treatment process. The researcher got a sense that if the patient is non-compliant with medication there is a sense of no hope in instances of recovery. Gerry seemed to get lost in his point and quickly moved on to a need for more educational opportunities in relation to the psychological field.

“...compliance is one of the biggest failures in the process. People with schizophrenia have a tendency to not be compliant...you would see that as a symptom...they become probably disillusioned with the whole thing...” “There is no educational opportunities for staff to upskill themselves...”

In relation to challenges in treating individuals with schizophrenia Mary felt that a lack of education was the greatest challenge. Mary seemed to want to connect more with the patient and know how to help them work through their illness.

“...well education is number one, ... it's about being able to talk, I think a lot of the time they don't get that chance. Sometimes as a nurse I don't know what to say or when to say or have I the knowledge or right to say it.”

There was a sense of doubt in Mary when she had a patient under her care with regards to diagnosis. Mary seemed nervous as she shared her opinion on the diagnosis.

“...I think her illness, even though she was diagnosed with schizophrenia but we, I always thought it was the sexual abuse maybe as a younger child and I feel, while she was seeing a very good psychologist, I think the psychologist used to get so far and stop, the breaks between were too long...she used to act out and get very upset...she didn't trust us...and we haven't the experience either...”

The researcher sensed in Mary a sadness around her inability to care for this patient at a deeper level. There was a level of sadness and frustration in Mary's answer around the mental health services inability to meet the needs of the patient at a therapeutic level. Mary believed that the patient would have benefited from this more so.

“I think if that young girl had talk therapy on a, I think on a, definitely once a week, and develop a trust with somebody she would have been fine...not with the way it was going, I'm not, the psychologist did her level best, but her time frame wasn't sufficient and there was nobody there to take over, and I felt if anything it compounded the young girl's problems, it was just scratching at the base and getting nowhere.”

John identified the fact that his knowledge and that of the system is heavily ingrained in the medical model. In a model that has been statistically proven in relation to relapse reduction due to medication adherence. The medical model certainly does solve the immediate problem but it also contributes to the retention of the master/slave structure, the sense of ultimate responsibility lies with the doctor. This burden hangs over the doctor in his or her role, located in the power to diagnose and prescribe; they are thrown into the role of the subject supposed to know in a system that limits their knowledge to that of seeing the patient as an object as oppose to a subject. In a sense this system defends against the anxiety the patient attempts to provoke, however, the anxiety and the sense of helplessness from the nurses suggest that the anxiety simmers at the level of the unconscious.

4.4 Theme Three: The Relationship

The therapeutic relationship is a fundamental component of mental health care. It is the means by which a professional will hope to engage with, and effect change in a patient. It is evident from the data analysed that the patient has the most contact with the psychiatric nurse and the psychiatrist to a lesser degree. The relationship that exists between the psychiatrist and the patient is one that focuses on the symptoms and medical treatment of the patient. The relationship that is discussed and described is one that is supportive, and influenced by the multi-disciplinary team's approach to treatment. The role of the therapeutic relationship was a process that was either misinterpreted or denied completely in relation to the treatment of schizophrenia. The transference and the counter-transference that inevitably plays out between the mental health professionals and the patients was another element that came through in the analysed data.

Ciara had the greatest level of insight into the importance of the relationship. There was a real sense of Ciara's training coming through in her interpretation of developing a rapport with the client.

“Am, you have to work a lot harder to establish a relationship with the [schizophrenic] person. I would definitely be someone who would believe that regardless of what your approach is, it is down to the therapeutic relationship at the end of the day. That is the vehicle for change really and most clients will be able to establish that rapport with you but I suppose with the schizophrenic you have to work that bit harder for them to trust you, am, you are also dealing with a lot of chaos...you have to kind of be a lot more flexible and a lot more patient with a schizophrenic...”

Ciara also identified how the medicalised approach to treatment can have limiting effects on the therapeutic approach to treatment. Ciara feels that patients that are diagnosed with schizophrenia need more flexibility in regards to attendance as they are dealing with a lot of chaos and require more time in relation to working (therapeutically) through a difficult stage.

“We kind of have hard and fast rules and polices about engagement... we have to be quite strict about our appointments to get everyone in and seen, we don’t have that flexibility. Sometimes you know when you start doing CBT with a client, their anxieties or their depression, whatever it is they are trying to avoid is going to get worse for a few sessions and I always explain that to them. But if you can get the medical team or whoever else to just wait and let them through this and see can they get over this piece, that does so much for their belief in it, but you have to have a team that is supportive of it.”

In her capacity as a community mental health nurse, Mary spoke empathically and indirectly about the importance of the relationship. Mary felt that her work has affected her emotionally at times and seemed disturbed that other staff members seemed untouched by it.

“...but sometimes you can get staff that are indifferent and just seem to be able to carry on and ah, “look this is your job.” But it is, you still have to be human, and you have to be the, you have to see the person as a whole and try and treat the person but also as yourself, you have to be aware of your own capabilities...”

Mary also seemed unnerved as she spoke of a difficult experience she had with a patient diagnosed with schizophrenia. There was a sense here of sadness and regret in Mary voice. She felt that she or her colleagues hadn’t the capacity to deal with the patient acting out and was upset at the fact that this individual’s needs could have been met with a greater frequency of the psychological approach as oppose to medication. There was a real sense of anxiety and hopelessness in the final sentence of Mary’s response as she felt she was ill equip to give what she felt the patient needed.

“...it was an impossibility for her [psychologist] to see her more but it used to leave that young girl in a very distressed state because she used to get so far with her and then there was nothing for maybe two months, again and I think the back lash was with the staff and we haven’t the experience either of, we didn’t know how far we could delve... sometimes as a nurse I don’t know what to say or when to say or have I the knowledge or a right to say it.”

Joe felt that psychological interventions were secondary to medical intervention. Joe stated that the most crucial process in the treatment of schizophrenia is to contain the symptoms via medication and if a patient acts out, to review the medication and proceed with this from of treatment. In a matter of fact manner, Joe stated that it is important “*you talk about it [schizophrenia] being contained,*” and “*see what we can do and try and bring about normality*”. The researcher sensed a level of intolerance for the experience of the patient. Joe shifted his focus to supporting the family involved in this process when discussing diagnosis. There was a real sense of us and them in his answer, with a greater focus on the relationship with the family as opposed to the relationship with the patient.

“...how long will it take [recovery], how long is a piece of string... it is important to be able to just provide am, support for family members because quite often by the time you meet the patient for the first time they have been to hell and back.”

There is a sense that the patient acts out because they do not have the sufficient language and so regress into the imaginary. When patients act out there is a requirement of the mental health staff to respond to the patient. Through the mental health professional’s own anxiety, fear of the unknown and their own lack they act out under the imposition of medication. Thus, the relationship is left suspended in the imaginary.

Gerry suggests that the medical model has an overwhelming influence on his way of working in the past and also on his way of working with a client in his present capacity as a CNS. The researcher sense a struggle in his responses, there was a vulnerability when he discussed the importance of providing a safe space for clients and the need for patients to developing trusting relationships with the mental health professionals.

“Well I suppose realistically, (pause), having, like I grew up in the medical model, so I suppose in a way you become institutionalised into the medical model, you don’t see anything else...from going away and studying CBT...and studying addictions and

motivational interviewing it kind of opened up a bigger field...realistically it is about being open minded to the different therapies and not to be afraid of them.....it wasn't just down to medications, it was also down to a variety of other therapies in, in, including as I call it the talking therapies, which allows the safe exploration, and a safe space for the patient to explore their inner thoughts, but then that's all down to having a trusting relationship with the person they are working with."

In his response to how he manages the challenges of working with schizophrenia Gerry discussed the sense of safety and support he receives from his external supervisor and a sense of remorse was evident when he identified that lack of a safe environment for the patients with schizophrenia.

"I can go and talk and I can am, I suppose deal with all these issues in a very safe environment, ah, all I am sorry for is that some patients don't have or aren't given the opportunity of that safe environment."

Both Michael and John shared a common sense of vagueness and distrust in the use of psychological interventions. In Michael's discussion of the biopsychosocial model towards diagnosis and treatment, there was a lack of clarity and knowledge of the psychological piece. The researcher felt an uncomfortable tone in his response. There was a "when I see it I will believe it" attitude in John's response towards the use of psychological interventions, *"...I haven't seen a whole lot of work being done all due to resources mostly, of things like CBT for psychosis...I haven't really seen any benefits of that, I can't speak to that."*

Michael identified social aspect in line with the social worker, the biological aspect in line with medication and in his response to the psychological aspect there was a sense of foreclosure on this area. Michael felt that *"...the psychological point of view is a little bit harder to answer...it is a little bit more vague."* Michael's interpretation of this element of the biopsychosocial model is the nurse providing one to one with the patient if time allowed, *"...it would be kind of things like you know, it might be one to one with the nurse, depending on time really."*

There was a shift in John's thought process in regards to the value he initially placed on psychological interventions at the beginning of the interview. When discussing changes, he would like to see in the future John felt that there is a need for more psychological supports such as psychotherapy in order for patients to cope with their experiences.

“Having more supportive psychologists, more talk therapies available would be a future benefit because I really see a need for this and it isn't available... in the team at the moment we would have one psychologist and three doctors, so there is a bit of an imbalance there...”

The overall sense of the relationship between the patient and the health professional has been greatly considered. From the perspective of the nurses the ability to connect with the patient at a level that medication can't meet was of crucial importance. There was a real sense of hopelessness as long as the relationship is met through the guise of the medical approach. From the beginning of the interview there was a resistance in Michael and Joe's responses around the use and effectiveness of psychological interventions throughout, their views seemed to be inherent to the current trends in the mental health services. As John has stated there exists an imbalance between the medical and the psychological approaches to treatment (three doctors and one psychologist) and Michael and Joe represent this trend in acknowledging its existence but giving like importance to its effectiveness. It seems from what has been explored that there is a place for the use of psychotherapy in the mental health services but as Ciara suggested the greatest obstacle to this is the current mind-set of the service providers as a whole. It is evident that little is known about the transference and counter-transference that exists in every relationship, again this further strengthens the importance of psychotherapeutic interventions to work through the transferences and counter-transferences experienced within the therapeutic space.

CHAPTER FIVE: DISCUSSION

5.1 Introduction

The primary aim of this research is to explore the mental health professionals' experiences of working with a diagnosis of schizophrenia and their perceptions around the use and efficacy of psychological interventions such as psychotherapy. The three themes that have emerged from the analysis of the data, subject versus symptom, the master discourse and the relationship will be further discussed in this chapter. It seems that all three themes are heavily influenced by one common factor, the medical model. This notion will be further explored in the context of each theme. Although the overall sense of the place of psychotherapy in the treatment process is quietly positive, there is a level of anxiety within the context of this belief as the participants continue to work in a system that is heavily influenced and directed by the medicalised approach to the treatment of mental illness; this too will be further discussed.

5.2 Subject versus Symptom

The notion of subject versus symptom came to light in the process of analysing the participant's descriptions of their experience of working with individuals diagnosed with schizophrenia. The more experienced professionals offered a reflection of the methods of treatment in the late 1970's up to the early nineties. There was a sense that the walls of the asylum acted as concrete containers, suspending the psychotic patient in his or her distortions of reality while also keeping the professionals at a safe distance through an abuse and over reliance upon medication. Steiner (2011), argued that the walls of the asylum needed to be softened through a relational human approach based on understanding. The answer to this conundrum was to integrate mental health services and patients into the community and operate service delivery in the community setting. Evans argues that the relationships with the mental health professionals and clinical teams, to some extent have replaced the asylum and yet, since its

inception community care has never been adequately resourced (2016, P. 6). In the community mental health setting, staff are now more exposed to the anxiety, pain and disturbance of the patient without the supportive, rigid container formerly provided by the institutional setting. Evans (2016) claims that there are now conflicting pressures within the system, which impinge on the professional's clinical judgement or capacity to think objectively. There is an expectation on mental health professionals to keep patients out of hospitals as an admission is often looked upon as a failure in the treatment process.

Three of the participants, John, Michael, and Joe focused their understanding of and treatment approaches to schizophrenia on the containment of the symptom as though the symptoms had a contagious quality. There was a detached sense in the approach to treatment and medication was viewed as the most effective and appropriate intervention in treating a diagnosis of schizophrenia. Michael felt that the use of psychological interventions such as psychotherapy would aggravate the symptoms even more. Michael also seemed to have a very limited knowledge of psychotherapy and referred mostly to the supportive role of the nurse. Michael, John and Joe at various levels remained stuck in the conscious, medically observable approach to treating and eliminating the symptoms and gave little to no discussion around attempting to understand what the patient is attempting to communicate. Patient's diagnosed with schizophrenia often communicate their distress and concerns in a chaotic and complicated way. What is forgotten within the institutionalised thinking of the professionals is that communication takes place on an unconscious as well as conscious level. This difficult nature of psychotic communication can overwhelm mental health professionals who feel tormented and fearful of the fragility of the human psyche. This exposure to such a fragmentation of the mind inevitably leads the professional to keep the patient and their disturbance at a psychological distance and keeping the lid on this 'Pandora's box' through the use of diagnostic manuals and anti-psychotic medication (Evans, 2016, P.120). It has been suggested that such

an outlook on the treatment of schizophrenia would suggest an avoidance of their own anxiety and fear of 'madness'. This avoidance is based on the attitude that madness comes from intimate emotional contact with others. The result is a continual blighting of the sense of contact and community between staff and patients (Hinshelwood, 2004, P. 123).

In the university discourse knowledge is understood as a defence against the truth and the generation of knowledge is preferred over the unconscious. The knowing subject is the agent and the unconscious remains excluded. In the context of the three participants here the university discourse does not come to terms with the reality of the world and instead strives to categorise and symptomize every aspect of the schizophrenic's experience. Verhaeghe (2004) argues that in the university discourse we encounter a diagnostic logic that excludes the subject, the subject is merely a product that an agent, such as a foreign body, psychic virus, or bacteria, has acted on. The mental health professionals need to communicate and endure a certain amount of the patients and their own anxiety (Evans, 2016, P. 133). Lucas (2009b) claims that the power of the communication can affect the clinician, evoking powerful countertransference responses, which can push them to ignore the degree of disturbance and inappropriately settle for a more ordinary or neurotic explanation for a patient's behaviour (Lucas, 2009b, as cited in Evans, 2016, P.133).

The remaining participants focused their attention more on the experiences of the patient. Gerry initially was caught in the need to control and dissipate the symptoms. However, towards the end of the interview he became reflective and more vulnerable in his opinions of the treatment approaches to schizophrenia. For Both Ciara and Mary their focus throughout the interview was entirely on their objective experience of working within the limitations of the current service delivery and how this has impacted both the patient and their position as mental health professionals. Hinshelwood (2004) claims that the psychological state of staff and patients interact in what Stanton and Schwartz (1954) termed the 'parallel process'. What this

suggests is that whatever the staff experience at an unconscious level on the side of the institution reflects back onto the patient. The reality that staff are themselves vulnerable, too, and they can also feel disturbed is a notion that needs consideration within the balance of recognising with this reality that staff are still not as vulnerable as psychotic patients (Hinshelwood, 2004, P. 14).

The shift from the institutional setting to community based care offers some sense of creating a 'normal' setting for the afflicted patient. It is evident that the mental health professionals still hold reminiscence of the institutional approach and the still prominent medical approach through their focus on alienating the symptom through the use of anti-psychotic medication. The mental health professionals whom exhibit a greater openness to the schizophrenic patient offer insight into the what is lacking in service delivery, the need for more and frequent access to therapeutic interventions.

5.3 Master Discourse

As suggested in the findings chapter the master discourse is structural to both the role of the psychiatrist and the medical approach, a model upon which the mental health system runs. It is clear from the responses received by the nursing staff that diagnosis and treatment approaches are influenced by the consultant psychiatrists. Both psychiatrists also concurred this fact but also acknowledged the fact that their education, observational training and experiences are vastly informed by a medicalised approach to treatment with minimal room for the psychological aspects of the treatment process. The master discourse is ruled by the master signifier, which has no literal meaning;

The master must be obeyed- not because we will all be better off that way- but because he or she says so. No justification is given for his or her power it just is... The master

must show no weakness and therefore carefully hides the fact that he or she is a being of language.

(Fink, 1995, P131)

Hegel identified that the master can only exist if there is a slave to carry out his bidding (Audi, 1999), consequently the role of master is often conferred on an individual, a position not necessarily of their choosing.

All six participants identified that psychotherapy is a missing component in the multi-disciplinary approaches and four out of the six identified from their own experience of working with schizophrenia that psychotherapy could offer value. These findings confirm the statement in a *Vision for Change* which identifies that service users and service providers both express a need for talking therapies alongside other interventions (Department of Health and Children, 2006).

The discourse of the medicalised approach to treating schizophrenia puts the psychiatrist in the position of 'subject supposed to know'. This is evident as all four nurses in their different roles identified the doctor as the one they report back to, the one that has the final say in the diagnosis and treatment process in involuntary cases and the one whose professional opinion influences the treatment approaches to schizophrenia. Michael, Joe and John exhibited a sense of firmness in their beliefs of the medical approach to treating schizophrenia, while Gerry, Ciara and Mary identifying the importance of medication they also felt that psychological approaches such as psychotherapy were also valuable in the treatment process.

According to Evans, the historic institutions developed an overly defensive organisational structure designed to avoid anxiety rather than think and feel. In mental health services, the main anxiety, which is largely denied, is concerned with the unpredictability of mental illness (Evans, 2016, P.10). There was an element of this anxiety inherent in the responses of the

psychiatrists and the chief nursing officer when discussing the efficacy of psychological approaches to treatment. The most mentioned support was one to one with the nursing staff or insight building sessions with the overburdened psychologist. However, the inevitable container for the management of symptoms and the ease of the mental health professionals' anxiety and fear of the unknown of the patients' experience is medication. A preoccupation about the diagnosis can be used to distance the professional from the patient and contribute to a rather mechanistic approach. It is also true that a rigid interpretation of the medical model can discourage thinking about the person behind the illness (Evans, 2016).

Michael expressed a concern that psychotherapy might unravel the doctor-patient relationship that is built on medical adherence and conformity to the recommendations of the treatment process. However, McCabe et al. (2012) suggest that therapeutic interventions improved adherence to medication. The use of psychotherapy invoked anxiety in the responses of the participants that were perceived to be in the position of the 'subject supposed to know' as the very model from which their knowledge was born may come in to question. Steinman (2009), suggests that psychotherapy in the treatment of schizophrenia has lost its footing in this era of antipsychotic medication. Although medication can be helpful and at times essential in severely acute situations if medication as the prime treatment modality does the trick, then the patient is better off very quickly (Steinmann, 2009, P.10). However, the residue of the symptoms only lie dormant in the unconscious until the patient is exposed to a level of anxiety that unleashes the experience again.

Stone (1983), in a reference to treating schizophrenia poignantly states, "*Many patients in the public sector, probably the majority, have become 'untreatable' because they have not experienced treatment adequate to their needs.*" (Steinman, 2009, P.26).

The over reliance on the medical model has left a system that is steeped in a denial of the subjective experience of the patient. There is a sense that the mental health system as a whole exists only in the imaginary. The term imaginary conjures up notions of illusion, fantasy and seduction, something we are drawn into. 'In man the imaginary is reduced, specialised, centred on the specular image' (Lacan, 1988b, p.282). This is true in all participants identifying the value of the multi-disciplinary teams and the integration of the mental health services into the community. However, the medical model as the master of all treatment approaches feeds the void that exists between the mental health professionals and the patients, a void that gives no voice to the inner workings of the schizophrenic patient.

5.4 The Relationship

The therapeutic relationship between people with schizophrenia and their medical professionals is integral to the recovery process in schizophrenia and influences the outcome of the illness (Ivezic, Ljubimir, & Urlic, 2001). It is evident from the data analysed that the notion of the therapeutic relationship is given little consideration in the context of the mental health system as a whole. The therapeutic relationship was identified as a missing element in the treatment process of the schizophrenic patient by Gerry, Mary and Ciara. The remaining participants failed to mention the relationship between patient and mental health professional in a therapeutic or relational context. There was a sense from the psychiatrists and the chief nursing officer that a therapeutic relationship was an impossibility with a schizophrenic patient in the acute phase. There was also a level of concern that the therapeutic encounter may compromise the medically motivated approach to treatment.

A particularly tragic aspect of schizophrenia is the isolation it produces in its sufferers. It *"causes people to feel disconnected from themselves, from others, from their environments and*

from meaning and purpose in life” (Manitoba Schizophrenia Society, 2000, P.8). Many psychiatrists may claim that the phenomenon of isolation and deteriorating identity is merely an aspect of the long-term effects of schizophrenia. In other words, it is part of the illness and not an effect of the institution (Hinshelwood, 2004, P.110). Both clinical nurse specialists and the community mental health nurse identified the importance of building a rapport with the patient and meeting the patient in their frame of reference. John acknowledged a need for more psychological approaches for working with patients more closely in relation to *“focusing therapy on dealing with those issues that medication can’t solve in the long term.”* There is evidence to suggest that a more positive therapeutic relationship leads to better adherence to treatment and more favorable outcomes across a range of diagnoses and treatments (Castonguay & Beutler, 2006; Frank & Gunderson 1990, Kirsch & Tate, 2006; Priebe & McCabe, 2008).

Through her training in CBT and Addiction studies Ciara was the most proficient in her understanding of the therapeutic process. She believes that the relationship is the vehicle that spurs change. Ciara also acknowledged the need for patience and flexibility when working with a person diagnosed with schizophrenia and finds that this currently is a limitation in service delivery. Mary also felt that the patients she experienced in her care would have benefited from weekly sessions with a psychotherapist as she identified that nurses lack the ability and understanding to communicate with patients at a therapeutic level. While Evans (2016) suggests that schizophrenic patients can benefit from psychotherapy, he also contends that patient’s also need mental health professionals who have the ability and the desire to be interested in the emotional aspects of minds, in their own minds and those of others and who can tune into a psychotic level of communication.

Both psychiatrists give little acknowledgment of the therapeutic relationship. In their responses John and Michael discussed interactions with patients on the level of medication reviews and

evaluations of symptom change. John eventually identified a possible niche for the place of psychotherapy in treating schizophrenia but felt that there was not enough research to prove its efficacy and he had not witnessed it in practice, thus his trust inevitably still rests in the medical model. Evans (2016) suggests that patients in a psychotic state of mind often communicate their psychological problems through “concrete thinking” or “concrete actions”. This sort of thinking is rigid and lacks the “as-if” quality necessary for symbolic thought and consequently there is no room for associations or imagination (Evans, 2016, P.105). Lucas (2009e) described this level of communication as the “psychotic wavelength” and argued that staff need to “tune in” to this psychotic wavelength (Evans, 2016, p.106). Lucas (2009e) further suggests that when staff are able to “tune in” to their patients’ communications in this way, it can help to change the patients’ monologue about their delusional world into a meaningful dialogue about their psychic state. The schizophrenic patients’ capacity for insight was deemed the greatest challenge in treatment adherence and outcome. However, it seems that it is also the mental health professionals lack of insight into the patients’ inner experience that may also affect treatment outcome. The demanding and difficult task of reflecting on patient’s concrete thinking and actions needs to be central to the mental health professional’s clinical work. Understanding the patient’s use of defenses helps the professional to make sense of what might have been disregarded as inexplicable behaviour (Evans, 2016). In not doing so the risk is that patient’s communications are dismissed as secondary to an illness and thus “un-understandable” (Jaspers, 1913) rather than inherently meaningful and an opportunity to learn more about the patients and enable patients to learn more about themselves (Evans, 2016, P. 2). This may be due to the fact that madness has a specific quality of terror for human beings. Together staff and patients avoid the fear, the fear of intimate emotional contact with the patient’s subjective experience of the illness (Hinshelwood, 2004, p.122). Another motivation for avoiding the unconscious is the threat that it poses to the master discourse. To unearth the

truth of the patient's experience is to expose the limitations of the medical discourse and threatens to expose its lack of knowing. Thus, the research findings strongly support the use of psychological interventions such as psychotherapy to fill this gap that inherently exists in mental health care.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

In conclusion, this study has found evidence that mental health professionals perceive that the inclusion of psychotherapy within the treatment process of a diagnosis of schizophrenia would primarily benefit the patient. The inclusion of psychotherapy would offer the patient the possibility of exploring the meaning of what has been referred to as their concrete thoughts and actions, to what mental health professionals have adduced to as symptoms.

It is evident that the mental health services and the professionals that represent it hold too closely the ideology of the medical model. The mental health system has to contain and care for patients with profound psychological difficulties and often with fragile egos that are prone to fragmentation when faced with psychological anxieties and conflicts. The danger is that mental health professionals respond to this by becoming mechanistic in their thinking. Mental health professionals avoid the painful realities about the extent of the patients' damaged thinking and the patients' sane part is then left to manage the psychotic part alone, without any psychological support. The parallel distancing of the patient and staff from contact with madness serves the objectifying and rigid principles of the medical approach to diagnosis and treatment. To an extent the Irish mental health services collude with the patient in taking up the position of the master discourse via the medical model and through the consultant psychiatrist and other members of the multi-disciplinary team. The mental health professionals are placed in the position of '*subject supposed to know*', and in giving into the patient's desires they relinquish the important content of the unconscious. Through the psychoanalytic lenses, although most participants were in favour of a psychotherapeutic intervention it seems that this was motivated out of a certain fear and anxiety of the unpredictability of the patient's illness and a desire to lead yet again the patient into a relationship with another '*subject supposed to know*'. This is the danger, it is imperative that the philosophy of the psychotherapeutic encounter is not engulfed by the demands of the master and university discourse via the medical

model. It has been suggested that mental health professionals in their own capacities also need to tune into the ‘psychotic wavelength’ in order to support their patients’ struggle with the psychotic aspects of the self. Psychological interventions such as psychotherapy remain secluded on the peripheries of the medically contained psychiatric services. However, when psychotherapy and psychiatry work well together, they create a clinical setting that offers both a listening approach in psychotherapy which also complements the objective and scientific approach of psychiatry, both working together in their best interests. As long as the mental health services avoid gaining as well as offering a psychotherapeutic understanding of the difficulties experienced by their patients, they continue to operate services that are built on an illusion and carry on in the imaginary realm, consequently to avoid anxiety and psychological vulnerability, keeping the truth at bay by whatever means, answering only a demand.

6.1 Recommendations

The recommendations are made as follows:

- Mental health professional’s need support in becoming skilled at initiating therapeutic alliance and managing transference.
- A total shift in approach to learning about and trying interventions with patients and engagement in supervision is required to unfreeze the current impasse in staff-patient relationships.
- Education and assessment training in differing approaches in psychotherapy should be offered to all mental health professionals, with a focus on accurate assessment of service users’ needs to ensure these are matched to an appropriate intervention.

6.2 Areas of Future Research

- The original sample for this research was to consist of psychiatrists only, due to time limitations and accessibility to this sample a more mixed sample was applied. Further research into the perceptions of a representative group, i.e. psychiatrists only or mental health nurses only would make interesting findings.
- Future research must also focus on the synergistic effects of combinations of psychological interventions with pharmacotherapy or psychosocial interventions.
- Currently there is conflicting evidence in the efficacy of the psychodynamic and psychoanalytic approaches to treating schizophrenia which is inadequate in facilitating their promotion in each approaches pure form.

6.3 Limitations

One of the main limitations in this study lies in the sample. Even though each participants' knowledge and experience gave great diversity and richness to the research, it is difficult to generalise and apply these findings across the nation or the mental health services as a whole. It is clear that some of the participants had conflicting responses informed by the capacity in which the work in relation to the schizophrenic patient.

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Appendix One:



A psychotherapeutic exploration of the treatment of Schizophrenia in Ireland.

Participant Information Sheet

My name is Nicola Harrison and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am interested in looking at the diagnosis and treatment of schizophrenia in Ireland. I am inviting psychiatrists to partake in offering their knowledge and experience in this area. If you would like to participate please read the detailed information provided below.

What is Involved?

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 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.

Withdrawal from the Study

If you initially decide to take part you can subsequently change your mind. You can request to have your data removed from the study. Additionally, under the Freedom of Information Act (1997) you have the right of access to information concerning you, which you may request from the researcher in writing.

For additional information please contact:

Researcher: Nicola Harrison nicola.harrison2@gmail.com

Research Supervisor: Dr. Grainne Donohue grainne.donohue@dbs.ie

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 / /

Appendix Two:



A psychotherapeutic exploration of the treatment of Schizophrenia in Ireland.

Consent Form

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/here to ask questions on any aspect of the study that concerned them.

Signature

Name in Block Capitals

Date

Appendix Three:

INTERVIEW QUESTIONS

- Q1.** What drew you towards specialising in the area of mental health?
- Q2.** As a professional, what is your experience of Schizophrenia?
- Q3.** What happens when someone diagnosed with schizophrenia presents to the services; could you take me through the steps involved?
- At what stage do you get involved?
- Q4.** Could you describe the process involved in deciding upon a care plan or intervention for a patient diagnosed with schizophrenia?
- What is your role in this?
- Q5.** What factors are considered when deciding upon an appropriate intervention?
- Q6.** How are these interventions monitored? Is there ever a decision made to alter them? What influences these decisions?
- Q7.** To what extent is the patient involved in the decision making around their care plan/recovery?
- Q8.** To what extent are family members involved in the decisions around their loved one's care plan?
- Q9.** Could you describe some of the psychological supports that are in place for patients diagnosed with schizophrenia in the service? How are these accessed?
- Q10.** In your opinion, what is the efficacy of psychological interventions being used to treat patients diagnosed with Schizophrenia?
- Q11.** Would you have any causes for concern regarding the use of psychological interventions in treatment of Schizophrenia?
- Q12.** What are the greatest challenges you face in treating individuals with a diagnosis of Schizophrenia?
- Q13.** Are there any particular difficulties you experience with this type of work? How do you manage this?

Q14. Is there anything else you would like to add?