An investigation into working alliance, compliance and congruence of beliefs among clients with a diagnosis of schizophrenia and their case managers.

Donal Leddy

D. Clin. Psy. 1999

University College London

ProQuest Number: U643578

ProQuest U643578

Table of contents

8.1 Themes

8.2 Clinical implications

8.3 Limitations of the study

8.4 Directions for Future research

8.5 Concluding remarks

Abstract

The therapeutic relationship is central to any intervention, and although relatively neglected in clients with psychosis, there is evidence of its importance in both case management and pharmacotherapy, the two cornerstones of the care of such clients. A therapeutic relationship might have a direct beneficial effect, as well as influencing compliance with treatment. A useful model of the alliance in the case management of clients with psychosis is the working alliance as it is applicable across treatments. Central to the working alliance is a sense of agreement, or congruence between client and clinician. Achieving congruence can be especially difficult in clients diagnosed with schizophrenia, due to disagreement among clinicians and clients over understanding the disorder, the severity of the phenomena under consideration, and aspects of the interventions used. The idea that some clients lack insight into their condition both reflects and exacerbates difficulties in establishing agreement. The concept of concordance draws together congruence of beliefs about the disorder and its treatment, adherence to treatment, and the alliance between clinician and client. In the present study, the associations between alliance, adherence and congruence of beliefs were examined in a cross-sectional, correlational study.

The participants were 40 clients with a diagnosis of schizophrenia, and the 10 case managers who cared for them in an inner-city multi-disciplinary community mental health team. All clients were receiving anti-psychotic medications. Measures used included the Working Alliance Inventory; the Causal Belief Questionnaire; the Insight Scale; the Manchester scale for assessing symptoms and side effects; and indirect measures of adherence with treatment, rated by the case managers. The participants were also asked open questions about helpful and unhelpful aspects of treatment. Multivariate techniques were used to analyse the data.

Case manager-rated alliance was positively associated with compliance with treatments. Client-rated alliance was negatively associated with compliance with medication, and positively associated with insight. A content analysis of the open questions suggested that clients and case managers had similar views over the helpful aspects of treatment, but differed over the unhelpful. The links between alliance and compliance are complex, perhaps reflecting the rating source, and judgements and expectation of treatment. The notion of concordance as defined was not supported, but the alliance seems to be an important factor in case management.

Acknowledgements

Table of Appendices

List of Tables

Chapter One

The Therapeutic Alliance and Psychosis

Any therapeutic enterprise involves a relationship between client and clinician. The nature of this therapeutic relationship, the importance it should be accorded, and its role in change have long been debated. The relationship has perhaps been most thoroughly and explicitly addressed in the domain of individual psychotherapy, but an understanding of the vicissitudes of the interaction between clients and clinicians may be useful across a range of settings and treatments. The following chapters represent an investigation of the therapeutic relationship in the context of the case management of clients with a diagnosis of schizophrenia. In Chapter One, the concept of the therapeutic relationship is introduced, along with a discussion of its importance and relative neglect in the care of people with psychosis. In Chapter Two, evidence is presented of the concept's utility in the care of this client group, for both case management and pharmacotherapy. In Chapter Three, the Working Alliance is suggested as the most appropriate model of the therapeutic relationship in this treatment setting, and the model is then related to that of more general agreement between client and clinician. In Chapter Four, the difficulties in achieving agreement in the domain of the case management of schizophrenia are examined. Chapter Five sets out both the aims of the present study and the specific research questions. In Chapter Six, details of the methodology are presented, and the results are analysed in Chapter Seven. In Chapter Eight, these results are considered with reference to the research questions, and the theoretical and clinical implications are discussed. This is followed by a consideration of the limitations of the present study and suggestions for future research.

1.1 History of the concept of the therapeutic alliance

Perhaps the first appreciation of the central importance of the relationship in the treatment of psychological problems is found in the work of Freud, and the concept of transference he developed. Freud conceptualised the relationship between therapist and client as being based on past experiences, which are transferred into the present therapeutic situation (Freud, 1905/1990). Transference was divided into positive (feelings of affection) and negative (feelings of hostility). The former was further divided into conscious, friendly feelings, and unconscious, erotic feelings. In Freud's formulation, the negative and erotic positive aspects of the transference represented the greatest resistance and a challenge to the therapy, and the friendly, positive feelings needed to be used to aid the therapy (Freud, 1912/1949). Thus he argued that "the first aim of the treatment consists in attaching (the patient) to the treatment and to the person of the physician" (Freud, 1913/1949, p.360) in order to foster these collaborative feelings.

Greenson (1967) conceptualised the relationship as consisting of the transference, which is a distorted view of the therapist, and the working alliance, the capacity of the client to carry out the work of therapy, and realistically appraise the therapist; "the relatively non-neurotic, rational rapport" (Greenson, 1967, p.192). He suggested that the client 'oscillates' between the transference and the working alliance.

Thus it has been proposed that the relationship has different aspects (Langs, 1976), and that it is useful to attempt to distinguish between these aspects (De Jonghe, Rijnierse & Jansson, 1991).

2

More specifically, a distinction has been made between those aspects of the relationship which help the therapeutic endeavour, and those which hinder it. The concept of a collaborative alliance between the therapist and the client has long been considered as helpful to the therapeutic process.

1.2 Current Opinion

There are many different models of the alliance (Bordin, 1994), but there are certain themes that appear relatively consistently.

1.21 Multidimensionality

The alliance is usually conceptualised as being multidimensional (Agnew-Davies et al., 1998) and in a factor analysis of three alliance measures, the two factors which are most consistently reported are an affective bond, and agreement on tasks and goals (Hatcher & Barends, 1996). This has echoes of Greenson's distinction between 'positive feelings' and the 'capacity to work' (Greenson, 1967). At the same time, many researchers seem to consider that the concept of a general alliance is also useful. This may reflect the potential difficulties in communication that could arise from the investigation of a multiplicity of different dimensions.

1.22 Role in Change

There are different, even conflicting, views of the role of the alliance in change. It has been viewed as the agent of change in itself (Henry and Strupp, 1994), and some have suggested that the struggle to form the alliance (Mallinckrodt, 1996), or to overcome ruptures in the alliance

(Safran, Muran & Samstaag, 1994) is an experience that can effect change. Other authors have suggested that the alliance may be a necessary condition for therapeutic techniques to work (Gaston and Marmer, 1994), facilitating other aspects of the change process, rather than being the central element of change (Raue and Golfreid,1994).

These disputes may be reflected in the distinction drawn between the specific and non-specific aspects of treatment, the former term referring to the technical aspect of treatment, the latter to the relationship between the client and clinician (Raue and Goldfreid, 1994). Those who view the alliance as the agent of change tend to view this distinction as not particularly helpful (Parloff, 1986), while the distinction is important for those who view the alliance as facilitative, allowing particular techniques to be effective.

Perhaps the more important issue is the interdependence of technique and the relationship between client and clinician (Safran, Muran & Samstag, 1994). It has been pointed out that the concept of the alliance is useful precisely because it allows both the technical and relational (specific and non-specific) aspects of treatment to be considered together, as interdependent factors (Horvath & Greenberg, 1994).

1.23 Relative Contributions

The third aspect of the alliance is the consideration of the relative contributions of both client and clinician factors to the alliance (Horvath & Greenberg, 1994). These can considered separately, and a distinction has been drawn between the therapist's facilitative behaviours, and

the client's capacity to be actively involved (Henry & Strupp, 1994; Coady, 1993). However, it is the emphasis on the interaction and mutuality between client and clinician that makes the alliance potentially such a useful concept (Horvath & Greenberg, 1989). It has been found that a key variable in forming an alliance is the complementarity, or degree of fit, between the interactional styles of client and clinician, regardless of the actual styles themselves (Keisler & Watkins, 1989). This supports the suggestion that specific behaviours or capacities are less important than the mutuality between the client and clinician.

However it is conceived and termed, there are many studies suggesting that the therapeutic relationship is a key predictor of outcome in therapy.

1.3 Reviews

In a meta-analysis, Horvath and Symonds (1991) reviewed 24 studies, with 20 distinct data sets, and found a reliable association between a good alliance and positive therapy outcome, especially when based on clients' assessment of the alliance. This effect occurred regardless of the type of treatment, which included psychodynamic therapy, cognitive therapy and eclectic or mixed therapies. The studies used a variety of measures.

Luborsky (1994), reviewing studies since 1976, found that the alliance, again measured in many different ways, positively predicted outcome in 19 out of 24 samples, over 18 studies.

In a review of their own work, the Vanderbilt research projects, Henry and Strupp (1994)

suggested that the alliance predicts outcome, adding that a poor alliance prevents change, regardless of the therapeutic technique employed.

Thus there is a body of evidence suggesting that the therapeutic alliance, however conceptualised, is related to positive therapy outcome (Horvath & Greenberg, 1994) and is a good predictor of outcome (Alexander and Coffey, 1997), and thus it seems to have construct validity.

1.4 Generalisability

However, most of the research into the relationship between clinician and carer has focused on psychotherapy with individuals with less severe forms of mental disorders (Alexander and Coffey, 1997; Frank & Gunderson, 1990). There has been a relative neglect of the importance and vicissitudes of the relationship with people suffering from the most severe mental disorders, especially psychosis (Frank & Gunderson, 1990), and particularly regarding rehabilitation strategies for psychotic patients (Goering & Stylianos, 1987). It is interesting to consider why the relationship between client and clinician might have been relatively neglected with regard to this client group and treatment modality.

1.41 The nature of psychosis

The first reason could be the nature of psychotic phenomena. People suffering from psychosis can be difficult to understand and to engage with (Frank & Gunderson, 1990), and doing so can be disturbing (Fowler, Garety & Kuipers, 1995). Psychotic phenomena represent some of the

most disturbing and, in Jasper's phrase, "non-understandable" (Jaspers, 1963) phenomena in the field of psychopathology. A person may experience fundamental distortions of perception and thinking, such as hallucinations, particularly in the auditory modality, or delusions, such as feeling that his or her thoughts are being controlled by external forces. Such features may represent a loss or blurring of the boundaries of the self, of which the person is unaware (Sims, 1988). Other disturbances of thinking include a breakdown in the flow of thought, which may manifest itself in speech which is difficult to comprehend. A person's affect can seem inappropriate, and perhaps partially as a result of the confusions of thinking, feeling and perceiving, a person may become withdrawn and isolated. Also, it has been suggested that a common feature of people with psychosis is a "lack of insight" into their condition (David, 1990), which may make clients unwilling to engage with clinicians.

Another difficulty in engaging with such clients may be the pessimism and despair associated with psychosis and its treatment, "the discouragement of recurring symptoms, the defeats of readmissions" (Strauss, 1992). While the perception that such disorders have chronic course may be partly due to the "clinician's illusion" (Harding & Zahmiser, 1994), whereby professionals see only the most severe cases, there is little doubt that the outcome for the most severe psychoses is worse than that for affective disorders, in terms of both psychopathology and negative social consequences (Marneros, Desiter & Rohde, 1992).

The combination of non-understandability and isolation, with fear and hopelessness potentially within both client and clinician, means that it can be difficult to form and understand

relationships with clients suffering from psychosis. It is interesting to note in this regard that Freud argued that it was not possible to develop a transference with a schizophrenia patient (Freud, 1915/1986). However, other clinicians have developed and described close relationships with psychotic patients (e.g. Fromm-Reichmann, 1959), and while all emphasise the difficulties involved, in and of itself that would be no reason to avoid such relationships.

It is also worth noting that psychotic phenomena may not be as non-understandable as they first appear. The concept of non-understandability has often been used, implicitly or explicitly, to distinguish psychotic from non-psychotic phenomena, but there are difficulties in specifying the distinction between psychotic and normal phenomena (Bentall, 1990). Psychotic phenomena have been conceptualised as severe manifestations of normal phenomena (Fowler et al., 1995; Costello, 1992), or as intelligible communications (Laing & Esterton, 1964). It is also interesting to consider the position held by some psychoanalysts, that psychotic phenomena are manifestations of the most primitive, infantile states, common to all individuals (Fairburn, 1940/1984).

1.42 The decline of psychotherapy

A second possible reason for the relative neglect of the alliance in psychoses is that psychotherapy has become less popular in the treatment of such disorders. This is for several reasons.

1.421 Efficacy

Firstly, the evidence for the efficacy of psychotherapy was largely based on individual case studies, which have limited generalisability. A review of studies of the efficacy of individual, insight-oriented psychotherapy suggested that it had no beneficial effects, and may even have had deleterious effects (Mueser & Berenbaum, 1990). A comprehensive review of the literature by Scott and Dixon found no consistent evidence of any benefits from insight-oriented psychotherapy (Scott & Dixon, 1995). It may be that the decline in psychodynamic treatments has led to a corresponding decline in interest in the therapeutic alliance. However, this would seem to be a case of 'throwing the baby out with the bath water' in that the whole issue of therapeutic relationships may have been dismissed along with a treatment that relies on a particular conceptualisation of the relationship, namely transference, and a particular way of using it, namely psychodynamic psychotherapy.

1.422 Milieu

Secondly, psychotherapy with psychotic clients may have become less popular because of changes in the treatment milieu. It has been argued that intensive psychotherapy with such a disturbed population requires an inpatient setting, and so the move from hospital to community based treatments would render it impractical (Goering & Stylianos, 1987). However, psychotherapy with psychotic clients is practised in a community setting (Jackson, 1991).

1.43 Medication

A third possible reason for the neglect of the alliance is the apparent success of anti-psychotic

medication, which has led some to suggest that biological treatments might be all that are necessary (Bentall, 1996). Indeed, the lack of interest in the relationship between the patient with psychosis and the clinician may be part of the current biological zeitgeist (Bentall, ibid.).

However, there is considerable debate over the efficacy of medication. Although medication can produce improvement in delusions and hallucinations for 60-70% of patients, symptomatic improvement does not necessarily lead to global improvement (Shepherd, Murray & Muijen, 1995), and medication does not generally produce an adequate sense of fulfilment or security (Meltzer, 1995). Also, it has been suggested that there has been a decline in the improvement rates of schizophrenia since the 1970's (Kane, 1999), and it has been speculated that this might be due to an over-emphasis on biological treatments (Diamond, 1997).

Thus although there are number of arguments as to why there might be a neglect of the alliance in the case of people with psychotic disorders, they are by no means conclusive.

Chapter Two

Case management, Compliance and the Working

Alliance

In this chapter evidence regarding the relationship between client and clinician in the treatment of psychosis is reviewed. Much of the evidence regarding the importance of the therapeutic relationship in the treatment of psychosis has emerged out of attempts to adapt to the realities of changes in the nature of care of such clients. The most important changes in treatment are the shift in setting from the hospital to the community, and the improvements in pharmacotherapy. Recent developments in psychological interventions are also briefly considered. Following this is a consideration of which is the most appropriate model of the therapeutic alliance for use in examining the case management of clients with psychosis. It is proposed that the most useful model is the Working Alliance (Bordin, 1979) and the chapter concludes with an examination of this model.

2.1 Case management

2.11 Community Care

Alongside advances in pharmacotherapy, the move from hospital to community care is probably the most important recent development in the treatment of psychoses. There were a number of forces behind this change in treatment setting, including concerns about the humaneness and actual therapeutic benefits of hospital care, as well as its cost effectiveness, and optimism about anti-psychotic medications (Bachrach, 1997; Carrier & Kendall, 1997).

There is little doubt that community care can be beneficial. A review of five controlled studies comparing home care with inpatient care (Muijen, Marks, Connolly, Audini & McNamee, 1992) suggested that clients cared for in the community showed a better outcome in terms of symptoms, social functioning and satisfaction with services. However, these and other studies also showed that the benefits were lost on the withdrawal of the experimental treatment and the return to standard outpatient treatment (Muijen at al., 1992; Hoult, 1986). This suggests that there are some components of effective community care which need to be carefully considered and fostered, and there is some debate over what these effective components are.

The difficulty in delivering effective community care was that services which had been located within one institution, the hospital, were now dispersed (Shepherd, 1990) leading to a fragmented and complex pattern of available services (Bachrach, (1992). This complexity meant that the very patients who were most in need of services found it most difficult to access them, namely those with the most severe disorders such as psychosis, who are often isolated and difficult to engage (Mueser, Bond, Drake & Resnick, 1998).

2.12 Brokerage Case Management

There was thus a clear need to "glue services back together again" (Shepherd, 1990) so as to ensure continuity of care, both over time and across service providers (Bachrach, 1993). This requirement for a mechanism to ensure the effective co-ordination of and access to services led to the development of 'case management'.

Although there are many different definitions and models of case management (Bachrach, 1993), there is some consensus on the essential ingredient, namely that the responsibility for developing and maintaining care lies with a single agency, usually an individual, the case manager. In earlier models of case management, often termed 'brokerage' models, the case manager was responsible for the implementation of care, but did not necessarily provide it (Holloway, McLean & Robertson, 1991). However, this model led to few benefits for clients. For example, a study of 435 clients, discharged from psychiatric hospital and followed up for 52 months, found that those receiving brokerage case management had increased hospitalisation rates, but similar use of ambulatory services, compared to clients receiving other outpatient services (Curtis, Millman, Struening & D'Ercole, 1992). These findings are consistent with other studies (Rapp, 1998).

2.13 Clinical Case Management

The apparent inadequacies of this model led to the development of what is termed 'clinical' case management, whereby as well as being responsible for co-ordination, the case manager directly provided care. In practice, this can include implementing psychological interventions, and administering medication (UK 700, 1999). A comprehensive review of the literature, examining 75 studies, found that clinical case management tended to be associated with reduced hospitalisation and improved housing conditions, and with moderate improvements in symptomatology and quality of life. However, there was little association with social functioning (Mueser et al., 1998).

In attempting to understand the differences in efficacy of the models, one could speculate that the key difference in the more efficacious models is that the case manager also acts as a clinician (Shepherd, 1990). A review of 24 studies of the outcome of case management found that although 75% more of the clients did better than in control conditions, there were no significant differences between the practice models reviewed (Gorey, Leslie, Morris, Carruthers, John & Chacko, 1998). It was suggested that the key variable affecting outcome was the working relationship between client and case manager (Gorey et al. 1998). This in turn could lead to the suggestion that the therapeutic alliance might be an important factor in the success of case management. It has been suggested that central to case management is a "secure and dependable supportive relationship" (Bachrach, 1993) with the case manager, and indeed there is some evidence that the therapeutic alliance is a useful concept in understanding the response to case management.

2.14 Research on the alliance in case management of psychotic clients

Preibe and Gruyters (1993) examined the predictive value of the helping alliance between 73 patients and their case managers, using hospitalisation, accommodation situation and work situation as the outcome criteria. Several aspects of the helping alliance, as defined for the purposes of the study and rated by the clients, were associated with better outcome. These were; feeling better understood and less criticised; feeling better after meeting case managers; and viewing treatment as right. However, the measure of the helping alliance had not been previously validated.

In a study of 143 clients with severe mental illness, Neale and Rosenheck (1995) found that a strong alliance, as rated by the case manager, was associated with a range

of case manager-rated positive outcomes, including improved symptomatology and global functioning. Client-rated alliance was associated only with client-rated measures of positive outcome, namely improvement, benefit and satisfaction. This study used a well-validated instrument, the Working Alliance Inventory (Horvath & Greenberg, 1989), and showed some discrepancy between client and case manager ratings of the alliance.

Klinkenberg, Calsyn and Morse (1998) investigated the role of the helping alliance between case managers and 105 homeless people with severe mental illnesses, two thirds of whom were diagnosed with schizophrenia. After 14 months of treatment, a strong alliance, as rated by the client, was found to be associated with greater consumer satisfaction. However, this study did not use a widely validated scale.

In a study of 96 clients with serious mental illness (Solmon & Draine, 1994) clients were allocated to either a case management team composed mainly of consumers of mental health services, or a non-consumer run case management team. The most important factor in explaining levels of satisfaction with treatment was the personal characteristics of the individual case managers, rather than which team the clients were cared for by. The researchers argued that this suggested that what they termed the 'non-specific element' of the working alliance, namely variables determining the relationship with the case manager, were more important than the specific element, i.e. the structure and nature of the intervention, in explaining overall satisfaction with treatment.

In summary, there is evidence that clinical case management, in which the case manager is directly involved with the client in treatment, is of greater benefit than models where the case manager is not so involved. There is also evidence that the working alliance may contribute to positive outcomes, and perceptions, of case management. Thus the working alliance may be a valid and clinically useful construct in case management of people with psychosis, as it is in psychotherapy with less disturbed clients.

2.2 Pharmacotherapy

The second major development in the treatment of psychosis has been the advances in pharmacotherapy, and neuroleptic medications are currently considered central to the treatment of psychosis (Day & Bentall, 1996). An important piece of evidence regarding the role of the working alliance in pharmacotherapy comes from a study into the relationship between alliance and outcome in the outpatient treatment of depression (Krupnick, Sotsky, Simmens, Moyer, Elkin, Watkins & Pilkonis, 1996). 225 clients were randomly assigned to one of four conditions; interpersonal therapy (IPT); CBT; imipramine with clinical management; or placebo with clinical management. A significant relationship was found between alliance ratings and outcome across all four conditions, and more of the variance on outcome was attributed to alliance than to treatment method.

There are two possible explanations for these findings that may be relevant to the treatment of psychosis. The first is that the alliance with the clinician might be a 'non-specific' factor in pharmacotherapy, "above and beyond the specific pharmacologic action of the drug" (Krupnick et al., 1996, p.537). The second is that

16

the positive association between outcome and alliance in the imipramine condition might be mediated by compliance with the medication. Although this would not necessarily explain the outcome in the placebo group, it is nevertheless a variable which was not controlled for, and one which may be particularly crucial in pharmacotherapy.

The first explanation could lead one to speculate whether the same is true of the pharmacotherapy of psychosis, namely that alongside the specific effects of the medication, there are non-specific effects reflective of the alliance with the case manager. It interesting in this regard to consider a report of two cases of treatment-resistant psychosis by Geisen and Feuer (1984), who argued that inter- and intra-personal factors could overwhelm the response to medication. Thus it may be possible that the vicissitudes of the alliance could mediate the effects of medication, beneficially or otherwise.

The second explanation, concerning compliance with medication, is also relevant to the treatment of clients with psychosis. It is useful to consider the question of terminology at this point. The term 'compliance' is widely used to refer to the degree to which a treatment is implemented, but the coercive overtones of this term have led some to suggest that 'adherence' may be a better alternative (Blackwell, 1976). More recently, it has been suggested that 'concordance' is a term that places appropriate emphasis on the views of the client, stressing as it does the importance of agreement between client and clinician (Bradley, 1999). The issue is particularly difficult in the treatment of psychosis, because there sometimes is coercion, in the form of compulsory admission to hospital and involuntary treatment. In this study, the terms

'compliance' and 'adherence' will be used interchangeably, to refer to the degree to which a client carries through a treatment, medical or otherwise, as suggested by health professionals. The word 'degree' is used to emphasise that compliance is rarely absolute (Bradley, ibid.). The term 'concordance' will be defined more specifically in a later chapter.

It has been suggested that non-adherence may be the most important contributing factor to failures in medical treatment of psychosis, and certainly the rates of non-adherence can be very high, with estimates of up to 75% in first episodes (Kissling, 1992), and even up to 80% (Corrigan, Liberman & Engel, 1990). Non-compliance has been associated with both more frequent (Green, 1988) and longer periods of hospitalisation (Hoge, Appelbaum, Lawlor, Beck, Litman, Greer, Gutheil & Kaplan, 1990), and would thus seem to be a construct with clinical and empirical relevance in the treatment of clients with psychosis (Horvath & Greenberg, 1987). It has been suggested in the literature that adherence would be improved by a good therapeutic relationship (Bradley, 1999; Cameron, 1996; Fenton, Blyler & Heinssen, 1997; Griffiths, 1990; Besch, 1995), and there is some evidence for this.

Frank and Gunderson (1990), found that among 143 clients with schizophrenia receiving two forms of psychotherapy, those who formed good alliances with their therapists were more likely to comply with medication after two years. The alliance was assessed by the therapist, using a standardised instrument. 74 % of those with fair alliances and 72% of those with poor alliances were non-compliant, as opposed to 26% of those with good alliances. This study also suggested that clients who developed good alliances were less likely to drop out of psychotherapy. 87% of those

with good alliances and 83% of those with fair alliances continued therapy for six months or longer, as against 42% of those with poor alliances. These findings suggest that the alliance may be associated with adherence to both medication and non-medical treatment.

Thus there is evidence that the therapeutic relationship can be important in pharmacotherapy, whether directly by influencing the somatic effects, or indirectly by influencing adherence to medication. Coady (1993) has highlighted this idea of direct and indirect benefits of the working relationship.

It is important to consider two other studies, which could support a rather different explanation of adherence. A study comparing adherence to anti-psychotic medication among 153 clients on a closed ward, an open ward, attending an out-patient clinic and on hospital leave found non-adherence rates of 7%, 32%, 35% and 63% respectively in these settings (Irwin, Weitzel & Morgan, 1971). This suggests that it may be the level of supervision that determines compliance.

A study of 202 clients with a diagnosis of schizophrenia found that the factor which had the most impact on non-adherence was not receiving mental health care over the preceding 3 month period (Nageotte, Sullivan, Duan & Camp, 1997). Only 26% of clients in such a situation were adherent, compared with 59% otherwise.

The above two studies could be taken to support the notion that it is not the quality of the relationship per se, but the level of supervision involved in more frequent

encounters, that effects adherence. More frequent contact might lead to a better relationship, but this could be secondary.

2.13 Psychological treatments

Some indirect evidence for the importance of the working alliance in the care of this client group comes from studies into cognitive-behavioural therapy (CBT) for psychotic disorders. There have been a number of individual case reports and small scale or uncontrolled studies into the effects of CBT on auditory hallucinations (Haddock, Bentall & Slade, 1996), delusions (Chadwick & Lowe, 1990), psychosis (Garety, Kuipers, Fowler, Chamberlain & Dunn, 1994) and schizophrenia (Kingdon & Turkington, 1991), all of which indicated that cognitive-behavioural techniques may be beneficial. These reported successes highlighted the need for large scale, controlled studies. In three such studies, alongside the specific effects of CBT, there were improvements in the control conditions, which were counselling (Tarrier, Yusupoff, Kinney, McCarthy, Gledhill, Haddock, & Morris, 1998), case management (Kuipers, Garety, Fowler, Dunn, Bebbington, Freeman & Hadley, 1997), and structured activity (Drury, Birchwood, Cochrane & MacMillan, 1996). Another study showed improvements regardless of which form of cognitive therapy was used (Tarrier, Beckett, Harwood, Baker, Yusupoff & Ugarteburn, 1993). Thus there may be non-specific elements to psychological interventions (Birchwood, 1999; Kuipers, 1999), which supports the idea that there may be benefits involved in the process of entering into a therapeutic relationship, regardless of the technical aspects of treatment. This is consistent with the findings of Solomon and Draine (1994), mentioned above. It was suggested earlier that the specific and non-specific aspects

of treatment might be best conceptualised as interdependent aspects of the therapeutic alliance.

It is interesting to note in this regard that a review of research into psychosocial treatments and schizophrenia by Bellack and Mueser (1993) suggested that the effects of such treatments may be temporary, and that ongoing intervention may be necessary. This has echoes of the importance of continuity of care in case management (Bachrach, 1993), and it is thus possible that in both case management and CBT the alliance between client and clinician is a "potent therapeutic factor" (Goering & Stylianos, 1990).

An interesting study, that relates to both compliance and psychological treatments, was carried out into the effects of 'compliance therapy' (Kemp, Hayward, Applewhaite, Everitt and David, 1996), a cognitive intervention based on motivational interviewing (Kemp et al., ibid.). Compared with supportive counselling, the experimental condition was associated with improvements in attitude, insight and compliance, maintained at six months (Kemp et al., ibid.) and at 18 months (Kemp, Kirov, Everitt, Hayward & David, 1998). Both groups had improved symptom scores, with no difference between them. There are two aspects of these findings relevant to the present study. Firstly, the symptomatic improvements in both conditions provide further support for the importance of non-specific elements of psychological interventions. Secondly, as compliance therapy emphasised collaboration within a therapeutic alliance (Kemp, David & Hayward, 1996), it may be that the improvements in compliance are related to the fostering of the alliance, as much as to any specific technical aspect of the intervention.

Thus there is a body of evidence to suggest that the therapeutic alliance may be an important concept in the treatment of psychosis, despite its relative neglect. This would justify research into the construct in the treatment of people with psychosis.

Chapter Three

The Alliance, Psychosis and Congruence

In this chapter, the question of the most appropriate model of the therapeutic alliance for case management of clients with psychosis is considered, and the Working Alliance (Bordin, 1979) is put forward as potentially the most promising model. The problems of establishing a working alliance with clients suffering from psychosis is then considered. The theme of congruence is introduced and its importance in terms of both the alliance and compliance is examined.

3.1 Which model of the therapeutic alliance?

However, the question arises of whether there are particular aspects of the care of people with psychoses that mean that some models of the therapeutic alliance are more helpful than others, particularly when one considers that the models have generally been developed for individual psychotherapy with less disturbed people. While there is no standard treatment package for people with psychosis, there are features of the care of such clients that will be common to most.

Most people with psychosis, who are in treatment, will receive care from a variety of professionals, in different modalities. Case managers tend to come from a range of professional backgrounds. This means that for a model of the alliance to be generalisable for all such clients, it has to allow for a variety of models of the disorder, and ways of working.

A second issue is the suggestion that, in terms of psychological treatments, highly emotive and insight-oriented techniques are less useful that those that are more structured and supportive (Goering & Stylianos, 1988; Fowler et al, 1995). Thus any conceptualisation of the working alliance might have to allow for not explicitly using techniques such as transference interpretation in treatment.

Thus what is required is a model of the alliance that is pan-theoretical, and applicable over a range of treatment modalities.

3.11 The working alliance

The alliance as conceptualised by many researchers is rooted in individual psychotherapy (e.g. Luborsky, 1994), especially psychodynamic therapy (e.g. Henry & Strupp, 1994). However, Bordin's (1979) concept of the Working Alliance is both pantheoretical (Safran et al., 1994; Horvath, 1994) and applicable to any therapeutic relationship, regardless of treatment style (Horvath, 1994). It is thus perhaps the most appropriate model of the therapeutic alliance to use in the understanding of the relationship between the client with psychosis and the clinician aiming to help him or her (Goering & Stylianos, 1988).

3.111 History of the concept

This concept is derived originally from the work of Greenson (1967), who attempted to classify different aspects of the therapeutic relationship, and conceived of transference, the working alliance, and the real relationship (Greenson, 1967). However, these concepts were still essentially psychoanalytic, as the working alliance was defined in relation to the transference. There was a need for a concept of the alliance that could embrace all

therapeutic relationships, so as to integrate the burgeoning research findings from diverse therapies (Horvath, 1994).

It is crucial to understand that Bordin was not attempting to replace concepts such as the transference; rather, he was emphasising that there is a feature common to all therapeutic endeavours, and that is a collaboration between the person seeking change and the person offering themselves as an agent of change (Bordin, 1980 [in Horvath and Greenberg 1987]). He collapsed Greenson's concepts of the real relationship and the working alliance, and used the latter term to describe this "collaboration for change" (Bordin, ibid.).

3.112 Aspects of the Working Alliance

Bordin envisaged the working alliance as a relationship comprising three aspects. The definitions of these aspects offered below are derived from a number of sources (Bordin, 1979, 1980 [in Horvath and Greenberg 1987], 1994; Horvath, 1994; Horvath & Greenberg, 1987, 1989; Goering & Stylianos, 1988; Gaston, 1990).

Goals

The first aspect is a sense of agreement and shared understanding about the goals of the therapeutic endeavour. These goals can be implicit or explicit, but the client must feel that they are relevant, and the clinician must have some evidence, direct or indirect, that the client shares and accepts them. The goals represent the client's wishes within the clinician's theoretical and practical framework, and achievement of these goals is the intended outcome of the therapeutic endeavour.

Tasks

Client and clinician must also have a sense of agreement about the tasks required to accomplish the goals, and an understanding and acceptance of their respective responsibilities in achieving the goals. Each must feel that the tasks are effective, relevant and reasonable. These tasks comprise the substance of the therapeutic endeavour, and the term refers to both cognitions and behaviours. The clinician tends to suggest and select the tasks, but agreement with the client is essential.

Bond

This third aspect refers to the human relationship which develops over the course of the interaction, and which helps to sustain the therapeutic endeavour. The term refers specifically to positive and mutual attachments, such as a shared sense of understanding, liking and trust.

3.113 Features of the model

Before considering the theory in more detail, it is worth emphasising the advantages of this model, in the context of case management of people with psychosis.

Pantheoretical

The great advantage of the concept of the working alliance, as mentioned above, is that it is generalisable across differing theories and practices. An important aspect of its generalisability is the use of relatively concrete terminology, which can be understood by people not acquainted with psychological theories (Horvath & Greenberg, 1987).

Operationalisable

Perhaps in part because of the concreteness of the concept, is has proved readily operationalisable, and an instrument has been developed specifically to measure the construct. The process of developing and validating of this instrument, the Working Alliance Inventory, is described by Horvath and Greenberg (1989). This instrument provides a means for the testing of specific hypotheses about the alliance and its aspects.

3.114 Theory and research

Below is an account of some of the theoretical aspects of the alliance and a presentation of research findings which may be relevant to the issue of the care of people with psychosis.

Working alliance theory seems to imply that there are two key elements of successful treatment; the building and maintaining of a strong alliance, and the power of the treatment (Bordin, 1994). These are examined in some detail below.

3.1141 The building and maintenance of a strong alliance

To understand this, one needs to look at the concept of the alliance more closely. The working alliance is above all else a measure of mutuality, collaboration and a sense of agreement (Horvath, 1994). This has a number of implications. Firstly, the emphasis is more on the degree of mutuality between client and clinician than on particular qualities of each (Horvath and Greenberg, 1994). Secondly, there is an emphasis on client and clinician as active participants in a process of negotiation (Bordin, 1994).

As the key element of a strong alliance is collaboration and mutuality, correspondingly the key issue in building, maintaining and improving the alliance is the establishment of agreement, which may involve the overcoming of disagreement. The challenges of establishing agreement in the building of an alliance may be somewhat different to those involved in establishing agreement in the maintenance and improvement of an existing one.

3.11411 Building

Bordin (1994) suggests that the key to building is negotiation of agreement on goals. The personal interaction involved in negotiation develops the bond. The treatment tasks, to a considerable extent, are dependent on the goals, and thus a clear understanding of the goals should be reflected in a strong commitment to the tasks.

There are two points to emphasise here. Firstly, the process of negotiation of agreement is central to the building of the whole alliance. In other words, it is not only the level of agreement that is important in treatment, but also the process of reaching agreement.

Secondly, the inter-relatedness of the three aspects is clear in this context. The bond mediates the extent of agreement of tasks and goals, and agreement on these dimensions in turn mediates the strength of the bond (Safran et al., 1994).

3.11412 Maintaining

In terms of maintaining and improving the alliance, the challenge seems to be rather different. As, by definition, some degree of agreement has been reached, the issue seems to

28

be more one of overcoming the disagreements which inevitably develop and improving the existing level of agreement further. Disagreements have been termed 'ruptures' (Safran et al., 1994) and can manifest themselves in different forms, including withdrawal from the tasks of treatment (Safran et al., ibid.). This may have parallels with the idea of non-adherence to treatments mentioned earlier. The suggestion seems to be that the key to overcoming ruptures lies in the inter-relation between the different aspects. When the commitment to, and understanding of, goals and tasks is rooted in positive bonds, this commitment and understanding can overcome ruptures (Bordin, 1994). Thus the ability to form positive bonds is essential for maintaining the alliance in the face of inevitable strains.

This suggests that the alliance develops over time in a number of ways. Firstly, the strength of the alliance fluctuates due to ruptures and repairs in the alliance. Secondly, a successful alliance should increase in strength over time, and some evidence suggests that this increase may be linear (Kivlighan & Shaughnessy, 1995). Thirdly, the relative importance of the three aspects of the alliance may change over time (Horvath, 1994). It has been suggested that the bond component takes longer to develop, becoming stronger over time, and is more important in the maintenance of an existing alliance than in the building of a new one (Pinsof, 1994). This is consistent with the notion that the goal aspect is more important in building.

3.1142 The power of the particular treatment

This refers to the clinical effectiveness of the treatment tasks in achieving the desired goals. The treatment should be appropriate to the problem, and while it is up to the clinician to decide whether a treatment is appropriate, obviously agreement with the client is desirable.

This situation is made more complex by that fact that different treatments pose different demands on the client, and on the different aspects of the alliance, and the client has to able to meet those demands. Thus the treatment has to be appropriate to the client's capabilities, which will to some extent be reflective of the presenting problems. The strength of the alliance thus also depends on a "goodness of fit" (Goering & Stylianos, 1988), or complementarity (Bordin, 1979) between the clinician, the client, and the treatment modality, in that agreement on tasks is not possible if the demands of the tasks are too great.

3.1143 Research

The value of the Working Alliance Inventory (Horvath & Greenberg, 1989; WAI) in predicting outcome was examined by Horvath (1994) who reviewed eight studies which used the WAI and found a strong link between the client's estimate of the working alliance and outcome of therapy. He further argued that there is evidence that this does not just reflect the level of progress, but is a true reflection of the dynamic between the participants.

The two studies below are mentioned as they may have some particular relevance to the use of the Working Alliance concept in the case management of people with psychosis. Samstag, Batchelder, Muran, Safran and Winston (1998), investigating the outcome of short-term psychotherapy, found that the WAI was predictive of both outcome and drop-out from treatment. Those who dropped out had lower scores than those with poor outcomes, who in turn had lower scores than those with good outcomes. This seems to have parallels with the findings of a relationship between compliance and the therapeutic alliance (Frank & Gunderson, 1990).

Mallinckrodt (1996), in a study of 34 clients in counselling, found that working alliance, using the WAI, indirectly influenced symptoms, mediated by social support. The author also noted that clients with low social competencies may be more prone to develop insecure and problematic emotional attachments to clinicians, which may be relevant to some patients with psychosis, as mentioned above.

3.2 The Working Alliance and Psychosis

It has been suggested that the process of building an alliance is particularly difficult in psychotic clients and takes correspondingly longer (Bordin, 1994). This is consistent with a study cited earlier, of clients diagnosed with schizophrenia who were undergoing psychotherapy (Frank & Gunderson, 1990), which suggested that it took six months for there to be a significant increase in the number of patients with a good alliance. The difficulty in forming the alliance was emphasised by the fact that after 12 months of psychotherapy only 41% of clients had formed good alliances. Furthermore, the findings suggested that if clients had not achieved a good alliance within that time, it was unlikely to be achieved at all. This is in striking contrast to the suggestion that with non-psychotic clients, an alliance can be formed within three sessions (Horvath & Greenberg, 1987).

From the perspective of working alliance theory, the relatively long time necessary to form an alliance, and the finding that the majority of clients do not form good alliances (Frank & Gunderson, 1990), seem to imply that there is some particular difficulty in achieving mutuality in the different aspects of the alliance. The theory further suggests that agreement on goals is the primary task in building an alliance, and also that the affective aspect of the

alliance is less important at this stage. Goals and Tasks can be considered as the cognitive aspects of the relationship, with Bond as the affective (Gaston, 1990). Thus the implication would be that there is some difficulty associated with mutuality in the both the cognitive and affective domains of the alliance. However the theory seems to suggest that, initially at least, the main difficulty would lie in the cognitive aspects of the alliance. These aspects of the alliance are considered in more depth below.

3.21 Cognitive aspects of the alliance

The definitions offered of the Goals and Tasks of treatment are liberal ones, specifying that they be considered relevant and reasonable. Indeed, it is this feature which allows the concept to be used across so many different treatments. When applied to case management, the Goals could be symptom relief, improved housing conditions, or better compliance, to name only a few possibilities. The appropriate Tasks will be correspondingly varied. Which Goals and Tasks are considered relevant and reasonable could reflect the clients' and the clinicians' beliefs about the nature of the problems faced by the clients, and about the most appropriate treatments. The issue of congruence of beliefs between client and clinician, and its relationship to treatment and the therapeutic alliance, has been considered by several authors. The term 'congruence' will be used to refer to similarity of beliefs, to distinguish the concept from agreement in the working alliance.

3.3 Congruence and treatment

It has been suggested that any relationship between client and clinician involves the interaction of the participants' "explanatory models" (Kleinman, 1978) of a disorder. These models concern different dimensions of the disorder, such as aetiology, pathology and

treatment, and there can be conflict between the client's and the clinician's models on any of these dimensions. Kleinman (ibid.) suggested that such conflicts can lead to problems, such as non-adherence to treatment. In a similar vein, Wile (1977) proposed that client and clinician each have ideas about cure, and that conflict between them may lead to resistance on the part of the client. Martin (1988) drew an important distinction between scientific and personal theories of disorders. Both are attempts to explain the phenomena, but scientific theories are in the public domain and need a degree of coherence and validity, while personal theories do not have these constraints and are less formal (Martin, ibid.). Duncan and Moynihan (1994) made a similar distinction between formal and informal theories of disorders and drew attention to the potential importance for treatment of the degree of similarity between theories, as did Martin (1988). McGovern, Newman and Kopta (1986) have called for research into the degree of similarity of clients' and clinicians' attributions for disorders, and the effects on the therapeutic relationship of the degree of similarity. Foulks, Persons and Merkel (1986) suggested that differences in theories may lead to difficulties in establishing a therapeutic alliance. Both Clarkson (1995) and Duncan and Moynihan (1994) suggested that it is up to clinicians to adapt their theories to those of clients. Eisenbruch (1990) argued that clients' views will probably be missed unless they are specifically asked for.

3.31 Research on congruence of models

It is useful to consider some research which bears on these issues. Hunt (1989), in a piece of qualitative research, investigated the explanatory models of women with physical illnesses, and found people held "elaborate prior constructions" (Hunt, ibid.). She also found that peoples' explanations fluctuated under a number of influences, including that of

the physician. Her findings suggested that in cases where treatment took place over an extended period of time, the physician's influence was more persistent. She also suggested that her results supported the idea that 'explanation' is best thought of as a process of interaction, rather than a static template (Hunt, ibid.).

Worthington and Atkinson (1996) investigated the effects of perceived aetiological attribution similarity on ratings of counsellor credibility, using 40 undergraduates role playing as clients. When counsellors' aetiological attributions were manipulated to correspond to the clients', the clients rated the counsellors higher on a scale of effectiveness. The authors suggested that this study supported the idea that attributional similarity was beneficial to the counselling process. They suggested that a useful area of research would be the effects of similarity at a later stage of the process, as the importance of aetiological attributions may be different.

Atkinson, Worthington, Dana and Good (1991) investigated the relationship between four variables; beliefs about the cause of psychological problems; preferences for counselling orientation; ratings of counsellor credibility; and satisfaction with counselling, among 69 clients and their counsellors. The researchers found that perceived, but not actual, similarity of aetiological beliefs was predictive of ratings of credibility and satisfaction. Furthermore, they found that the majority of clients' aetiological beliefs became closer to those of the counsellors over the course of the treatment.

Foulks et al. (1986) investigated the effects on treatment compliance of the degree of similarity between the views of 60 psychiatric outpatients (15% of whom were psychotic)

and clinicians on the causes of mental illness. Clinicians were assumed to have "standard psychological and psychiatric views about the genetic, biological, and social causes of mental illness" (Foulks et al., 1986). Their results suggested that clients who endorsed the medical model, and rejected non-medical beliefs, were more likely to comply with treatment, including medication and appointments.

Gillespie and Bradley (1988), in a study of people attending a diabetes clinic, found that the degree of discrepancy between the patients' and the doctor's beliefs about the causes of the illness could be reduced by encouraging both parties to make their opinions explicit and seek agreement. Importantly, they noted that it was the doctor's beliefs that changed, not the patients'.

Taken together, these findings support the idea that clients and clinicians each have theories about the cause of disorders, and that the interaction of these theories has an impact on treatment. More specifically, congruence of theories seems to be associated with positive rating of counsellors (Atkinson et al., 1991; Worthington & Atkinson, 1996), and adherence to treatment (Foulks et al., 1986). The question could be asked whether congruence of explanatory models is in any way related to agreement on Goals and Tasks aspects of the working alliance. Whilst the studies cited above do not examine the association between alliance and congruence of theories, the results would be consistent with the notion that the achievement of theoretical congruence might be associated with a strengthened alliance.

The next issue to address is congruence in a specific population, namely case mangers and their clients, and to consider what factors might influence the degree of congruence in this population.

Chapter Four

Beliefs about Schizophrenia

In this chapter the theme of congruence of beliefs between clients with psychosis and those caring for them will be examined. A framework for considering explanatory models is proposed, and the difficulties regarding achieving congruence is considered. Evidence regarding clients' and clinicians' beliefs is presented. The concept of insight will be examined in some detail, as it may be closely related to the theme of congruence, and the issue of compulsory treatment is also touched upon.

4.1 Dimensions of understanding

The purpose of this chapter is thus to review the literature, so as to consider the clinical and theoretical utility of the concept of congruence of beliefs within a particular population. To help in this task, it may be useful to consider congruence as consisting of agreement on a number of dimensions, similar to those suggested by Kleinman (1978). Adapting Kleinman's (ibid.) ideas, a possible taxonomy of the dimensions most relevant to psychosis would be aetiology, pathology, treatment and role. These dimensions are briefly elaborated on below.

Aetiology

This concerns the factors that cause the psychosis, and could also be taken to include factors which bring on or prevent relapse.

Pathology

This concerns the nature of the disorder, and explanations of the phenomenology of the disorder.

Treatment

This concerns the most appropriate treatment for the disorder, and could include consideration of side effects and secondary gains.

Role

This is particularly pertinent to psychosis, and concerns the issue of whether the person should be considered as ill or not, and what their role in the process of treatment should be. This dimension could also cover issues of the severity of illness, and subsequent limitations.

It should be noted that these dimensions do not have established construct validity, and there is a degree of overlap. They are thus perhaps best considered as separate, but related aspects of understanding, which are useful concepts for reviewing the literature.

4.2 Models

It is also perhaps useful to consider the distinctions which have been made between formal and informal theories (Duncan & Moynihan, 1994), scientific and personal theories (Martin, 1988), or academic and lay theories (Furnham & Bower, 1992). The literature also refers to "models" (Kleinman, 1978; Foulks et al., 1986) and

"attributions" (Worthington & Atkinson, 1996) as well as to theories. It is important to clarify the terminology that will be used in the present study.

As a taxonomy based on Kleinman's (1978) concept of explanatory models is being used to help understand the literature in this area, it would seem appropriate to use the term 'model' to refer to the explanations, theories and attributions held by clients and clinicians.

It would also seem that the terms 'formal', 'scientific' and 'academic' can be considered as equivalent in this context, and further that they all refer to models adhered to by clinicians, rather than clients. Thus such models will be referred to as 'clinician' models, and 'informal', 'personal' and 'lay' models will be referred to as 'client' models, although it is acknowledged that in fact there can be overlap between them.

4.3 Congruence of models and schizophrenia

The question that needs to be examined, with reference to case management of people with psychosis, is what factors may be associated with the degree of congruence between client and clinician models. It is argued below that there are aspects unique to psychosis and its treatment which will effect congruence. It is further suggested that these aspects are most apparent when one considers clients with a diagnosis of schizophrenia. There are a number of features of this concept which make the achievement of congruence particularly complicated, and these are examined in some detail below. However, they can be summarised by stating, firstly, that schizophrenia is a concept widely recognised by professionals and public, and

yet there is huge controversy surrounding models of the disorder. Secondly, the diagnosis tends to be given to those with the most severe psychotic symptoms, and thus difficulties associated with the care of clients with psychosis may be especially apparent, and a diagnosis of schizophrenia, perhaps more than any other psychiatric diagnosis, has "vast psychological, moral, medical and social implications" (Seigler & Osmond, 1966).

The remainder of this chapter will focus on the concept of schizophrenia, with a view to explaining why is raises particular problems in terms of congruence.

4.4 Definitions of schizophrenia

The intense controversy and disagreement which so characterise debates about schizophrenia include issues regarding its definition. Thus the brief account, given below, of the phenomena which are frequently considered as indicative of the disorder, is not intended to be definitive.

Schizophrenia can perhaps most simply be characterised as the most severe manifestation of psychosis. The phenomena that are taken as characteristic of schizophrenia are at the boundary of the human condition (Barrett, 1998) and include delusions (often of a bizarre nature), hallucinations, thought disorder and negative symptoms. There are several diagnostic systems available, the one most widespread in the NHS being the International Classification of Diseases (ICD-10). The ICD-10 diagnostic criteria for schizophrenia are presented in appendix 1. Approximately 1% of the population have a diagnosis of schizophrenia, a rate consistent throughout the world (Murray, 1997).

The next issue to consider is why it might be difficult to achieve congruence of explanatory models of schizophrenia. In the literature, the dimensions of pathology and aetiology are often examined together, as are the dimensions of treatment and role, and they will be examined in this way below.

4.5 Aetiology and pathology

4.51 Clinician disagreement

The first obstacle to achieving congruence between clients and case managers along these dimensions may be disagreement between clinicians. The debates over models of schizophrenia have been termed a "schism" (Hinshelwood, 1999), and models of schizophrenia have been compared to the productions of the very clients they seek to explain, being "self involved, and while they often display much internal consistency, they lack any comprehensible relation to each other" (Seigler & Osmond, 1966). Indeed, there are an almost bewildering range of clinician models of schizophrenia, and although it is not the purpose of this study to investigate theories of pathology or aetiology in detail, it is still useful to give the reader an idea of the breadth of theories.

4.511 Pathology

Theories of pathology can be conceptualised as being on a continuum, from dysfunction to hypersanity. Theories stressing dysfunction include neurochemical theories, which suggest that psychotic phenomena are the result of disorders of neurochemical regulation (Diamond, 1997), such as irregular activity in the dopaminergic system (Waddington, 1993), and neuroanatomical theories, which

suggest that the symptoms of schizophrenia are the result of alterations in the morphology of the brain (Diamond, 1997), such as increased ventricular size (Castle, Wessley, Van Os & Murray, 1998).

Other theories stress information processing deficits, in attentional and memory processes (Bentall, 1992; Diamond, 1997; Goldstein, 1990). It has been argued that some of the symptoms of schizophrenia may represent the person's attempts to construct sense out of disordered experience (Garety, 1992), which represents a shift from an emphasis on dysfunction, to adaptation.

Adaptation is stressed in psychoanalytic ideas, whereby symptoms are conceptualised as defensive adaptations in the face of the breakdown of perceptual and experiential boundaries (Bateman & Holmes, 1990), and attribution theories also suggest a motivational, protective component (Bentall et al., 1991), in particular to paranoia (Kaney & Bentall, 1989). Schizophrenia has also been conceptualised as a rational response to an adverse environment, with people opting out of intolerable social interactions, and losing confidence in the accuracy of perceptions (Sedgewick, 1969).

Others suggested that schizophrenia may not be a process within an individual, but rather a pattern of family communications that is intelligible (Laing & Esterton, 1964). Thus it becomes a social event, even a label that one person ascribes to another in a particular set of social circumstances (Laing, 1967). The process of diagnosing and treating schizophrenia was reconceptualised as the annexation and invalidation of a person whose experience might be not so much a breakdown, as a

breakthrough into realms of inner experience that are normally closed off (Laing, 1967).

4.512 Aetiology

A similar argument rages over the cause of the disorder, a related, but separate, dimension of understanding. There are a range of theories of the cause of the disorder, which can also be represented on a continuum, from molecular to societal. Schizophrenia may have a genetic basis (Diamond, 1997), although no specific gene has been identified (Wyatt, Apud & Potkin, 1996; Waddington, 1993), or be due to pre-and peri-natal brain insults (Waddington, 1993), perhaps due to a virus (Carrigan & Waltrip, 1990), or obstetric complications (Kendall, Juszczak & Cole, 1996).

Early childhood experiences have been implicated as causal (Bateman & Holmes, 1990), particularly the relationship between the infant and the mother (Hartwell, 1996). It has also been suggested that attributional biases may be the result of learning and life experiences (Bentall, 1992). Family speech patterns, parental interactions or family interactions have also been proposed as causal (Hartwell, 1996). There is evidence that a particular form of familial communication, expressed emotion, is implicated in relapse (Hirsh & Brisotw, 1993).

Wider social forces have been proposed as causal. In this regard, one should note both the higher rate of the diagnosis of schizophrenia among ethnic minorities, including African-Caribbean (Jablensky, 1999) and Irish people (Bracken, Greenslade, Griffin & Smyth, 1998), and the association between schizophrenia and unemployment (Bhugra, Leff, Mallett, Dev, Corrigan and Rudge, 1999). These

findings are consistent with the idea that adverse social circumstances may be implicated in the development of symptoms. Alternatively, it may be the diagnostic and treatment process that are at fault, pathologising and incarcerating the weak and vulnerable (Laing, 1967).

The above brief review suggests an almost bewildering range of clinician models of aetiology and pathology. One particular study, of psychiatrists' views of the aetiology of schizophrenia, found that 17 separate variables were identified as causal (Gallagher, 1977). The issue arises of why such disagreement might exist, and it is suggested that there are two main reasons.

4.513 Severity

The first lies in the severity of the disorder. Profound and disturbing questions over the fundamentals of human experience are raised in the investigation of schizophrenia, and such questions can expose basic intellectual fault lines, whether they are between nature and nurture, somaticist and mentalist (Beer, 1996), or genes and environment. Debates across these divisions can reflect beliefs, values and prejudices as much as data, theory and observation, and an intellectual stalemate can ensue, leaving clinicians in "opposing camps" (Hinshelwood, 1999).

Such opposition might be exacerbated by the particular urgency of the need for clinically effective interventions. The severity of the phenomena, combined with the extent of the diagnosis, leave clinicians with a well-spring of distress, which is difficult and costly to treat. The cost of care in England in 1992/93 has been estimated at £2.6 billion (Knapp, 1997).

4.514 Validity

4.5141 The medical model

The second reason may lie in questions over the validity of the concept of schizophrenia, which could arise because schizophrenia is a medical diagnosis, that does not fit into the medical model (Bentall, 1990). The medical model proposes that a diagnosis reflects a discrete disease entity, with a distinct pattern of subjective symptoms and objective signs, associated with a particular pathology and aetiology, with a predictable course and outcome, and a logically derived treatment (Forrest & Hay, 1973).

4.5142 Heterogeneity

Attempts at deriving reliable and valid psychiatric diagnoses encounter a fundamental problem. Researchers are faced with a range of phenomena of unknown aetiology and pathology, but in psychiatry there is no difference in the level of description between signs and symptoms, both being based on verbal reports or inference (Larsen & Opjordsmoen, 1996). Making links between observed phenomena and underlying pathology is thus particularly difficult, and researchers have tended to seek clusters of symptoms which occur together, and vary together, over time and with treatment. As yet, however, it has not proved possible to marry a distinct pattern of signs and symptoms, to predictable course, outcome and response to treatment.

Follow-up studies of those with a diagnosis of schizophrenia have shown wide variations in outcome in terms of general functioning (Opjordsmoen, 1991), and

different patterns of course (Marshall, 1990). There is also some evidence of different outcomes across different cultures (Lin & Klienman, 1988). There is similar heterogeneity in terms of response to treatment. Within-subject differences have been noted, in that different symptoms respond differently to treatment. Additionally, between-subject differences have been observed, as some clients with the diagnosis do not respond to treatment (Bentall, 1990; Larsen & Opjorsmoen, 1996).

The absence of necessary and sufficient symptoms for a diagnosis, the unpredictable response to treatment, and the variability of course and outcome all suggest that schizophrenia may not be a distinct entity after all. In the face of evidence both that diagnosis is reliable, and that schizophrenia is "a disorder with no particular symptoms, no particular course, no particular outcome, and which responds to no particular treatment" (Bentall, 1990), the validity of the whole concept comes into question.

Going back to the definition of the medical model, it is clear that in the light of the heterogeneity of symptoms, course, outcome and response to treatment, the only way to demonstrate the validity of the concept is by identifying a particular aetiology and pathology. It is also worth considering the opinion that schizophrenia is the "core concept of modern institutional psychiatry" (Marshall, 1990), and that there is considerable investment in demonstrating the validity of the construct. Thus identifying the aetiological and pathological processes of schizophrenia would fulfil two aims; firstly, it would demonstrate the validity of the concept of schizophrenia; secondly, it would demonstrate the validity of a particular view of the disorder. For

these reasons, there is intense debate over these two dimensions. However, the pathology and aetiology of the disorder remain at best poorly understood (Castle et al., 1998), at worst unknown (Bentall, 1990).

4.5143 Integrated models

At the same time, a conceptual framework is available which contains the potential for a more coherent picture. The vulnerability-stress model of Zubin and Spring (1977) was an attempt to create a second order concept to allow the range of aetiology and pathology to be drawn together, and comprehensive accounts of schizophrenia have been given within this framework. However, there is still debate over the nature of the vulnerability, the stressors, and the mechanisms by which they might interact. The fact remains that there are a range of clinician theories in circulation, which may have some impact on the possibility of congruence with client theories. Thus it would be useful to consider the nature of the latter, and some research into client models is presented below.

4.52 Client models of schizophrenia

Dittman & Schuttler (1990) carried out semi-structured interviews with 50 patients with a diagnosis of schizophrenia and found that 38% of these gave multifactorial explanations for schizophrenia, i.e. at least two reasons for being ill. The authors noted that the majority of patients gave explanations that were often similar to explanations given by psychiatrists. 30% gave a personal explanation, rooted in childhood or later life experience, 20% gave delusional explanations and 12% could give no explanation. The authors note that no clients gave a purely endogenous

explanation, and also highlighted the similarity between the multifactorial explanations and Zubin and Spring's (1977) vulnerability-stress model.

A study by Molvaer, Hantzi and Papadatos (1992) examined the causal attribution of 30 clients with psychoses and found that causes could be grouped into three factors; family or relationship problems; personal inadequacy; and chance.

Whittle (1996a), in the development of a questionnaire to assess causal beliefs, the Causal Belief Questionnaire, found that causal beliefs could be grouped into four factors, namely psychosocial, biological, structural, and stress factors. The results also suggested that clients held an array of beliefs, with about a quarter giving an explanation that could be considered as biopsychosocial. Only a few adopted exclusively organic explanations, and approximately half gave a psychosocial explanation. Thus the majority of clients held some form of psychosocial beliefs as to the cause of their psychological problems. It is worth considering that a careful examination of the content of the items in the questionnaire suggests that it investigates the dimensions of both aetiology and pathology.

A subsequent study by Whittle (1996b), of 53 psychiatric inpatients with a variety of psychological disorders, using the CBQ (Whittle, 1996a), suggested that clients' and relatives' causal beliefs could change in the course of hospital admission, in particular that those who had been admitted previously held stronger biological beliefs than new inpatients. The results also suggested that staff held reasonably consistent causal views. These findings implied that the treatment process can influence the causal beliefs of clients and their families.

The study cited earlier by Foulks et al. (1986) suggested that patients can adhere to several casual explanations at the same time, some of which may be contradictory.

4.522 Beliefs of the general public

It is also worth considering investigations into beliefs held by the general public, as this is of course the population from which clients are drawn. Furnham and Bower (1992) investigated the beliefs about schizophrenia of 106 people using a questionnaire, and found that beliefs did not fit simply with any academic model, with people using medical terminology, such as 'illness', without accepting the treatment implications. These researchers also found that people tended to favour psychosocial factors as causal. This is consistent with a study by Wolff, Pathare, Craig and Leff (1996) who, in a survey of 215 people, found that the most commonly cited cause of mental illness was environmental factors.

4.53 Congruence of client and clinician models

These studies suggest that there are two key features of client theories which may impact on congruence with clinician theories. Firstly, clients' theories tend to be multifactorial, bearing some resemblance to the vulnerability-stress model, and in this regard are rather like those of clinicians. Secondly, people tend to use terms without accepting strict meaning, or all the implications. This is consistent with Martin's (1988) suggestion that informal theories may have less internal consistency. However, a slightly different interpretation would be that people may be using psychiatric terms in the absence of other means of describing events (Leferink, 1988).

There would seem to be two potential consequences for congruence between client and clinician models. The first is that the range of theories available, and the different use of psychiatric terminology by client and clinician, would tend to increase the potential for conflict, and thus reduce congruence. The second possibility is that the adoption of multifactorial explanations would mean that there was an increased possibility that client and clinician would share some common ground.

Relevant here is a study by Kuyken, Brewin, Power & Furnham (1992) into causal beliefs about depression among clients, clinical psychologists and lay persons. Their finding of a range of beliefs, with relatively few differences between the groups, suggested that the multifactorial nature of beliefs may not hinder agreement. Their findings also indicated that people's beliefs included elements from contemporary academic models, and that people could access different models if they were asked explicitly about them. However, this is not to say that they would necessarily agree with the beliefs accessed. Thus causal beliefs other than those explicitly held were available, and could be accessed through questioning. If this finding is generalisable to schizophrenia, it would imply that the multifactorial nature of models may not be a bar to congruence. People would have access to a range of beliefs, and interaction with others could lead to different beliefs being accessed.

There is also some evidence that clients can come to adopt similar models to those of clinicians. The study cited above by Whittle (1996b), suggests that clients may adopt the causal beliefs implicit in the process of hospitalisation. This is consistent

with the finding that clients may come to adopt their counsellors' causal beliefs (Worthington & Atkinson, 1996). Working alliance theory suggests that this process would be associated with stronger working alliances. In this regard, it might be relevant to consider the finding of two studies. The first, into the self-concepts of chronically psychotic clients, found that older clients seemed to accept the implications of the medical model more than younger clients did (Thompson, 1988). Draine and Solomon (1996) used the WAI (Horvath and Greenberg, 1989) to investigate the alliance between 86 clients with severe mental illnesses and found that the strongest alliance existed between case managers and older clients. These findings are consistent with the notion that clients come to adopt the models of the clinicians, and that this process is associated with stronger working alliances. However, in no sense can they be seen as providing direct evidence for this suggestion.

Although the possibility would remain that clinicians would be reluctant to adopt different models, equally they should be able to access a wider range of beliefs than clients, due to their training and experience, and thus be able to adapt their models to those of the client. To do so would be in accordance with the suggestions of some clinicians (Clarkson, 1995; Duncan & Moyhihan, 1994), and indeed the available evidence suggests that clinicians can change their causal beliefs to match those of clients (Gillespie & Bradley, 1988). Were they to do so, and thereby increase the congruence between themselves and the client on these dimensions, would the process be associated with improved working alliance and adherence? The process of elaborating and negotiating over beliefs regarding aetiology and pathology might correspond to the process of negotiating Goals, which working alliance theory

predicts would be associated with a strengthened alliance. Correspondingly, shared beliefs regarding pathology and aetiology might imply shared beliefs regarding treatment, although beliefs across these dimensions are not necessarily as logically linked as one might think (Whittle, 1996a).

4.6 Treatment and role

The next issue to examine is congruence of beliefs along the dimensions of treatment and role, which can be considered together. The question thus arises of what factors might affect congruence of beliefs along these dimensions.

4.61 Discrepancy in Treatment beliefs

There is some evidence that there are wide discrepancies between mental health professionals and the public they serve, in terms of beliefs about treatment. Jorm et al. (1997) studied the differences between professionals' and the public's views of treatments, and found that those interventions rated by professionals as helpful in treating psychosis, namely medication and hospitalisation, were seen as harmful by the public, while treatments that the public perceived as helpful, such as special diets or vitamins, were seen as useless or harmful by professionals. If this discrepancy is reflected among clients, it would suggest a low degree of congruence of beliefs.

4.62 Clients' beliefs and compliance

A survey of inpatients' beliefs about the most helpful treatments found that talking to members of staff was rated as the most helpful therapeutic item, ahead of medication (McIntyre, Farrell & David, 1989). However, much of the research into clients' beliefs about treatment is carried out in the context of research into

compliance with medication. This is perhaps not surprising, when one considers that non-adherence to medication among clients with a diagnosis of schizophrenia is associated with hospitalisation (Ruscher, de Wit & Mazmanian, 1997) and that, perhaps due to this, a small number of clients account for a hugely disproportionate amount of health care resources (Hirsh & Bristow, 1993). The link between beliefs and compliance is also supported by the findings of Donovan and Blake (1992), who in a study of compliance with treatment in a rheumatology clinic found that non-compliance was based on a reasoned decision-making process. This suggests that one can conceive of cognitive and behavioural aspects of compliance (Cameron, 1996).

4.621 The Health Belief Model

Considerable effort has been expended on building models of compliance behaviour based on beliefs, such as the health belief model. This model proposes that clients are more likely to comply if they perceive themselves as vulnerable to a severe illness, and feel that the benefits of the treatment proposed outweigh the costs (Budd, Hughes & Smith, 1996). The results of research into the model as a predictor of compliance have been equivocal. Budd and colleagues found that the model did predict compliance, but the size of their sample did not justify their use of stepwise regression techniques in the data analysis (Tabachnick & Fidell, 1989). Another study found that although compliance could be predicted by beliefs regarding the costs and benefits of treatment (Ludwig, Huber, Schmidt, Bender & Greil, 1990), the rate of prediction was little greater than that of chance. A study using attendance at a depot clinic as a measure of compliance found that attenders did not differ from non-attenders in their health beliefs (Pan & Tatum, 1989). A

study of compliance with lithium therapy also found that health beliefs did not predict compliance (Connelly, 1984). All these studies drew a distinction between compliant and non-compliant clients, but compliance is perhaps better thought of on a continuum (Bradley, 1999; Fenton et al., 1997). It is interesting to consider a study by Ruscher, de Wit and Mazmanian (1997) which found that the most common reasons given for stopping medication were side effects, the belief that it did not work, and most commonly, opposition to the idea of taking medication. Whilst the first two reasons are consistent with the health belief model, the most common reason, of opposition to medication, does not fit easily into the model. Thus there may be aspects of beliefs about treatment that were not considered within that particular model. It may be that one problem with the Health Belief Model is that it does not address the issue of congruence of health beliefs between clients and clinicians.

Although research into the Health Belief Model has left the links between client beliefs and compliance unclear, it has provided a useful framework for categorising beliefs about treatment, namely the distinction between benefits and costs, or positive and negative aspects respectively.

4.63 Negative aspects of treatment

Side effects are the most obvious negative aspect of treatment, occurring in up to 75% of patients (Gerlach & Peacock, 1995). Davidhizar, Austin & McBride (1986) found that while clients had a range of attitudes towards medication, both positive and negative, there tended to be more negative views, and these were based mainly on experiences of side effects.

Any relationship between side effects and compliance is not a simple one. A review of the literature on compliance in schizophrenia by Fenton, Blyler and Heinssen (1997) suggested that side effects, particularly akathisia, are associated with a dysphoric response to medication, which is in turn associated with non-compliance. This is consistent with the suggestion by Awad (1993) that many clients feel that medication makes their condition worse, and that it is this subjective interpretation of the effects of medication, rather than the actual severity of side effects, which determines compliance. Hogan, Awad and Eastwood (1983) found that 89% of clients could be classified as compliant or non-compliant using a measure of subjective experiences, the Drugs Attitude Inventory (Hogan et al., 1983).

It is also important to consider the suggestion that clients' reports of their experiences of medication are not taken seriously (Awad & Hogan, 1994; Awad, 1993; McIntyre et al., 1989). This would suggest that there would not be congruence of beliefs. If clients' views are ignored, one might also expect that this would have detrimental effects on the working alliance, as a proper process of negotiation would not be taking place. This has parallels with the suggestion of the importance of eliciting models, which will otherwise remain unstated (Eisenbruch, 1990). In this regard, it is worth considering a study by Finn, Bailey, Schultz and Faber (1990) of clients with schizophrenia and the staff caring for them, which suggested that neither patients nor staff felt that the symptoms were significantly more troublesome than side effects, which thus implied that side effects are taken seriously by staff.

The possibility arises that it is the acknowledgement and discussion of side effects that mediates the association with compliance, a notion which is consistent with working alliance theory, and the emphasis on negotiation. Goodman (1992) notes that the experience of side effects can be associated with responses such as shame, or loss of control, and working alliance theory would suggest that the Bond, comprising as it does shared trust and empathy, might be the key element in mediating the behavioural and cognitive effects of such responses to side effects. She also notes that non-adherence has been linked to hostility, particularly towards the prescriber, that has not been adequately addressed. This hostility may in part be a result of unpleasant side effects.

Thus it may be that it is not only the presence of side effects, or even beliefs based on their subjective interpretation, that is the key factor, but rather it is the process of negotiation to reach congruence.

4.64 Positive aspects of treatment

Alongside the issue of the costs, or negative effects of treatment, is that of the benefits, or positive aspects. Not all patients benefit from medical treatment, as was highlighted earlier. Some symptom reduction occurs in 60-70% of patients (Adams and Howe, 1993), and it appears that the medications are specific to certain symptoms, namely hallucinations and delusions (Day and Bentall, 1996). In terms of relapse, 40% of medicated clients relapse in a year (Day & Bentall, ibid.). This may be due to some extent to non-compliance, but the fact is that normal treatment conditions do not provide protection (Kissling, 1992).

4.641 Clinicians' beliefs

Some psychiatrists do not see much benefit in treatment. A study by Packer, Prendergast, Wasylenki, Toner and Ali (1994), investigating the attitudes of psychiatrists to clients with chronic mental illness, found very pessimistic views of treatment, with 65% believing that such clients never change and 91% believing that such clients cannot form a therapeutic alliance. This is important in light of the suggestion that a clinician's belief in the efficacy of treatment is crucial in improving adherence (Griffith, 1990).

There is also some evidence that clinician beliefs about treatment may be based to some extent on factors other than their efficacy. Pallis and Stoffelmayr (1973) found that psychiatrists could be categorised into those with a 'psychological' orientation, and those with an 'organic' orientation. They further suggested that the orientation would have an impact on the type of treatment offered, and noted that that orientation was part of a general social attitude, and thus suggested that "discussion about the advantages of the various treatments will not be guided by factual arguments alone" (Pallis & Stoffelmayr, 1973). This may have important implications for the willingness of clinicians to accept different models of treatment, particularly those of the client.

4.642 Clients' beliefs

Clients have mixed views, some seeing benefits, others not. A perception of benefits of medication has been frequently associated with compliance (Budd et al., 1996; Buchanan, 1992), which would be consistent with the idea of reasoned decision-making as the basis for compliance, as suggested by Donovan and Blake

(1992). However, the position of clients with schizophrenia is complicated, because perception of the benefits of medication, ostensibly an issue of beliefs about treatment, is one that becomes entangled with the dimension of Role. In other words, clients may not see any benefits in medication because they do not consider themselves as suffering from an illness. It is worth remembering the finding that the most common reason for stopping taking medication was an opposition to the idea, regardless of beliefs about the benefits or side effects (Ruscher et al., 1997). In fact, perception of benefits of medication is frequently seen as some indication of clients' insight into their illness (Amador, Flaum, Andreasen, Strauss, Yale, Clark & Gorma, 1994; Adams & Howe, 1993; Buchanan, 1992).

4.65 Insight

It is worth examining the concept of insight in some detail, as it is frequently referred to in the literature, and a lack of insight has been identified as the most common feature of schizophrenia, ahead of any symptom (Birchwood et al., 1994). Estimates of the prevalence of poor insight in people with schizophrenia are as high as 89% (Amador & Strauss, 1993). Furthermore, a lack of insight into illness or the benefits of treatment is associated with poor clinical outcome (Amador & Strauss, 1993; Amador, Strauss, Yale, Flaum, Endicott & Gorma, 1993; David, 1990; Schwartz, Cohen & Grubaugh, 1997), with increased hospitalisation (McEvoy et al., 1989) and with non-compliance with medication (Smith et al., 1997). This perhaps raises the question of why insight is not considered as a symptom, as some have suggested (Amador et al., 1994). The reason is that there are considerable difficulties in defining quite what constitutes insight.

Many earlier studies adopted a unitary perspective on the phenomenon, that it to say that it was a feature that was either present or absent (Markova & Berrios, 1992), an approach that may have contributed to some of the very high estimates of the prevalence of poor insight. More recently however, it has been argued that insight is multidimensional in nature (Amador et al., 1994; David, 1990; Greenfeld, Strauss, Bowers & Mandelkern, 1989). This more complex approach would help explain such phenomena as patients denying that they are ill but accepting treatment, or acknowledging some symptoms but not others. Thus awareness of need for treatment may be distinct from awareness of symptoms (Kim, Sakamoto, Kamo, Skamura & Miyaoka, 1997). David (1990) argued that there are three overlapping components to insight; the ability to label certain mental events as pathological; recognition that such events are indicative of a mental illness; and compliance with treatment (David, ibid.). Amador and his colleagues suggested that the two important dimensions to poor insight are a lack of awareness that a symptom is present, even when confronted by an observer pointing it out, and a failure to attribute any symptoms present to an illness (Amador & Strauss, 1993; Amador et al., 1993).

Some disagreement also surrounds the processes underlying insight. Lack of insight could represent a neurological dysfunction. An analogy has been drawn with anosognosia, which is associated with frontal lobe deficits (Amador et al., 1994; Dixon, King & Steiger, 1998), and the brain malfunction underlying psychotic symptoms could create a similar kind of unawareness (Birchwood et al., 1994). Thus poor insight would be due to a disorder of perception (Markova & Berrios, 1992). Against this, some studies suggest that insight is independent of test performance,

neurologic abnormalities or global measures of cognitive performance (Cuesta & Peralta, 1994; Kemp & David, 1996).

Alternatively, lack of insight could have a defensive function, acting as a self-serving bias (Amador & Strauss, 1993). Evidence for this comes from studies of recovery from psychosis (Birchwood et al., 1994), in particular the phenomenon of post-psychotic depression (Dixon et al., 1998). Unawareness of symptoms has been shown to be related to measures of depression in subjects with schizophrenia, suggesting a degree of self-deception (Dixon et al., 1998). Thus lack of insight may be associated with volition rather than perception, with interpretation and processing being different for motivational reasons (Markova & Berrios, 1992).

The difficulty with the concept of insight is that it can confuse, rather than clarify. There are two potential problems with the concept. Firstly, the link between perceptions of the benefits of medication and insight is problematic. One can envisage a situation where a person does not derive benefits from medication, so does not take them, and is then labelled as being both non-compliant, and as having poor insight. This relates to the notion mentioned above that clients' perceptions of medication may be ignored, or pathologised as indicative of poor insight. The multi-dimensional models of insight outlined above may represent an attempt to avoid such problems.

Secondly, the clinical utility of the concept is questionable. Clients who do not believe that they are ill or need treatment are frequently non-compliant (Axelrod & Wetzler, 1989; Cuffel, Alford, Fischer & Owen, 1994; Nageotte, Sullivan, Duan &

Camp, 1997; Hoge, Appelbaum, Lawlor, Beck, Litman ,Greer, Guntheil & Kaplan, 1990; Bartko, Herceg & Zador, 1988) and dissatisfied with their treatment, seeing it as unhelpful (Barker, Shergill, Higginson & Orrell, 1996). If clinicians explain this away as 'poor insight', there seems to be potential for an unproductive stalemate, which may end in hospitalisation. This perhaps accounts for the negative attitudes towards working with chronically mentally ill clients identified by Packer et al. (1994). On the other hand, it would do a grave disservice to clients to simply accept people's beliefs that they do not need treatment, when they are in need of some intervention.

4.651 Insight and congruence

A possible way out of this is to note that although insight is generally defined as a process internal to the individual, this is not the whole picture. Insight could also be conceptualised as a set of attributions regarding symptoms (Birchwood et al., 1994). Budd et al. (1996) argued that insight represented congruence with psychiatric opinion. In this conceptualisation, lack of insight would reflect a difference in the explanatory models of client and clinician (Greenfeld et al., 1992). Thus the notion of degree of insight can be thought of as reflecting the degree of congruence between the client's model, and an often unstated, implicit medical model, along some of the dimensions defined above. The dimensions that would seem most relevant are those of Treatment and Role, although all four could be implicated. Defining insight as congruence along these dimensions would place the issue of insight in the context of the relationship between client and clinician. This is consistent with the suggestion that insight may increase within a good therapeutic alliance (Heinrichs, Cohen & Carpenter, 1985).

The degree of congruence could reflect experiences of treatment, and processes such as defences or neurological impairments. It might be possible to increase the degree of congruence to some extent by negotiation. Some indirect evidence to support this comes from studies of cognitive interventions with delusions (Chadwick & Lowe, 1990; Milton, Patwa & Hafner, 1978; Watts, Powell & Austin, 1973). These studies found that, in terms of reducing the conviction with which the beliefs were held, direct confrontation of delusional beliefs was less useful than discussion of the content of beliefs, the evidence for them, and the possibility of alternatives.

4.66 Compulsory treatment

The theme of insight leads on to another aspect of treatment with implications for the working alliance, namely the issue of involuntary treatment. The number of involuntary admissions under the Mental Health Act 1983 has risen by 66% in the last ten years, from 15,440 in 1987-88, to 25,100 in 1997-98 (Clinical Psychology Forum, 1999). As of 31 March 1998, 12,700 people were detained in hospital (ibid.). While forced hospitalisation and medication may be necessary at times, it is important to note that they might also be inimical to the formation and maintenance of a working alliance, and indeed, can be conceptualised as measures needed in the absence of such an alliance (Clarkson, 1995). This is a particularly worrying thought when one considers that different groups in society have different rates of involuntary hospitalisation, with African-Carribeans (Bhui, Brown, Hadie, Watson & Parrott, 1998) and Irish people (Bracken, Greenslade, Griffin & Smyth, 1998) being most likely to be detained in hospital. This may reflect higher incidence of psychosis in these groups (Bracken et al. 1998), but it would be an issue of some

concern if it also reflected poorer congruence, whether in terms of alliance, compliance or explanatory models. The increase in the rate of compulsory admissions under the Mental Health Act 1983 serves to stress the importance of understanding factors affecting congruence between case managers and their clients.

Chapter Five

From Motivations to Questions

The purpose of this chapter is firstly to give the motivations for carrying out the present study. This is followed by a statement of the general themes of the study and a presentation of the specific research questions.

5.1 Motivations

There are two prime motivations for the present study. The first arises from findings that positive ratings of the therapeutic alliance are associated with positive assessments of outcome in the case management of clients with psychosis (Preibe & Gruyters, 1993; Neale & Rosenheck, 1995). As case management is the "cornerstone" (Shepherd, 1990) of mental health care of the seriously mentally ill, an investigation into factors that influence the working alliance, and thus maybe indirectly influence positive outcome, is clinically useful.

The second motivation is that research into compliance with treatment, especially medication, is important with this client group. Non-compliance has been frequently cited as a factor in relapse and subsequent hospitalisation (Green, 1988; Hoge et al., 1990). Apart from the distress associated with relapse and hospitalisation, the latter also accounts for a disproportionate amount of the cost of caring for clients with psychosis (Hirsh & Bristow, 1993). Thus strategies aimed at increasing compliance are a priority for mental health professionals, and an investigation of factors which predict non-compliance is therefore a useful contribution to this field.

64

The principle of clinical governance has it that interventions should have demonstrated clinical and cost effectiveness (Department of Health, 1997), and this study represents an attempt to examine variables which may influence both the efficacy and the costs of treatment of clients with schizophrenia, namely alliance and adherence.

5.2 Themes

The next concern is to identify the themes of theoretical interest in the literature which underpin the two clinically important factors of alliance and compliance mentioned above.

5.21 Alliance and compliance

The first theme is the link between alliance and compliance. The study by Krupnick et al. (1996), showing that the alliance predicted outcome in the pharmacotherapy of depression, did not control for compliance. Thus it would seem important to examine the relationship between alliance and compliance. The study by Frank & Gunderson (1990) investigated compliance and alliance among psychotic clients, but in a different setting which most clients in this country do not encounter, namely individual psychotherapy. Perhaps more importantly, the study did not include client ratings of the alliance alongside those of clinicians.

5.22 Congruence of beliefs

The second theme raised in the literature is a possible relationship between congruence of explanatory models, the alliance and compliance. It was suggested that there are several dimensions of explanatory models over which there could be

difficulties in establishing congruence. There seems to be some evidence of a link between compliance and congruence of causal beliefs (Foulks et al., 1986), although this study did not actually measure clinician beliefs. A link with the alliance was suggested in the above study, but not investigated. The review of the literature in the preceding chapter suggested that the dimensions of aetiology and pathology were particularly controversial in the case of schizophrenia, and could perhaps be considered together. Congruence regarding treatment is also considered.

5.23 Insight

It was also suggested in the introductory chapters that the concept of insight may be related to some of the above dimensions. This concept has been linked with compliance (Fenton et al., 1997) and in this study possible links with alliance will also be investigated.

5.24 Aspects of the alliance

Another theme of interest is the development of the aspects of the working alliance. The literature suggested that the development of the working alliance would take longer with this client group (Bordin, 1994) and there was a suggestion of six months as the time frame envisaged as being necessary (Frank & Gunderson, 1990).

5.35 Concordance

Finally, it has been stated that central to the development of the working alliance is agreement between the client and clinician. This agreement has been termed concordance (Horvath and Greenberg, 1989), a term which has also come to be used in the field of pharmacology (Mullen, 1997), as mentioned earlier. Concordance in

this context refers to the notion that both client and clinician have valid views on the nature and treatment of a problem, and that by a process of negotiation agreement on treatment can be reached, which would lead to a therapeutic alliance, and increased adherence (Bradley, 1999). The concept of concordance is thus one that may draw together the themes discussed above, as the variables linked together in the definition offered by Bradley (ibid.) are adherence, therapeutic alliance and negotiation over treatment in the context of clients' and clinicians' health beliefs. In particular, there would seem to be some parallels between the constructs of concordance and the working alliance, in that both place some emphasis on the views of both the client and the clinician, and the process of negotiation to reach agreement. However, the concept of concordance may be particularly useful, as it can be defined to include both cognitive and behavioural components. This would allow for the term to be used to cover both adherence to treatment and the agreement central to the working alliance. The concept of concordance could then be a construct which would account for the finding of an association between alliance and adherence (e.g. Frank & Gunderson, 1990), and thus be a conceptual link between adherence and alliance. Equally, concordance offers a conceptual link between congruence of beliefs and compliance, as suggested by Foulks et al. (1986).

Thus the three concepts of alliance, compliance and congruence could be linked by the overarching construct of concordance. Consequently, an important theme of this study is the investigation of the validity of the construct of concordance, using a definition based on Bradley (1999). Concordance can be defined as a sense of agreement and mutuality between client and clinician, in the cognitive, behavioural and affective domains, based on negotiation and leading to adherence. The validity

of the construct will be examined by considering the covariance of the variables of alliance, compliance and congruence. If the construct of concordance as defined is valid, and if the measures of alliance, compliance and belief discrepancy are valid, then one could predict that the three latter variables would vary together.

5.4 Specific research questions

These themes lead to a number of specific research questions.

Question one

This question concerned variables that predicted compliance with treatment, and was divided into two parts.

1.1 Which variables best predict compliance with medication?

1.2 Which variables best predict compliance with non-medical treatments?

It was expected that the variables that would best predict both of these variables would be those conceptualised as aspects of concordance, namely the working alliance and causal belief discrepancy. Working alliance is probably best rated by more than one source, and as the study was concerned with the sense of agreement between client and clinician, these were considered the two best sources. As compliance was conceptualised as an aspect of concordance, compliance with medical treatments was expected to predict compliance with non-medical interventions and vice-versa. For the purposes of this study, the variables of working alliance, compliance and causal belief discrepancy are referred to as 'concordance variables'.

It was deemed necessary to include other variables which had been found to be associated with compliance, including insight (Kemp & David, 1994), side effects

(Fenton et al., 1997), subjective experience of medication (Hogan et al., 1983), and level of supervision (Irwin et al., 1971; Nageotte et al., 1997). Due to the heterogeneity in the symptomatology of clients with a diagnosis of schizophrenia, it was also desirable to control for this, by including symptom severity as a variable. These variables are referred to, for the purposes of the study, as 'control variables'.

Question Two

The next research question concerned variables that predicted the working alliance. This question was also divided into two parts.

2.1 What variables best predict the working alliance as rated by the case manager?

2.2 What variables best predict the working alliance as rated by the client?

The 'concordance variables' were expected to be the best predictors. The working alliance as rated by one source was also expected to predict the alliance as rated by the other, and thus the case manager's alliance rating was expected to predict the client's, and vice versa. It also seemed necessary to control for the same variables as in the previous question, so that any links found between the 'concordance variables' would not be due to the control variables.

Question Three

3. Can measures of concordance be used to distinguish between client-case manager relationships that are six months old or less, and those that are longer than six months?

This question concerned the separate aspects of the working alliance, as well as other measures of concordance. As it had been suggested in the literature that six months might be necessary for the development of the alliance, it was hypothesised that one

could distinguish relationships that were established for up to six months from those that had been established for longer. It was specifically hypothesised that this could be done on the basis of the concordance variables.

Question Four

This question concerns clients' and case managers' beliefs about treatments. The question is in two parts.

4.1 What treatments did clients and case managers identify as being helpful and unhelpful?

4.2 What aspects of these treatments were identified as being helpful or unhelpful?

This question was concerned with congruence of beliefs along a different dimension. The researcher was not aware of a validated instrument which operationalised the concept of discrepancy of beliefs regarding treatment and thus this question was investigated using qualitative methods.

Chapter Six

Method

6.1 Participants

6.11 Clients

The clients were people selected from all those cared for by an inner city Community Mental

Health Team (CMHT). All clients were subject to the Care Programme Approach (CPA),

under which each client has a planned programme of care and a named key worker, in

addition to a case manager (Burns, 1997). The selection procedure identified those with a

diagnosis of schizophrenia, according to ICD-10 criteria, who were being treated with

neuroleptic medication. Each client was required by the policy of the relevant trust to have

recorded a diagnosis according to ICD-10, determined by a psychiatrist, and this information

was available from a database held by the trust involved. The clients cared for by the CMHT

did not include those with a primary diagnosis of substance abuse, or with organic brain

damage, so such clients were, by definition, excluded from the study. The clients cared for

by the team have had at least two hospital admissions, with at least one within the last five

years. As no resources were available for language interpretation, only English-speaking

clients could be interviewed. In practice, no clients were excluded from the study on this

basis.

40 clients participated in the study (33 male and 7 female). The mean age of the clients who

participated was 42 years, 11 months (s.d. 10 years, 8 months). Information on ethnicity was

gathered from the trust database, based on clients' reports of their own ethnicity. 11 of the clients were African-Caribbean, 4 were Irish, 12 where white of UK origin, 2 were white of non-UK origin, 6 were African and 5 Asian.

32 of the clients had medication administered by their case managers, 4 by other professionals, and 4 self-administered their medication. 12 of the clients lived alone and 6 lived with their families or friends. 7 lived in semi-supervised hostels and 15 lived in supervised hostels, with 24-hour staff cover. In terms of frequency of contact, 14 met with their case managers at least once a fortnight, 15 met at least once a month, and 11 met less than once a month.

Of the 61 clients who were eligible for the study, 15 clients refused to participate, and 6 did not attend appointments sent out for them.

6.12 Case Managers

Ten case managers participated in the study. All were members of the same CMHT, which was established to care for the "long term, severely, mentally ill" (Operational policy). The team aimed to adopt a multidisciplinary approach to providing care, along the principles of clinical case management. Each case manager had responsibility for a defined caseload. The model of case management practiced by the team was the modified team model, whereby as well as the designated case manager, another member of the team has sufficient knowledge of the client to make an appropriate response if the designated case manger is unavailable (UK

700, 1996). The team had an open referral policy, i.e. anyone could make a referral to the team. The team did not provide an out of hours service, but was available to provide a service 52 weeks of the year. Contact was maintained with clients during any periods of hospitalisation. Seven of the case managers who participated were Community Psychiatric Nurses (CPN's), one was an Occupational Therapist (OT), one was a Consultant Psychiatrist, and one was a Health Care Assistant.

6.2 Measures

The following measures were used with the clients.

1. Manchester Scale (Krawiecka, Goldberg & Vaughn, 1977) (appendix 2)

2. Insight Scale (Birchwood, Smith, Drury, Healy, Macmillian & Slade, 1994) (appendix 3)

3. Drugs Attitude Inventory (10 item version) (Awad, 1993) (appendix 4)

4. Working Alliance Inventory (12 item version) (appendix 5)

5. Causal Belief Questionnaire (client version) (Whittle, 1996a) (appendix 6)

The following measures were used with the case managers.

1. Working Alliance Inventory (12 item version) (Tracey & Kokotovic, 1989) (appendix 7)

2. Causal Belief Questionnaire (Whittle, 1996) (staff version) (appendix 8)

3. Compliance scale (Kemp et al., 1996) (appendix 7)

These are examined in more detail below.

<u>Manchester Scale (Krawiecka, Goldberg & Vaughn, 1977)</u>

This consists of a set of 14 rating scales, and is designed to provide a quick, reliable clinical assessment of chronically psychotic clients which is sensitive to change. The first four rating scales are based on the client's answers to questions about his or her symptoms, and are scored on a scale from zero to four, with the higher number representing a greater degree of severity of the particular symptom. The guidelines for the use of the five point scales (appendix 9) provide advice on the kind of information that is required to make an assessment in each of the diagnostic areas (depression, anxiety, delusions and hallucinations). The next four scales, also scored from zero to four, are based on the researcher's observations of abnormal phenomena during the interview. In order to quantify the severity of symptoms, the individual answers to the eight symptom items were summated. This gave a score with a possible range of 0 to 32.

The last six scales concern possible side effects of anti-psychotic medication, and are scored on a scale from zero to two, with the higher numbers corresponding to more severe side effects. In order to quantify the severity of side effects, the scores on the six side effect items were summated, giving a score with a range of 0 to 12.

It is important to note that this scale is not intended to be used without any prior knowledge of the clients. Thus the researcher read the clients' notes, in order to be aware of areas in which the clients have been experiencing symptoms, as recommended by Krawiecka et al. (1977).

<u>Insight Scale (Birchwood, Smith, Drury, Healy, Macmillian & Slade, 1994)</u>

This scale was designed to allow researchers to derive a measure of a psychotic client's insight into his or her illness, in terms of their need for treatment, their awareness of having an illness, and appropriate relabelling of their symptoms (Birchwood et al. 1994). This three-component model of insight was introduced by David (1990). The developers of the scales emphasised how it allowed for a speedy assessment, in a relatively objective way. The scale consists of eight statements, and the client is asked to rate the extent to which each statement applies to them, inasmuch as they agree, disagree, or are unsure about whether it applies to them. These three categories are scored zero, one or two, with the higher number corresponding to greater insight. The scores were combined to give a summated rating score, with a range of 0 to 16, with the higher scores reflecting greater insight. The internal consistency of the scale was assessed by the developers of the scale using Cronbach's alpha, which was found to be 0.75.

<u>Drug Attitude Inventory (DAI [10]) (Awad, 1993)</u>

As originally developed, the scale had thirty items (DAI; Hogan, Awad & Eastwood, 1983) and was designed as a reliable measure of the self-reports of clients with a diagnosis of schizophrenia about their experiences on medication, intended to be predictive of medication compliance (Hogan et al., 1983).

A discriminant function analysis was used to develop the shorter version of the scale (DAI-10; Awad, 1993), using the ten items that produced the greatest group separation between

dysphoric and non-dysphoric clients. The Cronbach's alpha for this scale has been reported as 0.77 (Van Dongen, 1997).

It is a self-report scale, and the client is asked to rate ten statements about the effects of medication, and feelings about medication, as either true or false, as applied to them. Responses were given a score of either two or zero, and combined to give a summated score with a range of 0 to 20, with a higher score indicating a less dysphoric subjective experience of medication.

Working Alliance Inventory (12-item version) (WAI[12]) (Tracey & Kokotovic, 1989)

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was originally developed for use in psychotherapy research, but has been adapted for use in case management research (Horvath & Greenberg, 1989). The original scale consisted of 36 items and had three sub-scales designed to operationalise the three components of the working alliance as conceptualised by Bordin (1979), namely affective Bonds, shared Tasks and shared Goals (Bordin, 1979). This model was developed to be applied across theoretical orientations and treatment environments (Horvath & Greenberg, 1987) and thus the scale was also devised to be used regardless of treatment orientation or setting (Tracey & Kokotovic, 1989).

The twelve items version (WAI[12]; Tracey & Kokotovic, 1989) was developed using confirmatory factor analysis, selecting the four highest loading items on each sub-scale. The

76

WAI[12], like the WAI, is a self-report scale, and each item is responded to on a seven point Likert scale. The WAI[12] thus allows for both a global rating of alliance, with a possible range of 12 to 84, and a rating on each of the three factors (Task, Goal and Bond). The three sub-scale scores are derived in the following way; the Task score by summating the totals of questions 1, 2, 8 and 12; the Goals score, by summating the totals of questions 4, 6, 10 and 11, and the Bond score, by summating the totals of questions 3, 5, 7 and 9. Thus each of the three sub-scales has a possible range of 4-28.

Two versions of the WAI[12] were used, a client version and a case manager version. The WAI[12] (case manager version) was developed from the client version, using points of reference set out by Horvath and Greenberg (1987). For the client version, the Cronbach's alpha for the overall score, and the scores on the Task, Goal and Bond aspects were 0.98, 0.90, and 0.92 respectively. For the staff version, the alpha scores for the overall scores, and Task, Goal and Bond aspects were 0.95, 0.83 and 0.91 respectively (Tracey & Kokotovic, 1989).

Compliance measure (Kemp, Hayward, Appelwhaite, Everitt & David, 1996)

Compliance with anti-psychotic medication was assessed using a seven point scale devised by Kemp and her colleagues (1996). The measure is observer-rated, and was designed to be quick and suitable across a range of treatment settings, and with a range of interventions. The measure correlated with self-reported measures of attitudes to treatment, lending it a degree of concurrent validity (Kemp et al., 1996).

The same scale was used to assess clients' compliance with non-medical treatments. These were defined as any interventions, administered by people other than the case manager, and other than pharmacological or other medical procedures, aimed at alleviating mental health problems. The case managers' involvement was excluded from this measure, on the grounds that the clients' involvement with tasks carried out in conjunction with their case managers was already assessed using the WAI[12] (client and case manager versions; Tracey & Kokotovic, 1989), and thus this measure would be confounded with the alliance measure.

Causal Belief Questionnaire (CBQ; Whittle, 1996a).

The CBQ was designed to elicit clients' beliefs about the cause of their psychiatric problems, regardless of which particular diagnosis they may have received. It was also intended to be used with a Western population, excluding beliefs which are more associated with non-western cultures. With the exception of that proviso, the beliefs which comprise the items of the scale were chosen to reflect a range of current theories regarding the aetiology and pathology of psychiatric disorders (Whittle, 1996a).

The CBQ is a self-report scale, with 22 items, each of which is responded to on a seven point Likert scale. The instrument allowed for a score to be derived on each of four factors, each representing particular categories of causal beliefs, namely psychosocial, biological, structural and stress. The Cronbach's alpha scores for the four factors are 0.83, 0.69, 0.77 and 0.73 respectively (Whittle, 1996a).

Two versions of the scale were used, a client version and a case manager version. The latter differed from the former in that the initial question asked about psychological problems that "this client may have expereinced, as opposed to "you have expereinced".

The degree of discrepancy between clients' and case managers' CBQ (Whittle, 1996a) scores was determined using a procedure based on that developed by Atkinson et al., (1991). The absolute difference between a client's and their case manager's score, on each of the 22 items, was obtained. For each client-case manager dyad, these absolute differences were then summated, giving a total score, with a possible range of 0 to 132. The higher the score, the greater the discrepancy of causal beliefs.

Open questions (appendix 10)

The clients and the case managers were also each asked some open questions about their views on treatments for schizophrenia. The researcher recorded their answers, and confirmed the answers with the subjects afterwards. In one case, the subject preferred to write the answers directly.

Demographic information (appendix 11)

Information regarding the type and dose of medication, and who administered it, were gathered from the case managers and the medical notes. Also gathered from the case

managers was information regarding the frequency of contact that they had with the client, and information about the client's living situation.

6.3 Procedure

Ethical approval was sought and obtained (appendix 12), and an Honorary Research contract was granted. A list of clients, cared for the team, with a diagnosis of schizophrenia according to ICD-10 diagnostic criteria was obtained from the trust database. The case notes of these clients were then consulted to confirm this diagnosis, as each client had an ICD-10 diagnosis recorded in their notes. In each case the diagnosis was confirmed. This list comprised 89 clients.

6.31 Pilot study

In order to pilot the measures, a staff member was asked to complete the questionnaires for five of her clients, in order to identify any mistakes in the questionnaires, or areas of possible confusion. Some typographical errors were identified and corrected, but no other changes were made. The data from these questionnaires was used in the study.

6.32 Main study

In the case of the 89 clients who had a diagnosis of schizophrenia, the case managers were approached for their opinion as to the appropriateness of approaching the client. It transpired that 16 clients had been discharged from the care of the team since the time that the list was compiled, and these were thus excluded from the study as they were no longer receiving case

management from this particular CMHT. Three clients who were inpatients were also excluded, although those just discharged from hospital were not. In seven cases, the case managers suggested that it would not be appropriate to approach the client, due to the client's mental state. One client was excluded from the study, as he was not receiving anti-psychotic medication. One client on the list died shortly before the present study began. Thus of the 89 clients on the list, 61 were eligible for the study.

If the case managers felt that it was appropriate to interview the client for the purposes of the study, they were then asked for their opinion as to the best way to approach the client. In practice, this meant that either the case managers spoke to the clients at their next meeting, or over the telephone, and asked them if they would be prepared to meet with the researcher, or the researcher was invited by the case managers to be present when the case manager next met the client, or the researcher was advised to contact the client directly to arrange an appointment. The case notes were then consulted again, to ascertain the nature of the client's symptomatology, for the purposes of assessment using the Manchester scale (Krawiecka et al., 1977).

If the client agreed to meet with the researcher to discuss the study, at the first meeting the client was given the information sheet (appendix 13), and the nature of the study was explained. The client was given the opportunity to ask questions of the researcher, and was asked if he or she was willing to give informed consent.

If the client gave informed consent, then the measures were administered, in the following order.

1. The Manchester scale (Krawiecka et al., 1977).

The clients were informed that the questions were about how they had been feeling over the past week, and each of the eight symptom items were inquired about. The clients were then informed that the next questions were about any side effects of medication experienced in the last week, and the six side effect items were administered.

The remaining questionnaires had instructions, which were read out by the researcher.

2. The Insight Scale (Birchwood et al., 1994).

3. The DAI (Awad, 1993).

4. The WAI [12] (client version) (Tracey & Kokotovic, 1989).

5. The CBQ (client version) (Whittle, 1996a).

When administering the CBQ (Whittle, ibid.), the researcher emphasised to the clients that they might not know the answers to each question, but that the questions were asking for their opinions.

6. The open questions.

The client was given a copy of the relevant questionnaires, and the researcher asked the questions and recorded a summary of the client's response, the accuracy of which was then confirmed with the client. The open questions were asked after completion of the questionnaires.

After the interview with each client had been completed, arrangements were then made to meet with the respective case manager, to carry out the staff interview. Again, the subject was given a copy of the questionnaire, and the researcher asked the questions and recorded the case manager's response.

The questionnaires were administered in the following order.

1. Demographic information.

This was gathered either from the case manager, or the case notes, if the former could not provide the information.

2. The WAI [12] (case manager version) (Tracey & Kokotovich, 1989).

3. The CBQ (case manager version) (Whittle, 1996).

4. The open questions.

Ratings of compliance with both medical and non-medical treatment were also gathered on those who either refused to participate, or did not attend their appointments with the researcher. This information was gathered from their respective case managers.

Chapter Seven

Results

The first part of this chapter describes the analysis of the quantitative data, and the second part the analysis of the qualitative data. Both parts are presented with reference to the specific research questions.

7.1 Quantitative data.

7.11 Responders and non-responders.

A t-test was used to determine whether there was any significant difference between participants and non-responders in terms of compliance with anti-psychotic medication and non-medical interventions, as rated by the case manager. For the non-responders, data was only gathered on those who refused, as opposed to those who were judged inappropriate for the study. The responders had significantly higher compliance with medication ($F_{(60,1)}$ = 6.6, $p < 0.05$), and significantly higher compliance with non-medical treatments ($F_{(60, 1)}$ = 4.3, $p < 0.05$).

7.12 Multivariate analysis

In order to investigate the first three research questions, multivariate techniques were used. The questions were: a) which variables best predict compliance? b) which variables best predict the working alliance? c) which variables predict whether a client has been allocated to a case manager for more or less than six months?

The following section thus consists of two parts; firstly, the preparation of the data for multivariate analysis; and secondly, the use of multivariate techniques to answer the specific questions.

7.121 Data Preparation

The data was screened in order to ensure that the distributions were consistent with the assumptions of multivariate analysis. The screening procedure involved examining a number of the variables for missing data, reliability, normality, outliers and multicollinearity.

Missing data

There were no cases of missing data.

Reliability

The internal reliability of the instruments was assessed using Cronbach's alpha. Alpha scores of 0.7 or higher were considered indicative of adequate internal reliability. The alpha coefficients for the measures are presented in Table 1. In view of the low internal reliability of the DAI (Awad, 1993), a principal components factor analysis was carried out, to identify the items which were the source of the poor reliability. One factor was identified, and three items (questions 2, 5, and 6) had loadings of less than 0.3 on this factor. Cronbach's alpha was calculated for the DAI when these three items were withdrawn, and the new alpha coefficient was alpha = 0.62. This was still too low, and the questionnaire was thus not used in the data analysis.

Table 1. Internal reliability coefficient's for the rating instruments intended to be used in the multivariate analysis.

Measures [a]	Cronbach's alpha
CBQ total (Case Manager)	0.81
CBQ total (Client)	0.86
Drugs Attitudes Inventory	0.53
Insight Scale	0.82
WAI[12] (Case Manager)	0.91
WAI[12] (Client)	0.84
Goal (Case Manager)	0.71
Task (Case Manager)	0.80
Bond (Case Manager)	0.86
Goal (Client)	0.72
Task (Client)	0.63
Bond (Client)	0.71

[a] CBQ = Causal Belief Questionnaire (Whittle, 1996). WAI[12] = Working Alliance Inventory, 12-item version. Goal, Task and Bond refer to the sub-scales of the WAI[12] (Tracey & Kokotovich, 1989).

The items of the Task sub-scale of the WAI[12] (Tracey & Kokotovich, 1989), as rated by the client, were not subjected to a factor analysis, as there were only four items comprising the score. To have reduced this number, by dropping some items, would have left the validity of the score open to question. Thus this item was also not used in any further data analysis.

Linearity & Homeoscedasticity

Linearity and homeoscedasticity were investigated through the use of scatter plots, and were found to be satisfactory.

Normality

The means, standard deviations, minimum scores, maximum scores, kurtosis and skew of the measures used are presented in Table 2.

The skewness of compliance with medications was significant ($z = -3.10$, $p < 0.05$). The variable was transformed by reflecting it, and taking the logarithm. The process of reflection involves taking the highest value of the variables, adding one to it, and then subtracting each of the scores on that variable (Tabachnick & Fidell, 1989). The new variable was termed 'reflected compliance'. It is important to note that the interpretation of a reflected variable is the opposite of the interpretation prior to reflection (Tabachnick & Fidell, 1989). Thus whereas a high score prior to transformation represented high compliance, in the case of the transformed variable a high score represented low compliance.

Table 2. Means, standard deviations, minimum and maximum scores, kurtosis and skew of the variables.

Variable	Mean	S.D. [a]	Min.	Max.	Kurtosis	Skew
Causal Belief Discrepancy	41.9	10.1	13	61	1.0	-0.31
Side effect severity	0.70	0.72	0	2	-0.89	0.53
Symptom severity	7.5	4.7	0	19	-0.48	0.30
Insight Scale	7.9	3.6	0	12	-0.59	-0.74
How long known (months)	16.3	15.5	2	48	-0.31	1.0
Compliance (medication)	5.7	1.5	2	7	0.30	-1.17
Compliance (non-medical)	4.7	2.1	1	7	-1.30	-0.50
WAI $_{12}$ (Case Manager)	61.7	12.2	39	81	-1.0	-0.2
WAI $_{12}$ (Client)	59.1	11.8	30	80	0.31	-0.64
Goal (Case Manager)	19.2	4.9	10	27	-1.10	-0.46
Task (Case Manager)	20.4	4.3	11	26	-0.56	-0.62
Bond (Case Manager)	22.2	4.0	12	28	-0.30	-0.20
Goal (Client)	17.1	5.2	4	26	-0.26	1.0
Task (Client)	20.4	4.6	10	28	-0.15	-0.69
Bond (Client)	21.6	4.2	9	28	2.14	-1.1

[a] S.D. = Standard deviation.

The kurtosis of the Bond sub-scale of the WAI[12], as rated by the client, was high enough to indicate a failure in normality. However, it was to be used discriminant function analysis, which is robust to failures of normality, if caused by kurtosis, as long as the degrees of freedom of error are above 20. The degrees of freedom in this case was 39, and thus the variable was not transformed.

Outliers.

Using Malalanobis distance with $p < 0.01$, no cases were identified as multivariate outliers.

Multi-collinearity

A correlation matrix for the variables that were to be used to answer the research questions is presented in Table 3. Due to the high correlation of the Task and Goal sub-scales of the WAI, as rated by the case manager ($r = 0.87$, $p > 0.01$), these two variables were collapsed to form a new variable, termed 'Treatment'. The reliability of this variable, assessed using Cronbach's alpha, was sufficiently high for the variable to be used in multivariate analysis (alpha = 0.87).

The data was thus prepared for use in multivariate analysis. The specific research questions were then answered, using a number of multivariate techniques. The first two questions were answered using hierarchical multiple regressions, and the final question using a discriminant function analysis.

Table 3. Correlation Coefficients (Pearson's r) for variables used in the multivariate analysis.

	Bond (case manager)	Bond (Client)	CBQ Discrepancy	Reflected Compliance	Non-medical Compliance	Goal (case manager)	Goal (client)	Insight	How long known	Side effect severity	Symptom severity	Task (case manager)	WAI [12] (case manager)	WAI [12] (client)	Frequency of contact
Bond (case manager)	1.0	.17	-.12	.55	.28	.69**	.46**	.10	.22	-.39*	-.35*	.70**	.86**	.44	.36**
Bond (Client)		1.0	-.03	-.01	.15	.20	.48*	.38*	-.11	.13	-.25	.11	.18	.75*	.07
CBQ Discrepancy			1.0	.03	-.03	-.15	-.28	.09	-.04	-.16	-.02	-.14	-.15	-.16	.04
Reflected Compliance				1.0	.33*	.55**	-.01	.07	.15	-.18	-.33	.59**	.61**	.05	.26
Non-medical compliance					1.0	.58**	.14	.16	-.05	.05	-.05	.52**	.51**	.19	.25
Goal (case manager)						1.0	.43**	.21	.12	-.23	-.18	.86**	.94**	.41	.28
Goal (Client)							1.0	.28	.24	-.05	-.23	.34	.45	.88	.09
Insight								1.0	-.03	-.04	.07	.11	.16	.44**	.08
How long known									1.0	.07	.04	.30	.23	.16	-.03
Side effect severity										1.0	-.10	-.20	-.29	-.07	-.08
Symptom severity											1.0	-.25	-.27	-.25	-.55
Task (case manager)												1.0	.93**	.34	.28
WAI [12] (case manager)													1.0	.43**	.33
WAI [12] (client)														1.0	.11
Frequency of contact															1.0

* = $p < 0.05$, ** = $p < 0.01$

7.122 Investigation of the research questions using multivariate techniques

Question 1.1 What variables best predict compliance with medication?

A hierarchical multiple regression analysis was employed, to investigate whether the addition of concordance variables improved the prediction of compliance with medication, above that afforded by control variables.

The variables entered in the first stage were the 'control variables'. These were a) symptomatology, b) side effects, c) degree of insight and d) level of supervision. This last variable was based on the case manager's reports on the frequency of contact with the client. Those meeting fortnightly or more frequently were coded '1', those meeting between fortnightly and monthly '2', and those meeting less than monthly '3'. Thus this variable was an ordinal variable, which can still be used in a multiple regression (Tabachnick & Fidell, 1989).

The variables entered in the second stage were the 'concordance variables'. These were a) compliance with non-medical treatment, b) the working alliance as assessed by the case manager and c) the client, and d) the degree of discrepancy in causal beliefs between client and case manager.

After both steps had been completed, R was significantly different from zero, R = 0.70, F $(8, 31) = 3.65$, $p < 0.01$. The semi-partial correlations and increase in F, for each of the steps, are presented in Table 4.

Table 4. Semi-partial correlations and increase in F for a hierarchical multiple regression, with reflected compliance with medication as the dependant variable, and prediction equation.

Step	Variables	B [a]	Beta [b]	sr^{2} [c]	F incr. [d]
1	Insight	-0.02	-0.16	0.16	1.65
	Symptom severity	0.03	0.29		
	Side effect severity	0.02	0.02		
	Frequency of contact	0.04	0.06		
2	Working Alliance, rated by the Case Manager	-0.02	-0.59	0.33	4.91**
	Working Alliance, rated by the Client	0.02	0.40		
	Compliance with non-medical treatments	-0.03	-0.13		
	Causal Belief Discrepancy	-0.01	-0.15		

[a] Regression coefficient

[b] Standardised regression coefficient

[c] semi-partial correlations

[d] Increase in the F ratio

** = $p < 0.01$

Prediction equation (7.1)

(Reflected compliance) = 2.19 - 0.02 (Insight) + 0.03 (Symptom severity) + 0.02 (side effect severity) + 0.04 (Frequency of contact) - 0.02 (Working alliance, rated by the case manager) + 0.02 (Working alliance, rated by the client)

After stage 1, with demographic variables in the equation, $R^2 = 0.16$, adjusted $R^2 = 0.06$, $F_{(4, 35)} = 1.65$. Thus the control variables did not predict a significant amount of the variance in compliance with medication.

After stage 2, with the concordance variables entered into the regression equation, $R^2 = 0.48$, adjusted $R^2 = 0.35$, $F_{(8, 31)} = 3.65$, $p < 0.01$. Thus the concordance variables accounted for 33% of the variance in the rating of compliance with medication. The two variables that were significant predictors of compliance with medication were the working alliance as rated by the case manager ($t = 3.08$, $p < 0.01$), and as rated by the client ($t = 2.36$, $p < 0.05$). The case managers' rating of the alliance was a negative predictor (Beta $= -0.59$), while the clients' was a positive predictor (Beta $= 0.39$). When interpreting the Beta values it is important to note that the variable 'reflected compliance' had been transformed, and thus the interpretation of the relationship of compliance to the measures of alliance was reversed.

In summary, the control variables (severity of symptoms and side effects, frequency of contact and insight) did not predict adherence. With these variables controlled for, the two variables which predicted a significant amount of the variance in compliance with medication were the measures of the working alliance. However, while the case managers' ratings were positive predictors, the clients ratings were negative ones. Thus, while a stronger alliance as rated by the case manager predicts better compliance with medication, the reverse is true of alliance as rated by the client - stronger alliance predicts poorer compliance. Compliance with non-medical treatments, and the discrepancy in causal beliefs between client and case manger, did not predict adherence to medication.

Thus some of the variables which could be conceptualised as being aspects of concordance were the best predictors of adherence, but the relationship was more complex than expected.

Question 1.2. What variables best predict compliance with non-medical treatments?

A second hierarchical multiple regression analysis was carried out, similar to that described above. With compliance with non-medical treatments as the dependant variable, the control variables were entered in stage 1, and the measures of concordance in stage 2. The control variables were a) degree of symptomatology, b) severity of side effects, c) frequency of contact between client and case manager and d) level of insight. The concordance variables were a) compliance with medical treatment, b) the clients' ratings of the working alliance and c) the case managers' rating, and c) the rating of discrepancy between causal beliefs.

After both steps had been completed, R was significantly different from zero, R = 0.62, F $(8, 31)$ = 2.43, p < 0.05. The semi-partial correlations and increase in F for each of the steps are presented in Table 5.

Table 5. **Semi-partial correlations and increase in F for a hierarchical multiple regression, with compliance with non-medical treatments as the dependent variable., and prediction equation.**

Step	Variables	B [a]	Beta [b]	sr^2 [c]	F incr. [d]
1	Insight	-0.002	-0.004	0.09	0.93
	Symptom severity	0.13	0.31		
	Side effect severity	0.84	0.29		
	Frequency of contact	0.57	0.22		
2	Working Alliance, rated by the Case Manager	0.09	0.51	0.28	3.63 *
	Working Alliance, rated by the Client	0.01	0.06		
	Reflected Compliance with medication	-0.71	-0.16		
	Causal Belief Discrepancy	0.02	0.08		

[a] Regression coefficient

[b] Standardised regression coefficient

[c] semi-partial correlations

[d] Increase in the F ratio

** = p < 0.01

Prediction equation (7.2)

(Compliance with non-medical treatment) = -3.76 - 0.002 (Insight) + 0.13 (Symptom severity) + 0.84 (side effect severity) + 0.57 (Frequency of contact) + 0.09 (Working alliance, rated by the case manager)

For the variables entered in stage 1, $R^2 = 0.097$, adjusted $R^2 = -0.006$, $F (4, 35) = 0.93$. These variables did not predict a significant amount of the variance in compliance with non-medical treatments.

After stage 2, with the measures of concordance entered into the equation, $R^2 = 0.39$, adjusted $R^2 = 0.22$, $F = 2.4$, $p < 0.05$. The variable that was a significant positive predictor of adherence was the working alliance as rated by the case manager (Beta = 0.51, $p < 0.05$).

In summary, symptoms, side effects, insight and frequency of contact did not predict adherence significantly. When these variables were controlled for, the working alliance as rated by the case manager was a significant, positive predictor of adherence to non-medical interventions. Alliance as rated by the client, causal belief discrepancy and compliance with medication were not significant predictors. Thus only one concordance variable predicted adherence with non-medical treatment. Overall, the best predictors of compliance were the ratings of working alliance, although in different ways. None of the other variables were significant predictors.

Question 2.1. What variables best predict the working alliance, as rated by the case manager?

Another hierarchical multiple regression analysis was carried out to investigate the extent to which several variables predicted the working alliance as rated by the case manager. The variable entered in the first stage of the equation were the four control variables, which were a) symptom severity, b) side effect severity, c) frequency of contact and d)

degree of insight. The concordance variables were entered in the second stage, and these were a) compliance with medication, b) compliance with non-medical treatments, c) working alliance as rated by the client, and d) the discrepancy in causal beliefs between client and case manager.

After both steps had been completed, R was significantly different from zero, R = 0.80, F $(8, 31) = 7.131$, $p < 0.01$. The semi-partial correlations and increase in F, for each of the steps, are presented in Table 6.

After stage 1, the control variables accounted for 14% of the variance in the working alliance as rated by the case manager ($R^2 = 0.23$, adjusted $R^2 = 0.14$, F $(4, 35) = 2.65$, p < 0.05. The only regression coefficient that approached a significant level of difference from zero was that for severity of side effects, (Beta = -0.30, significance of t = 0.057).

After the concordance variable were entered into the equation, $R^2 = 0.65$, adjusted $R^2 = 0.56$, F $(8, 31) = 7.13$, $p < 0.01$. The three variables that accounted for the significant increase in R^2 were reflected compliance with medical treatment (Beta = -0.40, p < 0.01), compliance with non-medical treatment (Beta = 0.29, p < 0.05), and working alliance as rated by the client (Beta = 0.34, p < 0.05).

Table 6. Semi-partial correlations and F change for a hierarchical multiple regression, with working alliance as rated by the case manager as the dependent variable, and prediction equation.

Step	Variables	B [a]	Beta [b]	sr^2 [c]	F incr. [d]
1	Insight	-0.23	-0.07	0.23	2.65 *
	Symptom severity	-0.09	-0.03		
	Side effect severity	-4.21	-0.25		
	Frequency of contact	1.13	0.07		
2	Working Alliance, rated by the Client	0.35	0.34	0.42	9.14 **
	Reflected Compliance with medication	10.3	-0.40		
	Compliance with non-medical treatment	1.71	0.29		
	Causal Belief Discrepancy	-0.22	-0.19		

[a] Regression coefficient

[b] Standardised regression coefficient

[c] semi-partial correlations

[d] Increase in the F ratio

** = p < 0.01

Prediction equation (7.3)

(Working alliance, rated by the case manager) = 60.21 - 0.23 (Insight) - 0.09 (Symptom severity) - 4.21 (side effect severity) + 1.12 (Frequency of contact) + 1.71 (Compliance with non-medical treatment) + 0.35 (Working alliance, rated by the Client) - 10.34 (Reflected compliance with medication)

The combination of insight, symptom and side effects severity, and frequency of contact, significantly predicted the alliance as rated by the case manger. None of these variables made a unique contribution to the variance in alliance, but side effect severity approached significance as a predictor. With these variables controlled for, compliance with both non-medical and medical treatments, and alliance as rated by the client, were positive predictors of case manager rated alliance. All were positive predictors. Discrepancy of causal beliefs was not a significant predictor.

Question 2.2. What variables best predict the working alliance, as rated by the client?

To investigate this research question, a final hierarchical multiple regression was performed, with working alliance as rated by the client as the dependent variable. The control variables were entered in the first stage of the equation, namely a) level of symptomatology, b) severity of side effects, c) frequency of contact between client and case manager, and d) degree of insight. The concordance variables were entered in the second stage of the equation, these being a) compliance with medical treatment, b) compliance with non-medical treatment, c) working alliance rated by the case manager and d) degree of discrepancy in causal beliefs between client and case manager.

After both steps had been completed, R was significantly different from zero, $R = 0.71$, $F_{(8, 31)} = 4.0$, $p < 0.01$. The semi-partial correlations and increase in F, for each of the steps, are presented in Table 7.

Table 7. Semi-partial correlations and F change for a hierarchical multiple regression, with working alliance as rated by the client as the dependent variable, and prediction equation.

Step	Variables	B [a]	Beta [b]	sr^2 [c]	F incr. [d]
1	Insight	1.44	0.44	0.30	3.75 **
	Symptom severity	-0.97	-0.39		
	Side effect severity	-0.81	-0.05		
	Frequency of contact	-2.94	-0.20		
2	Working Alliance, rated by the Case Manager	0.46	0.47	0.21	3.28 **
	Reflected Compliance with medication	9.51	0.38		
	Compliance with non-medical treatment	0.30	0.53		
	Causal Belief Discrepancy	-0.10	-0.09		

[a] Regression coefficient

[b] Standardised regression coefficient

[c] semi-partial correlations

[d] Increase in the F ratio

** = $p < 0.01$

Prediction equation (7.4)

(Working alliance, rated by the Client) = 21.82 + 1.44 (Insight) - 0.97 (Symptom severity) - 0.81 (Side effect severity) - 2.94 (Frequency of contact) + 9.51 (Reflected compliance with medication) + 0.46 (Working alliance, rated by the case manager)

After the control variables were entered into the equation, $R^2 = 0.30$, adjusted $R^2 = 0.22$, $F = 3.75$, $p < 0.05$. Insight was a positive predictor (Beta = 0.48, $p < 0.01$), and symptomatolgy a negative predictor (Beta = -0.39, $p < 0.05$).

With the concordance variables entered in the second stage of the equation, $R^2 = 0.51$, adjusted $R^2 = 0.38$, $F (8,31) = 4.0$, $p < 0.01$. Two variables were significant predictors of the dependent variable. Reflected compliance with medication was a positive predictor of working alliance as rated by the client (Beta = 0.38, $p < 0.05$), as was working alliance as rated by the case manager (Beta = 0.48, $p < 0.05$).

In summary, insight was a positive predictor of alliance, symptom severity a negative. Side effect severity and frequency of contact were not significant predictors. Controlling for these variables, compliance with medication was a negative predictor, and case manager-rated alliance positive significant predictor of alliance. Compliance with non-medical treatments and causal belief discrepancy were not significant predictors.

Question 3. What variables predict whether a client has been allocated to a case manager for more or less than six months?

A direct discriminant function analysis was carried out, with seven variables as the predictors of membership of two groups. The predictor variables were aspects of the working alliance, namely Bond, Task and Goals, as rated by both client and case manager. As explained above, the Task and Goals as rated by the case manger were collinear, and had been collapsed to form a new variable, Treatment. The measure of Task as rated by the client did not have sufficient internal reliability, and was therefore

101

not included in the discriminant function analysis. Thus the variables used to calculate the discriminant function were a) strength of the Bond, as rated by the case manager, b) Bond, as rated by the client, c) agreement on Treatment, as rated by the case manger, d) agreement on Goals, as rated by the client, e) compliance with medication, f) compliance with non-medical treatment and g) degree of agreement over causal beliefs.

A discriminant function was calculated, with a chi-squared (7) = 23.7, p < 0.01. Thus there was statistically significant separation of the two groups, using the seven variables.

The loading matrix of the correlations between the predictor variables and the discriminant function is shown in Table 8. Three of these variables were significant predictors of whether the therapeutic relationship was more than six months old. The case managers' rating of Bond was significantly higher in the longer relationship group (mean = 23.8, s.d. = 4.1) than in the group of those with relationships of six months or less (mean = 19.9, s.d. = 2.5). Similarly, agreement on Treatment as rated by the case manager was significantly higher in the longer relationship group (mean = 43.3, s.d = 8.4) compared with the shorter relationship group (mean = 34.5, s.d. =7.3). Agreement on Goal, as assessed by the client, was also significantly higher in the longer relationship group, (mean = 19.1, s.d. = 5.17), compared with the shorter relationship group (mean = 14.6, s.d. = 4.23).

Table 8. Results of Discriminant Function Analysis.

Variable	r^a	F
Treatment, rated by the Case Manager	0.56	11.93 **
Bond, rated by the Case Manager	0.56	11.77 **
Goal, rated by the Client	0.48	8.60 **
Bond, rated by the Client	-0.17	1.05
Reflected Compliance with medication	-0.25	2.41
Compliance with non-medical treatment	0.18	1.27
Causal Belief Discrepancy	-0.07	0.18

[a] Pooled within-group correlations, between variables and the discriminat function

** $= p < 0.01$

This discriminant function correctly classified 88.2% of the shorter relationship group, and 87.0% of the longer relationship group. Overall, using sample proportions as prior probabilities, 87.5% of cases were correctly classified, compared with the 50% that would be expected by chance alone.

Using concordance variables, in 88% of cases one could correctly predict whether a case manager had been allocated to a client for longer than six months, or for a shorter period. Aspects of the working alliance as rated by the case manager, and the Goals aspect as rated by the client, were significant predictors, and were higher in the group were the case manger had been assigned to the client for longer than six months. The Bond as rated by the client, adherence to medical and non-medical interventions, and causal belief discrepancy were not significant predictors.

7.2 Qualitative data

The method chosen to identify themes in the data was a cross-case content analysis, a method appropriate for generating categories across a relatively large number of subjects. (Barker, Pistrang & Elliot, 1994; Ailiner & Dear, 1997). One of the principles of grounded theory was adopted, in that the categories and themes were generated through a process of open coding, rather than by being based on a priori theories (Henwood and Pidgeon, 1992). However, the method differed from grounded theory in that the categories were not generated during the process of data collection (Ingram & Hutchinson, 1999).

7.21 Research questions

There were two research questions being investigated.

Question 4.1 What treatments were identified as helpful and unhelpful?

Question 4.2 What aspects of treatment were considered to be helpful or unhelpful?

The first was examined using the responses to Open Questions 1 and 3 (Appendix 10), and the second using the response to questions 2 and 4. However, the analysis was similar for each research question.

7.22 Data Analysis

7.221 Data display

The answers to the open questions were transcribed and organised so that they could all be viewed together, as recommended by Huberman and Miles (1998).

7.222 Data reduction

The first part of this process involved the identification of substantive codes, i.e. words and phrases that organised the information into chunks of data (Forbes & Hoffart, 1998).

The second part consisted of noting patterns and clustering the answers into conceptual groupings (Brown & Stetz, 1999), identified by the researcher during the process of the data analysis. In deriving the categories, the researcher adopted the criteria set out by Strauss (1998), and Good and Watts (1994) who suggested that the categories in a classification system should fulfill certain criteria.

a) Each category should be unique, and explicitly defined.

b) Each category should be inclusive, and the set of categories should be exhaustive, so that every response could be allocated to a category.

c) The categories should have theoretical, as well as practical, value and be internally coherent.

To aid the process of developing conceptual groupings, the categories were developed sequentially, by clustering the responses that were closely related first, so as to maximise internal coherence. This process produced a large number of categories, which were then combined, whilst ensuring that each new category was also internally coherent (Good and Watts, 1994). These categories were then collapsed into broader theoretical constructs, also identified by the researcher (Brown & Stetz, 1999).

7.223 Verification

The final part of the process was the verification of the categories. This was done in two ways. Firstly, the face validity of the categories was checked by presenting the categories and the codes to a lay person, whose comments were helpful in minimising jargon in the category definitions. These category definitions and the codes were then presented to a chartered psychologist, who was asked to attempt to place the codes in the categories identified by the researcher. The percentage of codes in the same categories was recorded, and is presented as an indicator of the validity of the categories.

Data analyses were carried out separately for the client and case manager responses. As some participants gave several responses, and others gave no response, there are a different number of response to the number of subjects. In other words, the categorisation if of the type of response, rather than of the participant.

7.23 Findings

<u>**Question 1.** What were the treatments identified by the clients and case managers as being helpful and unhelpful?</u>

The analyses of the clients' and the case managers' responses were carried out separately, as these two groups should have very different experiences of the treatment process.

Clients' responses

The treatments identified by the clients could be categorised in the following way. The figures in parentheses refer to the number of times that each treatment was referred to as being either helpful or unhelpful.

1. *Injections* (helpful 7, unhelpful 8).

This referred to depot medication.

2. *Tablets* (helpful 3, unhelpful 3).

This category comprised oral anti-psychotic medications.

3. *Named anti-psychotic* (helpful 6, unhelpful 9).

A number of clients identified particular anti-psychotics by their brand names.

4. *Unnamed anti-psychotic* (helpful 8, unhelpful 2).

A number of clients referred to anti-psychotic medications more generally.

5. *Anti-depressant* (helpful 1, unhelpful 0).

One client referred to Prozac.

6. *Side effects medication* (helpful 2, unhelpful 1).

This refers to medication designed to counter the side effects of anti-psychotic medications.

7. *ECT* (helpful 0, unhelpful 4).

8. *Hospitalisation* (helpful 2, unhelpful 3).

9. *The environment* (helpful 1, unhelpful 0).

10. *Practical help* (helpful 3, unhelpful 0).

This category included help obtaining benefits, and supported housing.

11. *Talking* (helpful 3, unhelpful 1).

Clients referred to both "talking therapy", and to talking with staff and others in a more informal way.

12. *None* (helpful 3, unhelpful 8).

13. *Sectioning* (helpful 0, unhelpful 1).

14. *Leuchotomy* (helpful 0, unhelpful 1).

These categories could be collapsed into three over-arching categories.

1. *Medical interventions.*

The treatments in this category were a) Injections, b) Tablets, c) Named anti-psychotic medications, d) Unnamed anti-psychotic medications, e) ECT, f) Anti-depressants, and g) Side effects medication.

2. *Psychosocial interventions.*

The interventions included in this category were a) Talking, b) Practical help and c) Hospitalisation.

3. *None.*

Case managers' responses

The treatments identified could be classified in the following taxonomy. The number of case mangers who identified each intervention as helpful or unhelpful is shown in parentheses.

1. *Dynamic psychotherapies* (helpful 3 unhelpful 6).

Case managers made references to "psychotherapy", "regression techniques", "Laingian psychotherapy", and "counselling".

2. *Medication* (helpful 6 unhelpful 1).

Reference was made to both named medication, and to medication in a more general sense, including depot injections.

3. *Cognitive and behavioural therapies* (helpful 2 unhelpful 2)

Case managers referred to "CBT", "behaviour therapy", "problem solving" and "psychosocial family interventions".

4. *Supervision and support* (helpful 4 unhelpful 0).

Case managers mentioned "supported housing, 24 hour care and structure", "structured activities" and "day care activities". One case manger stressed the importance of "long term engagement".

5. *Sectioning and compulsory treatment* (helpful 0, unhelpful 1)

6. *ECT* (helpful 1, unhelpful 0).

These six treatment categories could be grouped together into three main categories.

1. *Medical interventions*

This category included a) medication and b) ECT.

2. *Psychosocial interventions.*

This category comprised a) dynamic psychotherapies, b) cognitive and behavioural therapies, c) supervision and support and d) sectioning and compulsory treatment.

3. *None*

The frequencies of codes in each of the over-arching categories, for both clients and case managers, are shown in Table 9.

Question 2. What aspects of treatments were identified as helpful and unhelpful by clients and case managers?

Helpful aspects

Clients' responses

34 responses were recorded. Three clients gave responses which were, in the opinion of the researcher, so delusional in quality that they would distort the data. These responses are also presented in Appendix 14. This selection of data, so that the responses analysed are appropriate to the question asked, is justified by Morse (1998).

The responses could be grouped into ten categories, which are given below, with some examples of each. All the codes are presented in the categories in Appendix 14. In the

Table 9. Frequencies of responses in each treatment belief category, given by clients and case managers.

	Clients (N = 40)	Case Managers (N = 10)
Helpful	Medical 27 (71%) Psychosocial 8 (21%) None 3 (8%)	Medical 7 (44%) Psychosocial 9 (56%) None 0 (0%)
Unhelpful	Medical 28 (70%) Psychosocial 4 (10%) None 8 (20%)	Medical 1 (9%) Psychosocial 9 (82%) None 1 (9%)

verification process described above, the chartered psychologist placed 89% of the items in the same categories as the researcher.

1. *Tranquilising.*

This category represented the most common aspect of treatment considered to be helpful. Clients' responses include stating that medication "calms me down", and "relieves stress and nerves". Another client referred to the "quiet and rest" of hospital.

2. *Instant effects.*

Responses in this category referred to the sense of the treatment taking effect as being helpful. A client commented that his medication was helpful because "I can feel it working".

3. *Compulsion.*

One client commented that a helpful aspect of injection was that "with the tablets, I don't take them everyday, but injections, I know I have to take them".

4. *Side effects prevention.*

This category refers to the helpful effects of medication which prevents side effects due to anti-psychotic medication. A client commented that medication "stops you shaking".

5. *Symptom prevention.*

This was given as the next most helpful aspect of treatment. Of tablets, it was said that "they help prevent a nervous breakdown", while another client commented that injections were helpful as they made him "feel very confident, as the voices disappear". Another talked about "feeling right".

6. *Understanding.*

This category referred to the beneficial effects of gaining a better understanding of the nature and causes of mental illness. One client commented that talking therapy "helps you

to come to terms with the causes of mental illness... medications deal with symptoms, not causes. They're not a cure".

7. *Physiological action.*

This category consists of responses which referred to the physical processes involved in treatment. One client stated his opinion that "medication is useful because the brain is the most important part of the body, because thinking takes place there". Another said that "when you flip into the psychotic state, talking won't help. There's a chemical basis to the psychotic state".

8. *Safety.*

This category referred to the importance of a sense of security, mainly due to practical help. One client felt that the most helpful aspect of treatment was help dealing obtaining benefits, as "it is difficult to talk to DSS, and money gives you freedom to support yourself". With regard to supported housing, one client commented that helpful features were that she had "lived there before, not get pushed around, live with people who understand". Another client said of a supervised hostel that during his time there, he was able to "get to know the options, and things did not seem so strange".

9. *Don't know.*

A client commented of his medication that he was "not sure why, but it is helpful".

10. *Comfort.*

Responses in this category emphasised the effects of carers' attempts to help clients. One client said that people "try everything to help, they are kind and understanding", while another commented simply that "talking to people makes you feel better".

These categories could be grouped into two over-arching categories.

1. Stability

This category refers to those aspects of treatment which are helpful because they allow the clients more stability, normality or calm than they have without the treatment. The mechanisms by which this stability is achieved are less important than the experience of stability.

2. Being treated

The helpful aspects of treatment in this category are those that give the clients a sense that they are being treated, looked after or cared for in some way. It is not so much the effects of the treatment per se, as the experience of receiving it, or knowing that something is being done, that is helpful to the client.

Sanctuary

These categories can be collapsed into one over-arching category, which is termed 'sanctuary'. The helpful aspects of treatment are envisaged as those giving clients a sense of calm, and relief from unpleasant experiences, whether from the disorder or other aspects of treatment, as well as an experience of being cared for.

Case Managers' responses.

These could be grouped into seven categories. The chartered psychologist and the researcher agreed on 90% of the responses.

1. *Improved functioning*

Some responses emphasised how treatment could help by allowing for more general improvements in functioning. One commented that medications would "enable (the client) to function adequately in all areas of daily living activities".

2. *Improved access.*

This category refers to the opportunity to engage in a range of treatments, and the importance of doing so. Thus one case manager commented that medication "keeps the mental state stable, so you can then provide other treatments, such as day care activities". Another felt that medication "should only be used in conjunction with other types of support", and that "all available treatments...offer something to an individual, depending on his or her needs".

3. *Structure.*

Responses in this category stressed the importance of structure in relation to the limitations of the disorder. Thus psychotherapy was considered by one case manager to be "wishy washy, not concrete enough", while another felt that a problem with psychotherapy was that "there's no direction, patients have to find their own solutions, which is difficult for clients in a stressful situation". Another commented that the most helpful aspect of treatment was "structure.. and behavioural boundaries", to prevent clients being "a danger to themselves".

4. *Presence.*

Responses in this category referred to the importance of a consistent, trusting relationship with another person. One case manager emphasised the importance of a "dynamic space", another felt that the most helpful aspect of treatment was "help to express feelings, and talk about problems, and to trust someone...knowing someone is there makes you feel

positive". Another felt that long term engagement was important because "you build up trust, and the more a patient sees you as an asset, it helps". One commented that counselling was "an opportunity for the client and the counsellor to get to know one another".

5. *Understanding*

Psychosocial interventions were "educative", and helped by "dispelling myths of how a person thought about their illness". A case manager stressed how important itwas to help the client "identify underlying problems that the client experiences".

6. *Symptom management*

Responses in this category emphasised symptom relief. Thus one case manager commented that medication "gets rid of positive and negative symptoms", while CBT "helps people to manage and cope with their symptoms".

7. *Participation.*

Responses in this category stressed the benefit of clients and their families being actively involved in the treatment process. One felt that "client and family participation...was empowering for the patient and the family".

These categories could be collapsed into two over-arching categories.

1. *Containment*

This category refers to those aspects of treatment which are helpful because they give clients a sense of containment, safety or stability. Treatment is seen as helping the clients by allowing them to function without undue pressure, either from their symptoms or from external forces.

2. *Involvement*

This category refers to those aspects of treatment which are helpful because they encourage the client to be an active participant in their treatment, removing stigma and limitations that keep clients demoralised and disempowered, and allowing them to understand and make decisions about their treatment.

Framework

They could be collapsed into one category, here called 'framework'. This refers to treatment being helpful because it allows clients to engage in as normal a life as possible, including making decisions about their treatment, while giving them a frame of reference to understand their experiences, as well as support and protection, all of which increase the clients confidence.

Unhelpful aspects of treatment

Clients' responses

The researcher and the chartered psychologist agreed on 100% of the content of the categories.

1. *Poor efficacy.*

This category referred to the sense that treatment did not work. One client said of procycladine "I run out, and it does not make any difference". Injections "don't serve the purpose, they have no effect", while another commented that tablets "don't have any effect". Of ECT, it was said that it "didn't make any difference", and "the effects didn't last".

2. *Frightening side effects.*

This category referred to response which emphasised side effects of medication that were experiences out of the ordinary, or which would be difficult to explain. One client referred to "dribbling and swelling". Another client commented that ECT "destroys brain cells".

3. *Stigma and stress.*

This category referred to responses stressing how distressing an experience treatment could be, due to the clients' interpretations of what was happening to them, rather than to specific effects of the treatment itself. One client stated that "being zonked out on medication and being restrained is demoralising". Another criticised ECT, because people experience "pain and stress because they feel it is dangerous". Of hospital, one client said that she "did not like the place or the people, it is dirty and untidy".

4. *Lack of freedom.*

One client felt that this was a problem as he "did not want to take" the medications. Another client stated that the problem of hospital was that "your freedom is restricted". Another commented that an unhelpful aspect of hospital is that one can become "institutionalised".

5. *Agitation.*

One client commented that due to medication he "could not sit down, pacing up and down", another that medication "made me nervous and restless all the time". An effect of tablets was that "you can't sleep", and side effects medication was said to "makes you shake and makes people behave strangely".

6. *Drowsiness.*

One commented that medication "makes you sleep all the time", another that it "slows you down too much".

These categories could be collapsed into one broad category.

Treatment deficiency

This category refers to those unhelpful aspects of treatment which are due to some failure or inadequacy of the treatment. It includes unintended and undesirable effects of treatment, and the failure of treatment to have the desired effect.

Case managers' responses

The researcher and the chartered psychologist agreed on 89% of the categories.

1. *Disorder limitations*

This category refers to the limitations imposed on what can be done with this client group, due to the nature of the disorder. A case manager commented that psychotherapy "could open up wounds, and clients couldn't rationalise what happened". Another suggested that psychotherapy "can't be done with someone who is too disturbed", whilst another felt that a problem with psychotherapy was the "mild learning difficulties" that some clients experienced.

2. *Labelling.*

This category refers to the risk of treatments labelling clients, and perpetuating rather than alleviating their distress. One commented that if clients were "heavily medicated, they don't progress, (and) become labelled chronically ill, which affects those caring for them, who continue with the same medications, and they become 'chronic'".

3. *Abuse.*

One commented that counselling could be "oppressive, and an abuse of power", while another felt that behavioural treatments were "more open to abuse, especially when people don't keep up to date".

4. *Mistrust.*

Responses in this category referred to the possibility of interventions making clients mistrust those trying to help them. One case manager felt that sectioning "backfires. (Clients) start distrusting professionals, and turn against everything". Another felt that psychotherapy could "make the patient non-compliant, and antagonistic to medication, projecting their problems on to others".

These categories can be broken down into two categories.

1. Client limitations

The first refers to the client being unable to cope with the treatment, or misunderstanding the intentions of those treating them.

2. Clinician limitations

The second refers to the clinicians misusing treatment, through ignorance, frustration or hopelessness.

User limitations

These two categories could be collapsed into one over-arching category, user-limitations, referring to some limitation in the person either administering or receiving the treatment, rather than a limitation of the treatment itself.

7.24 Answers to the specific research questions

Both clients and case mangers identified a range of treatments as being helpful, and unhelpful, and they seemed to identify a broadly similar range of treatments. The treatments identified by both groups could be categorised into medical and psychosocial interventions.

Regarding the frequency figures, the data needs to be interpreted with caution, because of the small sample size of the case manager group, and the fact that the qualitative questions do not have established criterion validity. With this in mind, however, a number of possibly interesting features of the data presented in Table 9 can be commented on. While the pattern of responses between clients and case managers regarding what treatments are helpful seems to be broadly similar, there also seems to be a difference in the pattern of responses regarding treatments seen as unhelpful. The majority of responses in the client group refer to medication as unhelpful, which seems to contrast with the case manager group, in which medication was referred to as unhelpful only once. Equally striking, in the client group, medication seems to be referred to as helpful and unhelpful a similar number of times, again in contrast to the case manager group.

The categories generated for the helpful and unhelpful aspects of treatment, as perceived by the clients and case managers, seem at first glance to be quite different from each other. However, when the definitions of those aspects perceived as helpful are considered, the possibility arises that there are in fact similarities between the groups. The theme of *Sanctuary* seems to have parallels with the theme of *Framework*, as both appear to suggest the helpfulness of stability within a caring environment.

When the over-arching categories of the aspects of treatment that are perceived as unhelpful are considered, there seem to be more pronounced differences between the two groups, than with the helpful aspects. The theme of *Treatment deficiency* highlighted by clients refers to problems with the actual interventions, while the theme highlighted by staff, *User limitations*, seems to refer more to the client or clinician, and his or her abilities or attitudes regarding the treatment. This seems to suggest a fundamental difference in the perception of the locus of problems in treatment.

Chapter Eight

Discussion

The answers to the specific research questions can be used to address the important themes of the research which were identified in the introductory chapters. These themes are; the possible links between alliance and compliance; the role of congruence of beliefs; insight; the aspects of the alliance; and the concept of concordance. In the present chapter these themes are considered in turn, and explanations for the research findings are offered. Consideration is then given to possible clinical implications of the findings. The limitations of the present study are also discussed, and the chapter concludes with directions for future research.

8.1 Themes

8.11 Alliance and compliance

The first theme is whether there could be a conceptual link between alliance and compliance. The answers to research questions 1 and 2 suggest that there is, but that it is a complex one. Alliance as rated by the case manger had a positive association to compliance with both medication and non-medical treatments, while alliance as rated by the client was negatively related to compliance with medication, and not related to compliance with non-medical treatment.

8.111 Case manager-rated alliance and compliance

The positive association between case manager-rated alliance and compliance with treatment is consistent with the findings of Frank & Gunderson (1990). The lack of an association between frequency of contact and compliance meant that the results

did not concur with those of Irwin et al. (1971) and Nageotte et al. (1997). However, the present study was only a partial replication of the themes of those studies. The former study was particularly different in that it was conducted in an inpatient setting. Nageotte et al. (ibid.) found that non-adherence was associated with not receiving any mental health care over a three month period, but all the participants in the present study had received regular care from case managers within such a period. However, the results of the present study suggest that there is an association between working alliance and compliance, for which there a number of possible explanations. It should be emphasised that the methodology of the study imposes strict limitations on judgements over the validity of explanations.

8.1111 Causal links

Firstly, there could be a causal link between the alliance and compliance. It might be that a strong working alliance enables clients to adhere to the treatment. If this was the case, it could have important implications for the findings of Krupnick et al. (1996), namely that the relationship between alliance and outcome is mediated by compliance. A strong working alliance with a case manager may allow a client to engage in the treatment process, as suggested by Coady (1993).

A different causal explanation would be that clients who comply could have a better outcome, and this would be reflected in a better alliance, with the client agreeing with the treatment because it works. In this regard, it should be noted that symptom severity was a negative predictor of client-rated alliance, which is consistent with the view that better outcome leads to stronger ratings of alliance. Against this, it should

be said that there is evidence that the ratings of alliance are independent of the progress of treatment (Gaston, 1990).

In considering either of these explanations, it must be remembered that the cross-sectional correlational methodology does not allow judgements as to whether the association between variables is causal. Thus no definitive judgements can be made about the direction of any causality, and there may be mediating and moderating variables.

8.1112 Source of rating

Another explanation is derived from the observation that compliance was rated by the case manager, and thus the issue is one of a positive relationship between two ratings from the same source. It may be that case managers view adherence to treatment and a strong alliance as in some way equivalent. If a patient is adhering to treatment, medical or non-medical, the case manager may take that as indicating client agreement over Tasks and Goals. Similarly, if a client does not comply, the case manager may take it that the client does not agree over Tasks and Goals. From this perspective, non-compliance and a strong alliance could be seen as contradictory. This would be consistent with the notion of the two concepts as being aspects of a more general concordance between client and clinician. In this regard, it is worth considering the suggestion that working with clients with a diagnosis of schizophrenia can lead to feelings of frustration and hopelessness (Corrigan, Leiberman & Engel, 1990). As one of the primary purposes of a clinical case manager is to deliver treatment, the experience of treating a client who does not comply may exacerbate such feelings. Thus case managers may place great

emphasis on compliance with treatment, and one could speculate that the same is true of most clinicians, regardless of client group or treatment modality. Alternatively, case managers' ratings of compliance might be influenced by the alliance, with case managers tending to assume higher compliance in those clients with whom they feel they have a good alliance. A possible methodological limitation of the study in this regard was that questions to the case managers regarding compliance were always asked after their rating of the alliance. Thus any overlap between the two concepts may have been exacerbated by the order of questioning.

8.112 Client-rated alliance and compliance

The picture is considerably complicated, however, by the finding of a negative relationship between client-rated alliance, and compliance with medication. The first point to note is that the relationship only seems to apply to compliance with medication and not to compliance with non-medical interventions. In this regard it might be useful to bear in mind the suggestion, from the qualitative data, that clients have mixed feelings about medication, in a way which they do not about other treatments. There are a number of possible explanations for the negative relationship.

8.1121 Compulsion

Firstly, it may be that some clients feel compelled to take medication, but disagree with the idea of doing so. This explanation thus involves the concept of congruence of beliefs regarding treatment, and could explain clients having a high rating of compliance, but a low rating of alliance. The issue of compulsion would be

relatively straightforward if clients were subject to community supervision orders. Although data regarding this was not included in the study, the researcher was aware that very few clients cared for by the team were the subject of such orders. However, although clients may not have been under a legal compulsion to adhere to medications, they may still have felt compelled by more subtle pressures, such as a concern about upsetting their case managers. In this regard, it is interesting to consider the suggestion made above that case managers place considerable importance on compliance. Equally, clients may fear supervision orders or other legal powers, and thus avoid engaging with clinicians (Perkins and Repper, 1999), a suggestion which echoes the idea that the presence of a sense of compulsion is inimical to the formation of an alliance (Clarkson 1994) .

8.1122 Disagreement

A second explanation would be that some clients might agree that they need medication, but disagree about some other aspects of their treatment, and thus score the alliance as lower overall, even though they comply with medication. Thus clients may feel that they are not receiving some intervention which they believe would be appropriate. There is some evidence from psychotherapy research that clients and clinicians value different aspects of treatment (Yalom, 1989). Llewelyn (1988) found that clients placed more value on problem solving and reassurance, while clinicians were more concerned about increasing insight and understanding. Llewelyn (ibid.) also made the point that the issue is one of differing emphasis between client and clinician, rather than outright rejection of other aspects of treatment. Thus it may be that clients comply with medical treatment, but place less emphasis on compliance than case managers tend to.

The issue of beliefs regarding treatment was investigated in the qualitative data analysis, which seemed to suggest that there are no major differences between clients and case managers regarding what treatments are helpful, and what aspects are helpful. These findings can be considered in the light of those of Jorm et al. (1997), who found wide discrepancies between professionals and public over what treatments were considered helpful and unhelpful. Although any comparison should be viewed extremely cautiously, because of the different methodologies used, it may be that the views of clinicians and clients regarding treatment are closer than those of clinicians and the general public. It should also be noted that although both clients and case managers might agree that a treatment is helpful, resources might not permit its implementation.

8.1123 Understanding

A third explanation, developing from the two above, is that clients may agree that they need medication, but also feel that case managers do not understand or appreciate the difficulties that they experience as a result of taking medication. The qualitative data analysis suggested that clients have mixed views about medication, a finding that would be consistent with Davidhizar et al. (1986). The analysis further suggested that clients felt that the unhelpful aspects of treatment included side effects and poor efficacy. This seems consistent with the finding of Ruscher et al. (1997) that the most common reasons for stopping medication included side effects and a belief that medication did not work. The finding regarding side effects is also consistent with Davidhizar et al. (1986), who found that negative perceptions of medication were predominantly based on experience of side effects. They also seem

consistent with the finding of Awad (1993) that many clients feel that medication makes their condition worse.

The qualitative data also suggested that case managers have different perceptions of the unhelpful aspects of treatment, and thus there could be a sense among some clients of a disagreement with the case manager regarding the unhelpful aspects of treatment, and such a sense of disagreement might lead to a lower alliance rating. This raises the question of whether achieving more agreement in this domain would lead to higher ratings of alliance.

It is perhaps worth noting here that side effect severity approached significance as a negative predictor of alliance as rated by the case manager. This could imply that case managers were sensitive to the presence of side effects, and felt that they might pose a threat to the agreement between themselves and the clients.

8.1124 Splitting

A fourth explanation might be found in the psychoanalytic concept of the schizoid defence, which is postulated as comprising three defence mechanisms, namely splitting, denial and projection (Rycroft, 1995). The defence is posited as operating to reduce anxiety caused by conflicting feelings towards the same object (Goodman, 1992). A person may deny experiencing some of the feelings, thus splitting off a part of experience from awareness. Equally, a person may split the object, and be aware of one set of feelings towards one part of the object, and the conflicting set towards another part. Finally, the person, having denied and split off a set of

feelings, may project them on to another person, who is then perceived as having those feelings.

Goodman's (1992) account of how this may operate with regard to mediation is expanded on below, in an attempt to explain the finding of the negative relationship between client-rated alliance and compliance with medication.

There are three areas over which the client might have conflicting feelings. Firstly, the client may experience conflicting feelings towards treatment generally. This might be because although treatment is perhaps necessary, it also serves as a reminder of the distress suffered and limitations imposed due to the disorder. The client could split the treatment into two aspects, medication and the case manager, and be aware of positive feelings towards one aspect, such as medication, and negative feelings towards the other, the case manager. This could account for the client complying with treatment, while giving a poor rating of the alliance. Alternatively, the client may be aware of positive feelings towards the case manager, and negative towards the medication, which could account for high ratings of the alliance, in the face of poor compliance.

The same situation could arise if the client had conflicting feelings towards the case manager. In this scenario, the client might again be aware of one set of feelings towards the case manager, and another towards the medication. This could explain the results in the same way as above.

The client may have conflicting feelings towards the medication, with one set of feelings towards medication being projected onto the case manager, and the client only aware of the opposing feelings. The client would then experience disagreement with the case manager over medication. Thus the client might be left with negative feelings but might still comply, perhaps feeling coerced. The case manger would be perceived as having positive feelings, which could then lead to a perception of disagreement, and a lower rating of alliance. Equally, the client might be aware of only positive feelings towards medication, and comply, while experiencing negative feelings as belonging to the case manager, and thus disagreeing with him or her.

Alternatively, conflicting feelings towards the medication could lead the client to split the medication into 'good' and 'bad' medication. Although this would not explain the finding regarding alliance and compliance, it would be consistent with the qualitative data, where clients often made a distinction between one medication as helpful, and another as unhelpful. Whilst it may well be that some medications work better than others, it is worth noting the phenomenon of polytherapy (Van Horn, personal communication), whereby clinicians prescribe one medication, then another, often without discontinuing the first, until clients are receiving several anti-psychotics. Save in exceptional circumstances, this is contrary to good practice (Van Horn, ibid.) and could be explained, in part at least, by the idea that prescribers are splitting medication in the same way as clients.

It could also be speculated that although case mangers, as a group, do not seem to have such mixed views about medication, they are more split over psychosocial treatments. This is interesting in light of the suggestion by Pallis and Stoffelmayr

(1973), that clinicians could be categorised according to whether they had a 'psychological' or an 'organic' orientation towards treatment. The data suggests that case mangers broadly agree over medication, and thus all have an 'organic' orientation, but disagree over psychosocial treatments. Perhaps a more contemporary distinction would be between 'organic' orientation, and 'biopsychosocial' orientation, the latter referring to an approach which accepts the validity of models across the continuums of theory outlined in Chapter Four.

8.1125 Tolerance of hostility

It might be possible to draw together some of the issues raised in the above discussion, namely the expression of negative feelings towards medication and case managers; disagreement between client and case manager; and compulsion. A study by Keisler and Watkins (1989) which was cited earlier suggested that the ability of clients and clinicians to tolerate hostile transactions was associated with a stronger working alliance. It could be speculated that clients have hostile feelings, evoked by both the experience of side effects and the fact that their medication may not lead to symptom relief, and that even if it does, symptom relief does not necessarily lead to global improvement (Shepherd et al., 1995). There may also be hostility because case managers insist on compliance in the face of these experiences. This hostility may be felt towards the medication, or the case manger, or both. The key issue might be the ability of the case manager to tolerate some expression of this hostility, and it may be that disagreement with the clinician is just such an expression. Thus one could speculate that clients who feel able to express their disagreement may still continue to adhere to medication.

In this context, it is perhaps interesting to consider the concepts of intra-mural and extra-mural resistance (Newton, 1992). An extra-mural resistance is behaviour that threatens the therapeutic system, such as non-attendance, while an intra-mural resistance is behaviour that can be addressed within the therapeutic framework. Newton suggested a progression from extra-mural to intra-mural resistance, which reflects to some extent the development of the relationship between the client and the clinician. Although it is not clear how non-compliance with medication would fit into this scheme, Newton also proposed that there is a progression from non-compliance with treatment to non-agreement with the clinician. Thus it would be considered a relatively good sign if a client felt able to disagree with a clinician, if the alternative was to not comply with treatment. An important aspect of this idea is that it suggests that there are different levels of resistance, some more damaging to treatment than others.

8.12 Congruence

The second theme identified in the literature was the possibility that congruence of beliefs might be associated with compliance and alliance. The results seem simpler to interpret here, in that causal belief discrepancy was not predictive of alliance or compliance, nor did it distinguish between the longer and shorter relationships. The finding that belief congruence is not associated with compliance does not concur with the findings of Foulks et al. (1986), although the present study differed in that an attempt was made to measure the actual degree of discrepancy, rather than assuming a standard clinician viewpoint. The finding also does not support the suggestion of Kleinman (1978), that conflict of beliefs may lead to non-compliance.

The finding that causal belief congruence does not predict alliance, as rated by either source, does not concur with the suggestion of Foulks et al. (1986), who speculated that a lack of congruence in theories may make the establishment of a therapeutic alliance more difficult.

The finding that causal belief congruence did not distinguish the longer and shorter relationship groups is not consistent with the suggestion that clinician and client causal attributions converge (Atkinson et al., 1991). However, it is possible that some convergence did take place earlier in the relationship, as is suggested in the study by Atkinson et al. (ibid.), and that it did not increase thereafter. On the other hand, the finding could be seen as consistent with those of Hunt et al. (1989), who found that prior beliefs were very persistent, and that clinical input was only one of many influences on beliefs. Thus it may be that clients' beliefs are little influenced by those of case managers.

It is possible that a more important issue is a perception of agreement over causal beliefs, rather than the actual degree of discrepancy. This would be consistent with the findings of Atkinson et al. (1991), that perceived, rather than actual, aetiological similarity is associated with positive ratings of counsellors. In this regard it should be noted that the Working Alliance Inventory is a measure of perception of agreement. However, the finding that compliance with medication is negatively related to alliance, as rated by the client, suggests that clients may comply with treatment, without a perception of agreement over the Tasks and Goals. Similarly, a client may state that he or she agrees with the Tasks and Goals of treatment, but not

comply. Of course, the WAI (Horvath & Greenberg, 1989) is not an attempt to operationalise the concept of perceived discrepancy over beliefs about treatment.

With regard to congruence of beliefs about treatment, the qualitative data suggests that there may be some disagreements, particularly over the unhelpful aspects of treatment, but the methodology of the present study means that any links between these and alliance, compliance or causal belief congruence is highly speculative.

8.13 Aspects of the alliance

The third theme raised in the introduction was the development of the different aspects of the working alliance. The fact that it was possible to distinguish between therapeutic relationships which had existed for more than six months and those which had existed for six months or less, on the basis of some aspects of the working alliance, provides some support for the suggestion by Frank & Gunderson (1990) that the six month period is a clinically relevant one in the development of the alliance. The finding that some aspects of alliance are rated higher in longer relationships is consistent with Kivlighan & Shaughnessy (1995), who suggested that the strength of the alliance increases in a linear way over time. However, it should be noted that any conclusions about the development of the alliance aspects are very tentative, as this was not a longitudinal study, and the results could be due to cohort effects.

The findings were also consistent with the notion that Bond, as rated by the client, did not develop in the same way as other aspects of the alliance, in that it did not significantly change, whilst the other aspects assessed did. One possible explanation

would be that there may be particular problems in the development of this aspect of the relationship.

Some light may be thrown on this by research in the field of attachment, as there has been a suggestion that attachment history may be implicated in psychosis. Negative early parenting experiences have been associated with psychosis (Drayton, Birchwood & Trower, 1998), which is consistent with a finding that clients with thought disorder had less secure attachment than those with affective disorder, who in turn had less secure attachment than non-psychiatric controls (Dozier, 1990).

Attachment style has also been associated with the therapeutic alliance. Dolan, Arnkoff & Glass (1993) showed that attachment style, as rated by the client, was related to the therapist's perceptions of the working alliance. Mallinckrodt, Coble & Gantt (1995) found that among 76 female clients, adult attachment, in terms of recalled parental bonds, accounted for 23% of the variance in client-rated working alliance. Thus there may be some connection between attachment, psychosis, and the working alliance, although the direction of causality is unclear. If this was the case, the formation of a therapeutic relationship might be particularly problematic in this client group.

This is interesting in the light of the speculations above regarding difficulties in the expression of affect among this client group. One could speculate that such clients may find it difficult to form secure affective bonds, and thus to express affect, particularly hostile affect. Furthermore, if it is indeed the case that some clients' agreement over Tasks and Goals is not accompanied by an affective bond, one could

speculate that this accounts for some of the difficulties in maintaining compliance within this client group, in that the working alliance is not able to cope with the inevitable strains involved in the treatment of such a severe disorder.

8.14 Insight

The fourth theme was the concept of insight, and its relationship to the concepts of alliance and compliance. The only variable that associated with insight was working alliance as rated by the client. The finding that insight does not predict compliance does not concur with the findings of Lin et al. (1979) and Smith et al. (1997). It also does not concur with the suggestion of Thompson (1988) that clients who describe themselves as 'mental patients', as opposed to 'community residents', were more likely to be compliant with medication. However, the positive relationship between insight and alliance is perhaps consistent with Thompson's (ibid.) findings that clients who described themselves as 'mental patients' found staff more supportive than those who described themselves as 'community residents'. However, Thompson's (ibid.) study did not directly examine the concepts of insight or alliance.

An explanation for the finding may lie in the definition of insight upon which the measure is based, namely that there are three aspects to insight; compliance with treatment; ability to label mental events as pathological; and recognition that such events are indicative of mental illness (David, 1990). The finding could be explained by the suggestion that clients who accept the idea that they have an illness will be more willing to agree with mental health professionals, and thus have a higher rating of alliance. Alternatively, clients who have been able, for whatever

reason, to form an alliance may be more willing to accept the assumptions of the case manager. It is important to bear in mind that, as stated before, the methodology does not allow for conclusions about causality.

Perhaps a more striking notion is that the Insight Scale (Birchwood et al., 1994) is the only measure, apart from the WAI[12] (Tracey & Kokotovich, 1989), to be rated solely by the client. The study cited earlier by Neale and Rosenheck (1995) found that client-rated alliance was associated only with client-rated measures of outcome, and the corollary was the case for case-manager rated variables. Thus the positive association may reflect the source of the rating, as much as the construct measured. In this regard, it is interesting to consider that although the measure of insight contains a rating of compliance, it was still not associated with compliance as rated by the case manager. Issues of measurement are considered more fully below.

8.15 Concordance

The final theme to consider is the validity of the concept of concordance. The answers to the research questions do not seem support the construct validity of concordance as defined. There are two broad explanations for this. The first is that the concept as defined does not in fact have construct validity. The second explanation is that there may be some problems with the validity of the concepts of alliance, compliance or causal belief discrepancy. The measure of alliance has established construct validity, and the measures of alliance (Horvath & Greenberg, 1987) and compliance (Kemp et al, 1996) a degree of criterion validity. However, the concept of causal belief discrepancy seems to be more problematic. The concept is referred to in the literature, but that in itself does not make it valid. Perhaps the

most pressing problem is that the concept is not well operationalised, an issue which is dealt with in more detail below.

Aside from the issue of the validity of the concept of causal belief discrepancy, however, the results still do not support the validity of the concept of concordance as defined. The finding that is particularly problematic is that of the negative association between compliance with medication and working alliance as rated by the case manager. This seems to suggest that compliance takes place without agreement. However, a possible confounding variable is the sense of compulsion that a client may feel to adhere to medication, as mentioned above. It may also be that concordance requires only a tolerance of disagreement rather than actual agreement, a notion that would be consistent with the description of concordance offered by Bradley (1999).

The findings also suggested that the remaining aspects of the alliance developed differently from compliance and casual belief discrepancy, in that the latter variables did not differ significantly between the two groups. This again suggests that the validity of the concept of concordance as defined is not supported.

Overall, the results do not support the concept of concordance as defined. There seems to be a link between alliance and compliance, but it is a more complex one than the proposed definition of concordance would predict. Congruence of causal beliefs does not seem to be related to compliance or alliance. As the three concepts do not co-vary in the way predicted, and consequently do not seem to be aspects of an over-arching concept of concordance, as defined above.

In summary, the most important finding of the present study is the association between alliance and compliance, and in particular the complexity of the association between these two concepts.

8.2 Clinical implications

The clinical implications mostly arise out of the complex links found between compliance and alliance. A key question is whether case managers should put more emphasis on improving the alliance, or on improving compliance. The study does not allow conclusions to be drawn about any causal links between these concepts. However, the study does reinforce the idea that the working alliance is an important concept in the case management of clients with psychosis, and it may be that it would be most productive to work on the alliance, rather than on trying to increase compliance directly. Perkins and Repper (1999) point to two potential difficulties in interventions aimed directly at improving compliance. Firstly, the goals of the client and the clinician may differ, which can raise ethical problems in that the client may not be giving informed consent for the treatment. The second issue, perhaps even more serious, is that interventions aimed at compliance are often associated with forced treatment, which can worsen the relationship between the client and clinician, as clients may avoid services (Perkins & Repper, 1999). Thus it may be more helpful to aim interventions at the alliance, on the assumption that an improved alliance may bring improved compliance, along with other benefits. It is important to think about variables that can be manipulated, as suggestions about issues that case managers or other clinicians cannot change will be of relatively little use. The

study highlights some areas which might be useful to focus on for the development and maintenance of a therapeutic alliance.

The first area is the weaknesses of the alliance itself. Research in psychotherapy suggests that discussing a poor alliance, in particular problematic feelings towards the therapist, can improve an alliance (Foreman & Marmer, 1985). In particular, case managers could consider resentments that might be based on negative experiences of treatment. A second area which may give rise to problematic feelings is compulsory treatment. It is possible that the presence of the opportunity for compulsion distorts the therapeutic relationship, and while some degree of compulsion may or may not be necessary, its impact on the alliance needs to be better understood. A recent survey by the National Schizophrenia Fellowship found that 48% of users of mental health services supported the introduction of compulsory treatment in the community (The Guardian, 16/4/99). This could be interpreted as indicating that some clients are aware that they may become reluctant to take medication, but that in itself does not mean that compulsion is the best way to ensure adherence. Such concerns are reflected in the continuing debate over the use of the terms 'compliance', 'adherence' and 'concordance' (Perkins & Repper, 1999).

Another possible focus for improving the alliance concerns beliefs about treatment. Although the link between causal belief congruence and other variables was not established, the possibility was raised that differences over the unhelpful aspects of treatment may contribute to difficulties in the relationship, or with compliance. Case managers could emphasise consideration of clients' views regarding the

problems they experience with their treatments, and try to be aware of potential disagreements with clients, and if possible discuss them. Also making their own beliefs more explicit may be helpful. However, such suggestions are tentative, and would require more investigation.

The above suggestions are aimed at improving the working alliance, which may be clinically useful directly, as the relationship may beneficial in its own right, and indirectly, by improving improved adherence. Improving adherence, as stated before, has benefits in terms of reducing relapse and hospitalisation. It may also be of benefit by reducing the frustration and hopelessness that case mangers may be subject to, as they experience both clients repeatedly returning to hospital, and clients who do not adhere to a treatment which the case manager thinks is important. If staff felt that they were able to intervene in some way to increase compliance, then frustration, hopelessness, and ultimately staff turnover might conceivably be reduced. There is some tentative evidence from this study that the alliance does continue to develop, and thus reducing turnover in itself might serve to increase compliance. One client commented that one of the problems he experienced was that as soon as a relationship developed, the case manager left. While the study was in progress, a case manger left, and one of her clients was hospitalised shortly afterwards. Although in the context of this study, one cannot make claims about any link between the two events, it is important to bear in mind the idea that staff turnover may have a serious impact on clients.

It is useful to consider the clinical implications of this study for clinical psychologists in particular. The potential problems for clinical psychologists in

multi-disciplinary settings have been recently considered by Gelsthorpe (1999). One difficulty is that of presenting a different, psychological viewpoint, in an environment in which other paradigms may take precedence. One suggested solution was to gather research evidence, and the findings of the present study could help in this regard, by pointing to the importance of a psychological construct, the working alliance, in case management.

Another difficulty for psychologists in CMHT's is a sense that their professional identity can be subsumed within the team (Weaver, Renton & Tyrer, unpublished paper). The findings of the present study suggest that a way that psychologists can be of use is in helping other case managers to understand the psychological processes that underlie the building and maintenance of an alliance, and fluctuations in adherence. The use of psychological principles in the day-to-day care of psychotic clients has been termed "psychotherapeutic management" (Weiden & Havens, 1994), and the importance of both teaching and supervising mental health workers with regard to psychological processes has been highlighted (Weiden & Havens, ibid.) Thus imparting psychological principles to fellow staff members may be clinically useful, by both improving case managers' understanding of their relationship with clients and by giving psychologists a sense of their role within a multi-disciplinary team. In both of these ways, staff morale might possibly be improved, and staff turnover reduced.

8.3 Limitations of the study

Consideration of the possible limitations of the study will focus on a number of issues in turn.

8.31 Design

The first feature to comment on is the design of the study, namely that it was a cross sectional, correlational study. This obviously imposes limitations on the conclusions that can be drawn. A correlational study does not allow for inferences about causality. A cross sectional study does not allow for any consideration of how the variables may develop temporally, and thus again does not allow for causal inferences. However, a correlational study can be justified as long as it is appropriate to the questions asked. As exploratory, discovery-oriented research questions were asked, a correlational study is appropriate (Barker, Pistrang & Elliot, 1994).

By the same token, the research questions must be appropriate to the topic. It was felt that research questions were more appropriate than specific hypotheses, for two reasons. Firstly, there had been relatively little research into links between compliance, alliance and belief congruence, especially within the population of clients with psychosis in case management, and thus a more discovery-oriented approach was appropriate. Secondly, there are contradictory findings regarding variables associated with compliance, and this again suggested that research questions may be more appropriate.

Another possible limitation in terms of design is the mixed methodology, incorporating qualitative and quantitative data. A problem with this is that as different variables were examined in different ways, e.g. treatment beliefs qualitatively, and causal beliefs quantitatively, conclusions about the relationship between variables was limited. However, a validated measure for discrepancy of treatment beliefs was not available. Also, the use of mixed methodology allowed more questions to be considered from the same participants (Barker et al., 1994). In particular, qualitative data allows questions regarding interpretation to be considered (Turpin, Barley, Beail, Scaife, Slade, Smith & Walsh, 1997), and this may be particularly important in the area of treatment beliefs, where clinicians can tend to make assumptions about clients' perceptions of treatment that may be incorrect.

8.32 Generalisability

The second issue is that of limits to the generalisability of the findings, which effects the external validity of the study (Shapiro, 1989). The study could be criticised for drawing the sample from a limited population. The results might seem only generalisable to clients with a diagnosis of schizophrenia, with repeated admissions, who are cared for by case managers, in inner city areas. However, it was important to try and increase the homogeneity of the sample, in order to reduce the error. The selection criteria represented an attempt to control for such variables as diagnosis, previous hospitalisation, and whether clients were inpatients, or receiving compulsory treatment under the Mental Health Act 1983. While drawing the clients from one CMHT does clearly limit the external validity of the study, it can equally serve to increase the statistical conclusion validity (Shapiro, 1989). As the study was concerned with the particular themes of compliance, alliance and schizophrenia,

in the particular context of case management, the issue of external validity is less important than reducing error. Error could also have been reduced by increasing the sample size (Barker et al., 1994), and indeed a larger sample size would have been desirable, in order to increase the ratio of subjects to variables. The ratio of varaibles to subjects in this study (5:1) was the absolute minimum suggested by Tabachnick and Fidell (1989), but a ratio of 20:1 would be required before reduce error could be reduced considerably (Tabachnick and Fidell, ibid.). The focus on this specific population could also be justified by the current public debate regarding the community care of clients with a long-standing diagnosis of schizophrenia, particularly over the issue of compulsory treatment in the community (Perkins & Repper, 1999).

8.33 Non-responders

Another issue regarding the sample concerns the rate of non-responders, which could challenge the internal validity of the study (Shapiro, 1989). A strength of the study is that every member of the target population, i.e. clients cared for by the team, had the opportunity to be selected. A problem is that the non-responders differed from participants on one of the key variables in the study, in that their compliance with treatment was rated lower by case managers. It might have been useful to have gathered similar information about those who were considered inappropriate by the case managers, although there is clearly a difference between those who refuse and those who are judged to be inappropriate for other reasons, and equally some of those judged inappropriate might not have refused. In the interests of increasing homogeneity it was felt best to only gather data on compliance for those whose only reason for not being in the study was refusal or non-attendance. One might predict

that those who did not participate would have lower alliance as rated by the case managers, and it would have been possible to carry out some post hoc adjustments to limit the influence of the non-responders, but this represents at best only a partial compensation (Barker et al., 1994). Due to either direct refusal or non-attendance at appointments, 34% of eligible subjects were non-responders, which compares with a mean attrition rate of 17% in studies of case management of clients with severe mental illness (Mueser et al., 1998).

8.34 Diagnosis

Another sampling issue concerns the use of ICD-10 diagnosis as a selection criterion. There are two possible criticisms of this. The first, and most serious, is that the use of a diagnosis may not ensure homogeneity, which is important for internal validity (Shapiro, 1989). As is explained in the introduction, clients with a diagnosis of schizophrenia are characterised as much by the heterogeneity of their presentation, as by common characteristics. There are three responses to that criticism. Firstly, data on symptom severity was gathered, and used in the first step of the hierarchical regressions, to try to control for variance due to symptomatology. Secondly, choosing a population who had been considered as 'seriously mentally ill' also represented an attempt to control for symptom severity, and the course of the disorder, in terms of duration. Thirdly, the research was concerned with beliefs about the cause of a disorder which is widely assumed to have construct validity. Finally, service provision is often based on diagnostic categories. Thus it was considered appropriate to select only those who had been given the diagnosis of schizophrenia, and who had thus been exposed to the consequences, regardless of the validity of the diagnosis.

A second criticism of using ICD-10 criteria is that they are not as stringent as those of other diagnostic systems, such as DSM-IV (Murray, 1997), and thus might lead to a less homogenous sample. Against this, the diagnoses were readily available, which was important considering the time limitations of the study.

8.35 Measurement

The next issue relates to the decisions regarding measurement. There could be a concern regarding the overlap of some of the measures, which would make it difficult to examine the effects of one variable on another (Kemp et al, 1996). However, examination of the correlation matrices represented an attempt to eliminate problems of multicollinearity, and only previously validated instruments were used. This was particularly important, as a central theme of the study was the overlap of different constructs.

A major criticism regards the criterion validity of some of the measures, in particular the measures of causal belief discrepancy. Although the CBQ (Whittle, 1996) was validated, it had not been used in this way. Unfortunately, this researcher was not aware of any validated measures of the construct of causal belief discrepancy, applicable to the topic of schizophrenia. It might have been useful to make use of qualitative methods, in order to try to lend some concurrent validity to the measures, although the researcher was always mindful of the risk of overloading the clients with measures, which is a particularly acute problem with this client group.

Another criticism might be raised over the choice of an indirect measure of compliance, particularly a clinician rating, as opposed to a client rating. Direct measures of compliance might not be appropriate, however. Serum assays, as well as being expensive and not available for all anti-psychotics, are also invasive, and may have increased the rate of non-responders (Kemp et al., 1998). Urine tests may be inconvenient for clients (Besch, 1995) and overestimate compliance with anti-psychotics. Moreover, any test using body fluids technique is of limited utility in determining partial compliance (Kemp et al., 1998) as it is not sensitive to individual differences in pharmacokinetics (Besch, 1995). As argued in the introduction, compliance is perhaps most usefully considered on a continuum (Adams & Howe, 1993). Indirect measures have the advantage of being readily accessible, which was important considering the limited resources available for the present study, and evidence supports the validity of clinician ratings over client ratings (Besch, 1995). Although another clinician source could have been used, it should be noted that the case managers frequently administered the medication, and all had regular contact with clients, so there is no reason why another source would have given more valid ratings.

Another criticism regarding measurement concerns the source of rating of the alliance. It has been suggested that observer ratings provide an objective source of alliance rating (Horvath & Greenberg, 1987). There is also a potential difficulty with the accuracy of summated judgements (Horvath & Greenberg, 1987). However, each rating source has its own advantages and disadvantages, and the problem with observers is that they can only rate observable behaviour, whereas the

149

theme of this study was the sense of agreement, a cognitive variable. Thus observer ratings would have been less useful for the themes of the present study.

8.36 Important variables

A major limitation of the study is that the alliances with other clinicians were not considered. As each client was subject to the CPA, they would have a key worker as well as a case manager, and the relationship with this person may be important. Equally, no data was gathered regarding the back-up case managers, who may also be important figures for the client. The relationship with the prescriber was also not considered. Similarly, family support has been shown to be associated with adherence in outpatient populations (Fenton et al., 1997), and this has not been controlled for. Thus in interpreting the apparent links between alliance and compliance, it is important to bear in mind that other important relationships have not been controlled for.

Another potentially important variable that was not controlled for was the identity of the particular non-medical intervention which the client was receiving. It was clear that clients were offered a range of interventions, in a variety of settings, including day hospitals and day centres. It may be that compliance varied across interventions or settings. Similarly, the type of medication, and the mode of administration, was not controlled for in the analysis, although data regarding these variables was collected.

8.37 Statistical and clinical significance

A major criticism that could be levelled at the analysis is that although statistical significance was considered, clinical significance was not. It is possible that the variation in compliance or alliance, while statistically significant, was not clinically significant. For example, examination of the descriptive data suggests that mean compliance with medication was quite high, and the standard deviation small. This accounted for the skewness, and although transforming this variable allowed judgements about statistical significance, concerns remain about whether the variation in compliance was clinically significant. One solution would be to divide clients into complaint and non-compliant, but this approach brings its own problems. Not only does this ignore the issue of partial compliance (Bradley, 1999), it is also difficult to know where to draw the line between compliant and non-compliant. A similar issue arises with the rating of alliance, in that there is no established cut-off figure as to what represents a strong or a weak alliance. Perhaps the best way around this problem is to consider measures of functioning alongside these variables. Although symptomatology was measured, this does not predict global functioning, as has been pointed out, and some other measure might have been useful. Against this, the risk of overloading the clients with measures again arises. The findings need to be interpreted with these matters in mind.

8.38 Qualitative methods

This discussion of the limitations of the study has focused mainly on aspects related to the quantitative data. Important issues also arise concerning the qualitative data. Validity and reliability are just as important, and it is worth considering some steps that could have been taken to maximise these.

More information could have been recorded about the context in which the qualitative data was gathered, as factors such as the setting of the interview may have effected the participants' responses. A particular problem is that of investigator bias, which can be apparent in both the data collection and data analysis stages. Self-reports are particularly open to reactivity, with the participants responding to perceived demands of the researcher. This might have been a particular problem in this study, as the open questions were the final stage of data collection, and thus the participants would have had the maximum opportunity to become aware of the researcher's biases. Against this, spending as much time as possible with the participant before the open questions might also have made them feel more comfortable with the researcher, and thus more open in their answers.

Bias can be a challenge to the construct validity of the categories derived in the data analysis stage. Although attempts were made to set aside pre-conceptions about the issue of treatment by bracketing, it might have been useful to have carried out the type of 'thought experiment' recommended by Barker and his colleagues (Barker et al., 1994), in which the researcher identifies their expectations of the results, before data collection. The researchers biases and theoretical orientation could also have been described. However, the presentation of the data in appendix 15 offers the reader an opportunity to judge the validity of the categories.

Another possible criticism of the qualitative methodology was that there was no triangulation of data collection. This term refers to the technique of collecting data from different sources, or using different methods, in order to examine whether the

findings are similar, which facilitates more informed judgement as to their validity (Turpin et al., 1997). Another important technique for checking the validity of findings is to present the results to the participants and ask for their comments (Barker et al., 1994). However, limitation of time meant that these useful techniques were impractical.

8.4 Directions for future research

The next issue to consider is directions for future research, leading on from the present study. This author would suggest that the findings of the present study highlight the need for further research in a number of specific areas.

Firstly, the possible causal link between compliance and the alliance, and the direction of any link, need to be considered. This could be done by carrying out a longitudinal study, assessing the fluctuations in alliance and compliance. Safran and his colleagues offer a methodology for assessing the fluctuation in alliance over the course of each meeting (Safran et al., 1994) which uses the WAI (Horvath & Greenberg, 1989) and is relatively simple to administer. It would also seem important to assess the alliance with other people involved with the client, particularly key workers and family members, and to gather ratings of compliance from these multiple indirect sources.

A second area of research is the relationship between alliance, compliance and outcome. If a relationship between alliance and compliance does exist, this could account for findings of a relationship between alliance and outcome in pharmacotherapy (Krupnick et al., 1996). Equally, a strong alliance may bring its

own benefits (Harris & Bergman. 1987). Again, a longitudinal study would be required, along with careful assessment of compliance, perhaps using direct measures. Such a study would be a major undertaking.

A third area of research would be into the role of compulsion in compliance and alliance. One possible investigation into the effects of compulsion on alliance could involve assessing the client-case manager alliance in a group of clients under supervision orders, compared with a group of those who are not. Compliance could be controlled for using multivariate techniques. It would be useful to combine some qualitative data, to examine the reasons that clients give for adhering or not adhering.

A fourth issue is factors which could be manipulated to improve the working alliance. It was speculated that discussion of difficulties arising from treatment and an understanding of the psychological mechanisms at work might be helpful. A possible study could involve comparing alliance among two groups of case managers, with the dependent variable being training and supervision by a psychologist using the "psychotherapeutic management techniques" outlined by Weiden and Havens (1994). The control condition could consist of general supportive supervision.

More research would also be required on the psychological processes underlying the alliance in this population, perhaps using qualitative data, or intensive quantitative methods, such as those described by Alexander (1989).

Finally, the area of explanatory models should be examined more rigorously. Attempts could be made to generate valid measures of the discrepancy between models of psychosis. The qualitative data from this study could be used to design a quantitative measure of discrepancy in beliefs about treatment, the validity of which could be investigated by piloting it with a sample of mental health professionals, before a full scale validity study on the intended population, using factor analysis.

8.5 Concluding remarks

The present study represented an attempt to investigate the collaborative aspects of the therapeutic relationship in a client group and setting where such themes have been relatively neglected by researchers. The results suggest that the collaborative relationship may be a clinically useful concept in the case management of clients with psychosis. However, the relationship may be made more complex by features of the interventions used, such as severe side effects and compulsory treatment, and the nature of the psychopathology. It is important to investigate the collaborative, positive aspects more fully, but researchers must also consider the perhaps more challenging area of the troubled, negative aspects of therapeutic relationships, as both can be influential in any therapeutic encounter.

References

Adams, S. & Howe, J. (1993). Predicting medication compliance in a psychotic population. *Journal of Nervous and Mental Disease*, **181**, 558-560.

Agnew-Davies, R. , Stiles, W., Hardy, G., Barkham, M. & Shapiro, D. (1998). Alliance structure assessed by the Agnew Relationship Measure (ARM). *British Journal of Clinical Psychology*, **37**, 155-72.

Alexander, L. & Coffey, D. (1997). Understanding the therapeutic relationship. *Current Opinion in Psychiatry*, **10**, 233-238.

Alexander, P. (1989). Single case research. In G. Parry and F. Watts, (Eds.*)*, *Behavioural and Mental Health Research: A Handbook of Skills and Methods*. Lawrence Erlbaum Associates.

Ailinger, R. & Dear, M. (1997). Latino immigrants' explanatory models of tuberculosis infection. *Qualitative Health Research*, **4**, 521-531.

Amador, X., Strauss, D., Yale, S., Flaum, M., Endicott, J, & Gorma, J. (1993). Assessment of insight in psychosis. *American Journal of Psychiatry*, **150**, 873-879.

156

Amador, X., & Strauss, D. (1993). Poor insight in schizophrenia. *Psychiatric Quarterly*, **64**, 305-318.

Amador, X., Flaum, M., Andreasen, H. Strauss, D., Yale, S., Clark, S. & Gorma, J. (1994). Awareness of illness in schizophrenia and schizoaffective and mood disorders. *Archives of General Psychiatry*, **51**, 826-836.

Atkinson, D., Worthington, R., Dana, D. & Good, G. (1991). Etiology beliefs, preferences for counselling orientations, and counselling effectiveness. *Journal of Counselling Psychology*, **38**, 258-264.

Awad, A. & Hogan, T. (1994). Subjective response to neuroleptics and quality of life: implications for treatment outcome. *Acta Psychiatrica Scandanavia*, **89** (suppl. 380): 27-32.

Awad, A. (1993). Subjective Response to Neuroleptics in Schizophrenia. *Schizophrenia Bulletin*, **19**, 609-618.

Axelrod, S. & Wetzler, S. (1989). Factors associated with better compliance with Psychiatric Aftercare. *Hospital and Community Psychiatry,* **40** (4), 397-401.

Bachrach, L. (1992). Case management revisited. *Hospital and Community Psychiatry*, **4**, 209-210.

Bachrach, L. (1993). Continuity of care and approaches to case management for long-term mentally ill patients. *Hospital and Community Psychiatry*, **44**, 465-468.

Bachrach, L. (1997). Lessons from the American experience in providing community based services. In J. Leff (ed.) *Care in the community: illusion of reality?* John Wiley & Sons.

Barker, C., Pistrang, N. & Elliot, R. (1994). *Research methods in clinical and counselling psychology.* John Wiley & Sons.

Barker, D., Shergill, S., Higginson, I. & Orrell, M (1996). Patients' views towards care received from psychiatrists. *British Journal of Psychiatry*, **168**, 641-646.

Bartko, G., Herczeg, I. & Zador, G. (1988). Clinical symptomatology and drug compliance in schizophrenia patients. *Acta Psychiatrica Scandanavia*, **77**, 74-76.

Barrett, R. (1998). The 'Schizophrenic' and the Linimal persona in Modern Society. *Culture, Medicine and Psychiatry*, **22**, 465-494.

Bateman, A. & Holmes, J. (1995). *Introduction to psychoanalysis.* Routledge.

Beer, D. (1996). Psychosis: a history of the concept. *Comprehensive Psychiatry, 37*, 273-291.

158

Bellack, A. & Mueser, K. (1993). Psychosocial treatment for schizophrenia. *Schizophrenia Bulletin*, **19**, 317-336.

Bentall, R. (1990). The syndromes and symptoms of psychosis. In R. Bentall (Ed.), *Reconstructing schizophrenia*. Routledge.

Bentall, R. (1992). Psychological deficits and biases in psychiatric disorders. *Current Opinion in Psychiatry*, **5**, 825-830.

Bentall, R. (1996). From cognitive studies of psychosis to cognitive-behaviour therapy for psychotic symptoms. In G. Haddock & P. Slade (Eds.), *Cognitive-behavioural interventions with psychotic disorders*. Routledge.

Besch, C. (1995). Compliance in clinical trials. *AIDS*, **9**, 1-10.

Bhui, K., Brown, P., Hardie, T., Watson, J. & Parrott, J. (1998). African-Caribbean man remanded to Brixton prison; psychiatric and forensic characteristics and outcome of final court appearances. *British Journal of Psychiatry*, **172**, 337-344.

Bhugra, D., Leff, J., Mallett, R., Dev, G., Corrigan B. & Rudge, S. (1997). Incidence and outcome of schizophrenia in whites, Afro-Caribbeans and Asians in London. *Psychological Medicine*, **27**, 791-798.

Birchwood, M. (1999). Psychological and social treatments: course and outcome. *Current Opinion in Psychiatry,* **12,** 61-66.

Birchwood, M., Smith, J., Drury, V., Haly, J., Macmillan, F. & Slade, M. (1994). A self report Insight Scale for psychosis; reliability, validity and sensitivity to change. *Acta Psychiatrica Scandinavia,* **89,** 62-67.

Blackwell, B. (1976). Treatment adherence. *British Journal of Psychiatry,* **129,** 513-531.

Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice,* **16,** 252-260.

Bordin, E. (1994). Theory and research on the therapeutic working alliance: new directions. In A. Horvath & L. Greenberg (Eds.), *The Working Alliance: Theory, Research and Practice.* John Wiley & Sons.

Bracken, P., Greenslade, L., Griffin, B., & Smyth, M. (1998). Mental health and ethnicity: an Irish dimension. *British Journal of Psychiatry,* **172,** 103-105.

Bradley, C. (1999). Compliance in drug therapy. *Prescribers Journal,* **39,** 44-49.

Brown, M-A. & Stetz, K. (1999). The labor of care-giving: a theoretical model of care giving during potentially fatal illness. *Qualitative Health Research,* **9**, 182-197.

Budd, R., Hughes, I. & Smith, J. (1996). Health beliefs and compliance with anti-psychotic medication. *British Journal of Clinical Psychology,* **35**, 393-397.

Burns, T. (1997). Case management, care management and care programming. *British Journal of Psychiatry,* **170**, 393-395.

Cameron, C. (1996). Patient compliance: recognition of factors involved and suggestions for promoting compliance with therapeutic regimens. *Journal of Advanced Nursing,* **24**, 244-250.

Carrier, J. & Kendall, I. (1997). Evolution of policy. In J. Leff (ed.) *Care in the community: illusion of reality?* John Wiley & Sons.

Carrigan, D. & Waltrip, R. (1990). Viral theories of schizophrenia. *Current Opinion in Psychiatry,* **3**, 14-18.

Castle, D., Wessley, S., Van Os, J, & Murray, R. (1998). Psychosis in the Inner City. *Maudsley Monographs,* **40**. Psychology Press.

Chadwick, P. & Lowe, C. (1990). Measurement and modification of delusional beliefs. *Journal of Consulting and Clinical Psychology,* **58**, 225-232.

Clarkson, P. (1995). *The Therapeutic Relationship.* Whurr Publishers Ltd.

Clinical Psychology Forum, (1999), News, **125**.

Coady, N. (1993). The worker-client relationship revisited. *Families in Society,* **74**, 219-298.

Connelly, C. (1984). Compliance with outpatient lithium therapy. *Perspectives in Psychiatric Care,* **22** (2), 44-50.

Corrigan, P., Liberman, R. & Engel, J. (1990). From non-compliance to collaboration in the treatment of schizophrenia. *Hospital and Community Psychiatry,* **41**, 1203-1211

Costello, C. (1992). Research on symptoms versus research on syndromes. *British Journal of Psychiatry,* **160**, 304-308.

Cuesta, M. & Peralta, V. (1994). Lack of insight in schizophrenia. *Schizophrenia Bulletin,,* **20**, 359-366.

Cuffel, B., Alford, J., Fischer E. & Owen, R. (1996). Awareness of illness in schizophrenia and out-patient treatment adherence. *Journal of Nervous and Mental Disease*, **184**, 653-659.

Curtis, J., Millman, E., Struening, E. & D'Ercole, A. (1992). Effect of case management on rehospitalisation and utilisation of ambulatory care services. *Hospital and Community Psychiatry*, **43**, 895-899.

David, A. (1990). Insight and Psychosis. *British Journal of Psychiatry*, **156**, 798-808.

Davidhizar,R., Austin, J. & McBride, A. (1986). Attitudes of patients with schizophrenia toward taking medication. *Research in Nursing and Health*, **9**, 139-146.

Davis, K., Kahn, R., Ko, G. & Davidson, M. (1991). Dopamine in schizophrenia: A review and reconceptualisation. *American Journal of Psychiatry*, **148**, 1474-1486.

Day, J. & Bentall, R. (1996). Neuroleptic medication and the psycho-social treatment of psychotic symptoms: some neglected issues. In G. Haddock & P. Slade (Eds.), *Cognitive-behavioural interventions with psychotic disorders*. Routledge.

De Jonghe, F., Rijnierse, P. & Jansson, R. (1991). Aspect of the psychoanalytic relationship. *International Journal of Psychoanalysis*, **72**, 693-708.

Department of Health (1997). *The New NHS: modern, dependable.* HMSO.

Diamond, D. (1997). The fate of the Ego in contemporary psychiatry with particular reference to etiologic theories of schizophrenia. *Psychiatry*, **60**, 67-88.

Dittmann, J. & Schuttler, R. (1990). Disease consciousness and coping strategies of patents with schizophrenia psychosis. *Acta Psychiatrica Scandanavia*, **82**, 318-322.

Dixon, M., King, S. & Steiger, H. (1998). The contribution of depression and denial towards understanding the unawareness of symptoms in schizophrenia outpatients. *British Journal of Medical Psychology*, **71**, 85-98.

Dolan, R., Arnkoff, D. & Glass, C. (1993). Client attachment style and the psychotherapist's interpersonal stance. *Psychotherapy*, **30**, 408-412.

Donovan, J. & Blake, D. (1992). Patient non-compliance: deviance of reasoned decision-making? *Social Science and Medicine*, **34**, 507-513.

Dozier, M. (1990). Attachment organisation and treatment use for adults with serious psychopathological disorders. *Developmental Psychopathology*, **2**, 47-60.

Draine, J. & Solomon, P. (1996). Case manager alliance with clients in an older cohort. *Community Mental Health Journal*, **32**, 125-134.

Drayton, M., Brichwood, M. & Trower, P. (1998). Early attachment experience and recovery from psychosis. *British Journal of Clinical Psychology*, **37**, 269-284.

Drury, V., Birchwood, M., Cochrane, R. & MacMillan, F. (1996). Cognitive therapy and recovery from acute psychosis: a controlled trial I: Impact on psychotic symptoms. *British Journal of Psychiatry*, **171**, 319-327.

Duncan, B. & Moynihan, D. (1994). Applying outcome research: intentional utilisation if the clients frame of reference. *Psychotherapy*, **31**, 294-301.

Eisenbruch, M. (1990). Classification of natural and supernatural causes of mental distress. The *Journal of Nervous and Mental Disease*, **178**, 712-719.

Fairburn, W. (1940/1984). *Psychoanalytic Studies of the Personality.* Routledge.

Fenton, W., Blyler, C. & Heinssen, R. (1997). Determinants of medication compliance in schizophrenia: empirical and clinical findings. *Schizophrenia Bulletin*, **23**, 637-651.

Finn, S., Bailey, J., Shultz, R. & Faber, R. (1990). Subjective ratings of neuroleptics in treating schizophrenia. *Psychological Medicine*, **20**, 843-848.

Forrest, A. & Hay, A. (1973). The schizophrenias: operational definition. *British Journal of Medical Psychology*, **46**, 337-346.

Foulks, E., Persons, J. & Merkel, R. (1986). the effect of patients' beliefs about their illnesses on compliance in psychotherapy. *American Journal of Psychiatry*, **143**, 340-344.

Forbes, S. & Hoffart, N. (1998). Elders' decision making regarding the use of long-term care services: a precarious balance. *Qualitative Health Research*, **8**, 736-50.

Foreman, S. & Marmar, R. (1985). Therapist actions that address initially poor therapeutic alliance in psychotherapy. *American Journal of Psychiatry*, **142**, 922-926.

Fowler, D., Garety, P. & Kuipers, E. (1995). *Cognitive Behaviour Therapy for Psychosis*. John Wiley & Sons.

Frank, A. & Gunderson, J. (1990). The role of the therapeutic alliance in the treatment of schizophrenia: Relationship to course and outcome. *Archives of General Psychiatry*, **47**, 228-236.

Freud, S. (1912/1949). *The Dynamics of Transference*. Collected Papers, Vol. II., The Hogarth Press.

Freud, S. (1905/1990). *Fragment of an analysis of a case of hysteria*. Penguin Freud Library, Vol. 8.

Freud (1913/1949). *Further Recommendations in the Technique of Psychoanalysis: On Beginning the Treatment*. Collected Papers, Vol. II., The Hogarth Press.

Freud, S. (1915/1986). *The Unconscious*. In A. Freud (Ed.), the Essential of Psychoanalysis. Penguin.

Fromm-Reichmann, F. (1959). *Psychoanalysis and Psychotherapy: Selected Papers of Freida Fromm-Reichmann*, (Ed. D. Bullard). University of Chicago Press.

Furnham, A. & Bower, P. (1992). A comparison of Academic and Lay Theories of Schizophrenia. *British Journal of Psychiatry*, **161**, 201-210.

Gallagher, B. (1977). The attitudes of psychiatrists toward etiological theories of schizophrenia. *Journal of Clinical Psychology*, **33**, 99-104.

Garety, P. (1992). Making sense of delusions. *Psychiatry*, **55**, 279-91.

Garety, P., Kuipers, l., Fowler, D., Chamberlain, F. & Dunn, G. (1994). Cognitive behaviour therapy for drug resistant psychosis. *British Journal of Medical Psychology*, **67**, 259-271.

Gaston, L. (1990). The concept of the working alliance and its role in psychotherapy: theoretical and empirical considerations. Psychotherapy, 27, 143-153.

Gaston, L. & Marmer, C. (1994). The California Psychotherapy Alliance Scales. In A. Horvath and L. Greenberg (Eds.), *The Working Alliance: Theory, Research, and Practice*, John Wiley & Sons.

Geisen, L. & Feuer, E. (1984). The treatment-resistant patient and the need to stay crazy. *Psychiatric Quarterly,* **56**, 75-82.

Gelsthorpe, S. (1999). Psychiatry: we are all paid to disagree. Using the bad feeling positively. *Clinical Psychology Forum*, **127**, 16-19.

Gerlack, J. 7 Peacock, L. (1995). Intolerance to neuroleptic drugs: the art of avoiding extrapyrimidal syndromes. *European Psychiatry*, **10** (suppl. 1), 27-32.

Gillespie, C. & Bradley, C. (1988). Causal attributions of doctor and patients in a diabetes clinic. *British Journal of Clinical Psychology*, **27**, 67-76.

Goering, P. & Stylianos, S. (1988). Exploring the helping relationship between the schizophrenic client and rehabilitation therapist. *American Journal of Orthopsychiatry*, **58**, 271-280.

Goldstein, M (1990). Neurophysiology and neuropsychology of schizophrenics. *Current Opinion in Psychiatry*, **3**, 8-13.

Good, D. & Watts, F. (1994). Qualitative Research, in G. Parry and F. Watts, (Eds.), *Behavioural and Mental Health Research: A Handbook of Skills and Methods*. Lawrence Erlbaum Associates.

Goodman, A. (1992). Medication compliance and the psychodynamics of pharmacotherapy. *Integrative Psychiatry*, **18**, 181-190.

Gorey, K., Leslie, D., Morris, T., Carruthers, W., John, L. & Chacko, J. (1998). Effectiveness of Case Management with Severely and Persistently Mentally Ill People. *Community Mental Health Journal*, **34**, 241-50.

Green, J. (1988). Frequent rehospitalisation and non-compliance with treatment. *Hospital and Community Psychiatry*, **39**, 963-966.

Greenfeld, D., Strauss, J., Bowers, M. & Mandelkern, M. (1989). Insight and interpretation of illness in recovery from schizophrenia. *Schizophrenia Bulletin*, **15**, 245-252.

Greenson, R. (1967). *The technique and practice of psychoanalysis*. International Universities Press.

Griffiths, S. (1990). A review of factors associated with patient compliance and the taking of prescribed medicines. *British Journal of General Practice*, **40**, 114-116.

Haddock, G., Bentall, R. & Slade, P. (1996). Psychological treatment of auditory hallucinations: focusing or distraction? In G. Haddock & P. Slade (Eds.*), Cognitive-behavioural interventions with psychotic disorders*. Routledge.

Harding, C. & Zahmiser, J. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatrica Scandinavia*, **90** (suppl. 384), 140-146.

Harris, M. & Bergman, H. (1987). Case management and the chronically mentally ill: a clinical perspective. *American Journal of Orthopsychiatry*, **57**, 296-302.

Hartwell, C. (1996). The schizophrenogenic mother concept in American Psychiatry. *Psychiatry*, **59**, 274-297.

Hatcher & Barends, A. (1996). Patient view of the alliance in psychotherapy: exploratory factor analysis of three alliance measures. *Journal of Consulting & Clinical Psychology*, **64**, 1326-1336.

Healy, A., Knapp, M., Astin, J., Beecham, J., Kemp, R., Kirov, G. & David, A. (1998). Cost-effectiveness evaluation of compliance therapy for people with psychosis. *British Journal of Psychiatry*, **172**, 420-424.

Heinrichs, D., Cohen, B. & Carpenter, W. (1985). Early Insight and the Management of Schizophrenia Decomposition. *Journal of Nervous and Mental Disease*, **173**, 133-138.

Henry, W. & Strupp, H. (1994). The therapeutic alliance as interpersonal process. In A. Horvath & L. Greenberg (Eds.) *The Working Alliance: Theory, Research and Practice*. John Wiley & Sons.

Henwood, K. & Pidgeon, N. (1992). Qualitative Research and Psychological Theorising. *British Journal of Psychology*, **83**, 97-111.

Hinshelwood, R. (1999). The difficult patient: the role of 'scientific psychiatry' in understanding patients with chronic schizophrenia or server personality disorders. *British Journal of Psychiatry*, **174**, 187-190.

Hirsh, S. & Bristow, M. (1993). Psychological, family, ethnic, and community factors affecting the course and treatment of schizophrenia. *Current Opinion in Psychiatry*, **6**, 53-57.

Hogan, T, Awad, A. & Eastwood, R. (1983). A self-report scale predictive of drug compliance n schizophrenics: reliability and discriminative validity. *Psychological Medicine*, **13**, 177-183.

Hoge, S., Appelbaum, P., Lawlor, T., Beck, J., Liman, R., Greer, A., Gutheil, T. & Kaplan, E. (91990). A prospective, multicentre study of patients' refusal on anti-psychotic medication. *Archives of General Psychiatry*, **47**, 949-956.

Holloway, F., McLean, E. & Robertson, J. (1991). Case management. *British Journal of Psychiatry*, **159**, 142-148.

Horvath, A. (1994). Empirical validation of Bordin's Pantheoretical model of the alliance: The Working Alliance Inventory perspective. In A. Horvath and L. Greenberg (Eds.), *The Working Alliance: Theory, Research, and Practice*, John Wiley & Sons.

Horvath, A. & Greenberg, L. (1987). The development of the Working Alliance Inventory. In L. Greenberg & W. Pinsof (Eds.), *The psychotherapeutic research process: A research handbook.* Guildford Press.

Horvath, A. & Greenberg, L. (1989). The development and validation of the Working Alliance Inventory. *Journal of Counselling Psychotherapy*, **36**, 223-233.

Horvath, A. & Greenberg, L. (1994). Introduction. In A. Horvath & L. Greenberg (Eds.*) The Working Alliance: Theory, Research and Practice.* John Wiley & Sons.

Horvath, A. & Symonds, B. (1991). Relation between working alliance and outcome in psychotherapy: a meta analysis. *Journal of Counselling Psychology*, **38**, 139-149.

Hoult, J. (1986). Community care of the acutely mentally ill. *British Journal of Psychiatry*, **149**, 137-144.

Huberman, A. & Miles, M. (1998). Data Management and Analysis Methods. In N. Denizen and Y. Lincoln (Eds.), *Collecting and Interpreting Qualitative Materials.* Sage Publications Ltd.

Hunt, L., Jordan, B. & Irwin, S. (1989). Views of what's wrong: diagnosis and patients concepts of illness. *Social Science and Medicine*, **28**, 945-956.

Ingram, D. & Hutchinson, S. (1999). Defensive mothering in HIV positive mothers. *Qualitative Health Research*, **9**, 243-258.

Irwin, D., Weitzel, W. & Morgan, D. (1971). Phenothiazine intake and staff attitudes. *American Journal of Psychiatry*, **127**, 67-71.

Jablensky, A. (1999). Schizophrenia: epidemiology. *Current Opinion in Psychiatry*, **12**, 19-28.

Jackson, M. (1991). Psychotic disorders. In J. Holmes (Ed.), *Textbook of psychotherapy in psychiatric practice*. Churchill Livingstone.

Jorm, A., Korten, A., Jacomb, P., Rodgers, B., Polli, H., Christensen, H. & Henderson, S. (1997). Helpfulness of intervention for mental disorders: beliefs of health professionals compared with the general public. *British Journal of Psychiatry*, **171**, 233-7.

Jaspers, K. (1946/1963). *General Psychopathology*. Manchester University Press..

Kane, J (1999). Schizophrenia: How far have we come? *Current Opinion in Psychiatry*, **12**, 17-18.

Kane, S. & Bentall, R. (1989). Persecutory delusions and attributional style. *British Journal of Medical Psychology*, **62**, 191-198.

Kapur, S. & Remington, G. (1996). Serotonin-Dopamine Interaction and its Relevance to Schizophrenia. *American Journal of Psychiatry*, **153**, 466-77.

Kendall, R., Juszczak, E. & Cole, S. (1996). Obstetric complications and schizophrenia: a case control study based on standardised obstetric records. *British Journal of Psychiatry*, **168**, 556-61.

Keisler, D. & Watkins, L. (1989). Interpersonal complementarity and the therapeutic alliance: A study in relationship in psychotherapy. *Psychotherapy: Theory, Research and Practice*, **26**, 183-194.

Kemp, R., Kirov, G., Everitt, B., Hayward, P. & David, A. (1998). Randomised controlled trial of compliance therapy. *British Journal of Psychiatry*, **172**, 413-419.

Kemp, R., Hayward, P., Applewhaite, G., Everitt, B. & David, A. (1996). Compliance therapy in psychotic patients: randomised controlled trial. *British Medical Journal*, **312**, 345-9.

Kemp, R. & David, A. (1994) Psychological predictors of insight and compliance in psychotic patients. *British Journal of Psychiatry*, **169**, 44-450.

Kim, Y., Sakamoto, K., Kamo, T., Skamura, Y. & Miyaoka, H. (1997). Insight and clinical correlates in schizophrenia. *Comprehensive Psychiatry*, **38**, 117-123.

Kingon, D. & Turkington, D. (1991). The use of cognitive behaviour therapy with a normalising rationale in schizophrenia. *Journal of Nervous and Mental Disease*, **179**, 207-211.

Kissling, W. (1992). Ideal and reality in neuroleptic relapse prevention. Onset and Course of Schizophrenic disorders. *British Journal of Psychiatry*, **161** (suppl. 18), 133-139.

Kivlighan, D. & Shaughnessy, P. (1995). Analysis of the development of the working alliance using hierarchical linear modeling. *Journal of Counseling Psychology*, **42**, 338-349.

Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural systems. *Social Science and Medicine,* **12**, 85-93.

Klinkenberg, W., Calsyn, R. & Morse, G. (1998). The helping alliance in case management for homeless persons with severe mental illness. *Community Mental Health Journal*, **34**, 569-578.

Knapp, M. (1997). Costs of schizophrenia. *British Journal of Psychiatry*, **171**, 509-518.

Krawiecka, M., Goldberg, D. & Vaughn, M. (1977). A standardised psychiatric assessment scale for rating chronic psychotic patients. *Acta Psychiatrica Scandanavia,* **55**, 299-308.

Krupnick, J., Sotsky, S., Simmens, S., Moyer, J., Elkin, I., Watkins, J. & Pilkonis, P. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Programme. *Journal of Consulting & Clinical Psychology*, **64**, 532-539.

Kuipers, E. (1999). Commentary on Tarrier et al. *Evidence-based Mental Health*, **2**, 18.

Kuipers, E., Garety, P., Fowler, D., Dunn, G., Bebbington, P., Freeman, D. & Hadley, C. (1997). The London-East Anglia randomised controlled trial of cognitive-behavioural therapy for psychosis I: effects of the treatment phase. *British Journal of Psychiatry*, **171**, 319-327.

Kuyken, W., Brewin, C., Power, M. & Furnham (1988). Causal beliefs about depression in depressed patients, clinical psychologists and lay persons. *British Journal of Medical Psychology*, **65**, 257-268.

Laing, R. (1967). *The politics of experience.* Penguin.

Laing, R. & Esterton, A. (1964). *Sanity, Madness and the Family.* Tavistock Publications.

Langs, R. (1976). *The Therapeutic Interaction, Vol. II: A critical overview and synthesis.* Jason Aranson Inc.

Larsen, T. & Opjordsmoen, S. (1996). Early identification and treatment of schizophrenia: conceptual and ethical considerations. *Psychiatry*, **59**, 371-380.

Leferink, K. (1988). Private and Public in the Lives of Chronic Schizophrenia Patients. *Psychiatry*, **61**, 147-162.

Lin, K-M., & Klienman, A. (1988). Psychopathology and clinical course of schizophrenia: a cross cultural perspective. *Schizophrenia Bulletin*, **14**, 555-567.

Llewelyn, S. (1985). Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology*, **27**, 223-237.

Llewelyn, S., Elliot, R., Shapiro, D., Hardy, G. & Firth-Cozens, J. (1988). Clients perceptions of significant events in prescriptive and exploratory therapy. *British Journal of Clinical Psychology*, **27**, 105-114.

Luborsky, L. (1994). Therapeutic alliances as predictors of psychotherapy outcomes: factors explaining the predictive success. In A. Horvath & L. Greenberg (Eds.) *The Working Alliance: Theory, Research and Practice*. John Wiley & Sons.

Ludwig, W., Huber, D., Schmidt, S., Bender, W. & Greil, W. (1990). Assessment of compliance-related attitudes in psychiatry. *Social Psychiatry and Epidemiology*, **25**, 298-303.

Mallinckrodt, B. (1996). Change in working alliance and social support in brief therapy. *Journal of Counselling Psychology*, **43**, 448-455.

Mallinckrodt, B., Coble, H. & Gantt, D. (1995). Working alliance, attachment memories and social competencies of women in brief therapy. *Journal of Counselling Psychology,* **43**, 79-84.

Markova, I. & Berrios, G. (1992). The meaning of insight in clinical psychiatry. *British Journal of Psychiatry,* **160**-850-860.

Marneros, A., Deister, A. & Rohde, A. (1992). Comparison of long-term outcome of schizophrenic, affective and schizoaffective disorders. *British Journal of Psychiatry,* **161** (suppl. 18),44-51.

Marshall, M., Lockwood, A. & Green, R. (1996). Case management for people with severe mental disorders. *The Cochrane Library,* Issue 2.

Marshall, R. (1990). The Genetics of Schizophrenia. In R. Bentall (Ed.) *Reconstructing Schizophrenia.* Routledge.

Marshall, R. (1995). Schizophrenia: A Constructive Analogy or a Convenient Construct? In J. Ellwood (Ed.), *Psychosis: Understanding and Treatment.* Jessica Kingsley Publishers.

Martin, J. (1988). A proposal for researching possible relationships between scientific theories and personal theories of counsellors and clients. *Journal of Counselling and Development,* **66**, 261-65.

McEvoy, J., Apperson, L., Appelbaum, P., Ortlip, P., Brecosky, J. & Hammill, K. (1989). Insight and schizophrenia. Its relationship to acute psychopathology. *Journal of Nervous and Mental Disorders,* **177,** 43-47.

McGovern, M., Newman, F. & Kopta, S. (1986). Meta-theoretical assumptions and psychotherapy orientation: Clinician attributions of patients' problems causality and responsibility for treatment outcome. *Journal of Consulting and Clinical Psychology,* **54,** 476-481.

McIntyre, K., Farrell, M. & David, A. (1989). In-patient psychiatric care: The patient's view. *British Journal of Medical Psychology,* **62,** 249-255.

Meltzer, H. (1995). Multiple outcome criteria in schizophrenia: an overview of outcome with clozapine. *European Psychiatry,* **10** (suppl. 1), 19-26.

Milton, F., Patwa, V. & Hafner, R. (1978). Confrontation vs. belief modification in persistently deluded patients. *British Journal of Medical Psychology,* **51,** 127-130.

Molvaer, J., Hantzi, A. Papadatos, Y. (1992). Psychotic patients attributions for mental illness. *British Journal of Clinical Psychology,* **31,** 210-212.

Morse, J. (1999). What's wrong with random selection? *Qualitative Health Research,* **8,** 733-35.

Mueser, K. & Berenbaum, H. (1990). Psychodynamic treatment of schizophrenia: Is there a future?

Psychological Medicine, **20**, 253-62.

Mueser, K., Bond, G., Drake, R. & Resnick, S. (1998). Models of Community Care for Severe

Mental Illness: A Review of the Research on Case Management. *Schizophrenia Bulletin*, **24**, 37-

74.

Muijen, M, Marks, M., Connollly, J., Audini, B. & McNamee, G. (1992). The Daily living

programme: Preliminary comparison of community versus hospital-based treatment for the

seriously mentally ill facing emergency admission. *British Journal of Psychiatry*, **160**, 379-384.

Mullen, P. (1997). Compliance becomes concordance. *British Medical Journal*, **312**, 691-692.

Murray, R. (1997). Schizophrenia. In R. Murray, P. Hill & P. McGuffin (Eds.), *Essential of post-graduate psychiatry*. Cambridge University Press.

Neale, M. & Rosenheck, R. (1995). Therapeutic alliance and outcome in a VA intensive case

management programme. Psychiatric Services, **46**. 719-721.

Nageotte, C., Sullivan, G., Duan, N. & Camp, P. (1997). Medication Compliance among the

seriously mentally ill in a public health system. *Social Psychiatry & Epidemiology*, **32**, 49-56.

Packer, S., Prendergast, P., Wasylenki, D., Toner, B. & Ali, A. (1994). Psychiatric Residents'

Attitudes Toward Patients With Chronic Mental Illness. *Hospital and Community Psychiatry*, **45**,

1117-1121.

Pallis, D. & Stoffelmayr, B. (1973). Social attitudes and treatment orientation among psychiatrists.

British Journal of Medical Psychology, **46**, 75-81.

Pan, P.-C. & Tatum, D. (1989). Clinical characteristics, health beliefs and compliance with

maintenance treatment: a comparison between regular and irregular attenders at a depot clinic. *Acta*

Psychiatrica Scandinavia, **79**, 564-570.

Parloff, M. (1986). Frank's "Common elements" in psychotherapy: non-specific factors and

placebos. *American Journal of Orthopsychiatry*, **56**, 501-512.

Perkins, R. & Repper, J. (1999). Compliance or informed choice. *Journal of Mental Health*, **8**,

117-129.

Pinsof, W. (1994). An integrative systems perspective on the therapeutic alliance: theoretical,

clinical and research implications. In A. Horvath and L. Greenberg (Eds.), *The Working Alliance:*

Theory, Research, and Practice. John Wiley & Sons.

Preibe, S. & Gruyters, T. (1993). The role of the helping alliance in community care: a prospective study. *Journal of Nervous and Mental Disease,* **181,** 552-557.

Rapp, C. (1998). The active ingredient of effective case management: a research synthesis. *Community Mental Health Journal,* **34,** 363-379.

Raue, P. & Goldfreid, M. (1994). The therapeutic alliance in cognitive-behaviour therapy. In A. Horvath and L. Greenberg (Eds.), *The Working Alliance: Theory, Research, and Practice.* John Wiley & Sons.

Ruscher, S., deWit, R. & Mazmanian, (1997). Psychiatric patients attitudes about medication and factors affecting non-compliance. *Psychiatric Services,* **48,** 82-85.

Rycroft, C. (1995). *A Critical dictionary of psychoanalysis.* Penguin.

Safran, J., Muran, J. & Samstag, L. (1994). Resolving Therapeutic Alliance Ruptures: A Task Analytic Investigations. In A. Horvath and L. Greenberg (Eds.), *The Working Alliance: Theory, Research, and Practice.* John Wiley & Sons.

Samstag, L., Batchelder, S., Muran, J., Safran, J. & Winston, A. (1998). Early identification of treatment failures in short term psychotherapy. *Journal of Psychotherapy Practice and Research,* **7,** 126-143.

Schwartz, R., Cohen, B. & Grubaugh, A. (1997). Does insight affect long-term inpatient treatment outcome in chronic schizophrenia? *Comprehensive Psychiatry*, **38**, 283-288.

Scott J. & Dixon, L. (1995). Psychological interventions for schizophrenia. *Schizophrenia Bulletin*, **21**, 621-628.

Seigler, M. & Osmond, H. (1966). Models of madness. *British Journal of Psychiatry*, **112**, 1193-1203.

Shapiro, D. (1989). Outcome research. In G. Parry and F. Watts, (Eds.*), Behavioural and Mental Health Research: A Handbook of Skills and Methods.* Lawrence Erlbaum Associates.

Shepherd, G. (1990). Case management. *Health Trends*, **22**, 59-61.

Shepherd, G., Murray, A. & Muijen, M. (1995). Perspectives on schizophrenia: A survey of user, family carer and professional views regarding effective care. *Journal of Mental Health*, **4**, 403-422.

Sims, A. (1988). *Symptoms in the mind.* Balliere Tyndall.

Smith, C., Barzman, D. & Pristach, C. (1997). Effect of patient and family insight on compliance of schizophrenic patients. *Journal of Clinical Pharmacology*, **37**, 147-154.

Solomon, P. & Draine, J. (1994). Satisfaction with mental health treatment in a randomised trial of consumer case management. *Journal of Nervous and Mental Disease*, **182**, 179-184.

Strauss, E. (1998). Strategies of therapeutic intervention - Classification by restraining and driving forces. *Psychotherapy: Theory, Research, Practice and Training*, **35**, 283-290.

Strauss, J. (1992). The person-key to understanding mental illness: towards a new dynamic psychiatry. *British Journal of Psychiatry*, **161** (suppl. 18), 19-26.

Tabachnick, B. & Fidell, L. (1989). *Using multivariate statistics*. Harper Collins.

Tarrier, N., Yusupoff, L., Kinney, C., McCarthy, E., Gledhill, A., Haddock, G., & Morris, J. (1998). Randomised controlled trial of intensive cognitive behaviour therapy for patients with chronic schizophrenia. *British Medical Journal*, **317**, 303-307.

Thompson, E. (1988). Variation in the self-concept of young adult chronic patients: chronicity reconsidered. *Hospital and Community Psychiatry*, **39**, 771-775.

Tracey, T. & Kokotovic, A. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment*, **1**, 207-210.

Turpin, G., Barley, V., Beail, N., Scaife, J., Slade, P., Smith, J. & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: suggested guidelines for trainees and courses. *Clinical Psychology Forum*, **108**, 3-7.

UK 700 Group (1999). Comparison of intensive and standard case management for patients with psychosis. *British Journal of Psychiatry*, **174**, 74-78.

Van Dongen, C. (1997). Attitudes towards medications among persons with severe mental illness. *Journal of Psychosocial Nursing*, **35**, 21-25.

Waddington, J. (1993). Schizophrenia: developmental neuroscience and pathobiology. *Lancet*, **341**, 531-6.

Watts, F., Powell, G. & Austin, S. (1973). The modification of abnormal beliefs. *British Journal of Medical Psychology*, **46**, 359-363.

Weaver, T., Renton, A. & Tyrer, P. (unpublished paper). Longitudinal study of the process of case management for people with severe mental illness.

Weiden, P. & Havens, L. (1994). Psychotherapeutic management techniques in the treatment of out-patients with schizophrenia. *Hospital & Community Psychiatry*, **45**, 549-555.

Whittle, P. (1996a). Psychiatric disorder and the development of a Causal Belief Questionnaire. *Journal of Mental Health*, **5**, 257-266.

Whittle, P. (1996b). Causal beliefs and acute psychiatric hospital admission. *British Journal of Medical Psychology*, **69**, 355-370.

Wile, D. (1977). Ideological conflicts between clients and psychotherapists. *American Journal of Psychotherapy*, **37**, 437-449.

Wolff, G. , Pathare, S., Craig, T. & Leff, J. (1996). Community knowledge of mental illness and reaction to mentally ill people. *British Journal of Psychiatry*, **168**, 191-198.

Worthington, R. & Atkinson, D. (1996). Effects of perceived etiology attribution similarity on client ratings of counselor credibility. *Journal of Counselling Psychology*, **43**, 423-429.

Wyatt, R., Apud, J. & Potkin, S. (1996). New Directions in the prevention and treatment of schizophrenia: a biological perspective. *Psychiatry*, **59**, 357-370.

Zubin, J. & Spring, B. (1977). Vulnerability - a new view of schizophrenia. *Journal of Abnormal Psychology*, **86**, 103-26.

Appendix 1. International Classification of Diseases criteria for the diagnosis of schizophrenia (drawn from the ICD-10 manual).

The possible symptoms are:

(a) thought echo, thought insertion or withdrawal, and thought broadcasting;

(b) delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception;

(c) hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body;

(d) persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities (e.g. being able to control the weather, or being in communication with aliens from another world);

(e) persistent hallucinations in any modality, when accompanied either by fleeting or half-formed delusions without clear affective content, or by persistent over-valued ideas, or when occurring every day for weeks or months on end;

(f) breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms;

(g) catatonic behaviour, such as excitement, posturing, or waxy flexibility, negativism, mutism, and stupor;

(h) "negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance; it must be clear that these are not due to depression or to neuroleptic medication;

(i) a significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.

Diagnostic guidelines

The normal requirement for a diagnosis of schizophrenia is that a minimum of one very clear symptom (and usually two or more if less clear-cut) belonging to any one of the groups listed as (a) to (d) above, or symptoms from at least two of the groups referred to as (e) to (h), should have been clearly present for most of the time *during a period of 1 month or more*. Conditions meeting such symptomatic requirements but of duration less than 1 month (whether treated or not) should be diagnosed in the first instance as acute schizophrenia-like psychotic disorder and reclassified as schizophrenia if the symptoms persist for longer periods. Symptom (i) in the above list applies only to a diagnosis of simple schizophrenia, and a duration of at least one year is required.

Viewed retrospectively, it may be clear that a prodromal phase in which symptoms and behaviour, such as loss of interest in work, social activities, and personal appearance and hygiene, together with generalised anxiety and mild degrees of depression and preoccupation, preceded the onset of psychotic symptoms by weeks or even months. Because of the difficulty in timing onset, the 1-month duration criterion applies only to the specific symptoms listed above and not to any prodromal nonpsychotic phase.

Appendix 2. Manchester Scale (Krawiecka et al., 1977)

Manchester Scale

Symptoms	Absent	Mild	Moderate	Marked	Severe
Depressed	0	1	2	3	4
Anxious	0	1	2	3	4
Delusions	0	1	2	3	4
Hallucinations	0	1	2	3	4
Incoherence	0	1	2	3	4
Poverty of speech	0	1	2	3	4
Flattened affect	0	1	2	3	4
Psychomotor retardation	0	1	2	3	4

Side effects	Absent	Mild	Marked
Tremor	0	1	2
Rigidity	0	1	2
Dystonic reactions	0	1	2
Akathisia	0	1	2
Vision difficulties	0	1	2
Other (specify)	0	1	2

Appendix 3. Insight Scale (Birchwood et al., 1994)

Please read the following statements carefully and then tick the box which best applies to you

	Agree	Disagree	Unsure
1. Some of my symptoms were made by my mind	☐	☐	☐
2. I have always been mentally well	☐	☐	☐
3. I did not need medication	☐	☐	☐
4. My stay in hospital was necessary	☐	☐	☐
5. The doctor was right in prescribing medication for me	☐	☐	☐
6. I did not need to be seen by a doctor or psychiatrist	☐	☐	☐
7. If someone said I had a nervous or mental illness, they would be right	☐	☐	☐
8. None of the unusual things I have experienced were due to an illness	☐	☐	☐

191

Appendix 4. Drug Attitude Inventory (Awad, 1993).

Drug Attitude Inventory (DAI-10)

Please reply to the following statements about anti-psychotic medication, by circling **T** if you feel the statement is mostly_true, and **F** if you feel the statement is mostly false.

1.	For me, the good things about medications outweigh the bad	**T**	**F**
2.	I feel weird, like a "zombie", on medications.	**T**	**F**
3.	I take medications of my own free choice.	**T**	**F**
4.	Medications make me feel more relaxed.	**T**	**F**
5.	Medications make me feel tired and sluggish.	**T**	**F**
6.	I take medications only when I am sick.	**T**	**F**
7.	I feel more normal on medications.	**T**	**F**
8.	It is unnatural for my mind and body to be controlled by medications	**T**	**F**
9.	My thoughts are clearer on medications.	**T**	**F**
10.	By staying on medications, I can prevent getting sick.	**T**	**F**

Thank you for your co-operation.

Appendix 5. Working Alliance Inventory (Tracey & Kokotovic, 1989).

Please reply to the following statements about the meetings that you have with your case manager, by indicating how much you agree with the statements, on the scale provided.

1. My case manager and I agree about the things I will need to do to improve my situation.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
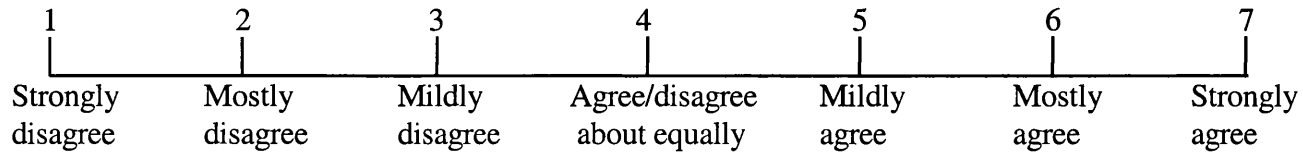
2. What I am doing in these meetings gives me new ways of looking at my problems.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
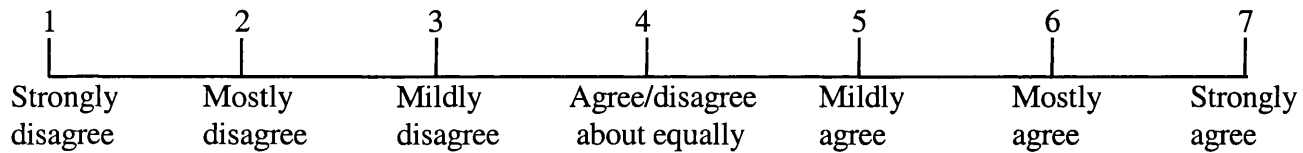
3. I believe my case manager likes me.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
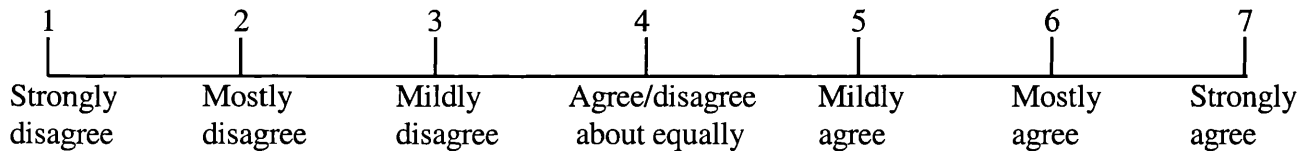
4. My case manager does not understand what I am trying to accomplish in these meetings.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
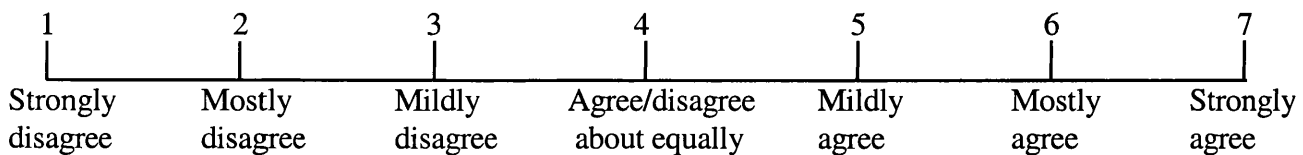
5. I am confident in my case manager's ability to help me.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
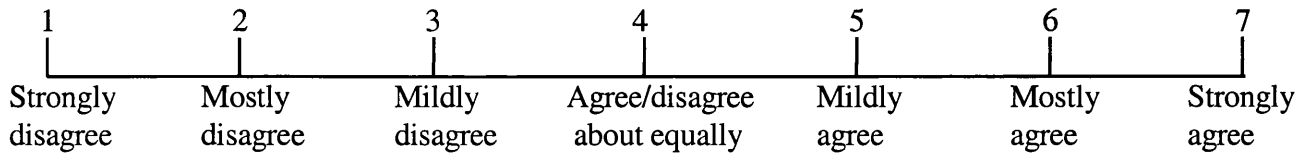
6. My case manager and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
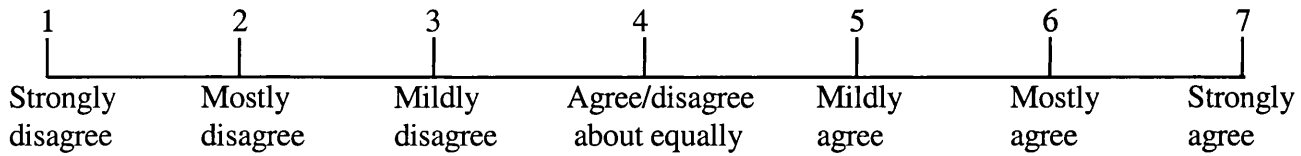
7. I feel that my case manager appreciates me.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
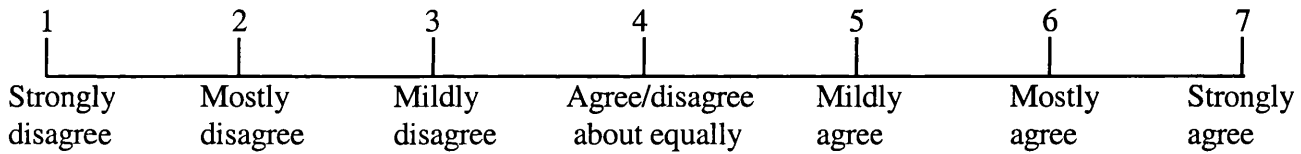
8. We agree on what is important for me to work on.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
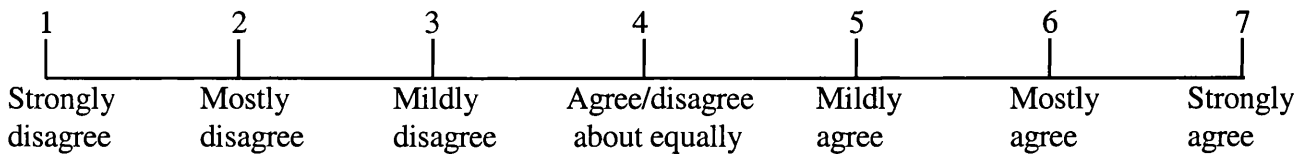
9. My case manager and I trust one another.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
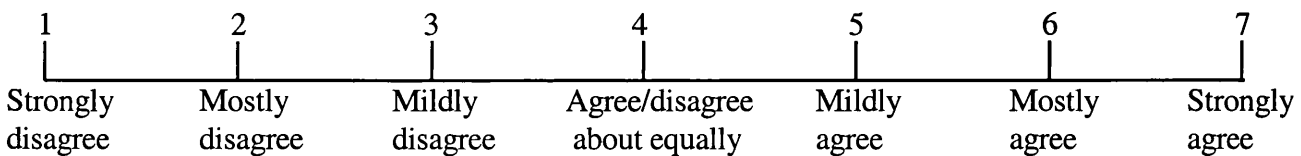
10. My case manager and I have different ideas on what my problems are.
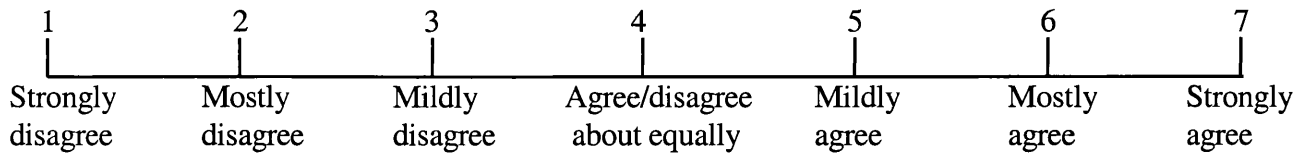
1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

11. We have established a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
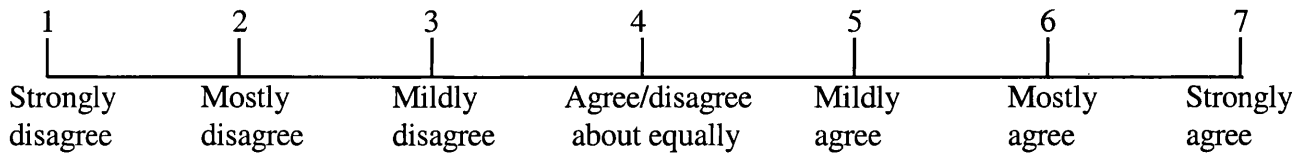
12. I believe the way we are working with my problems is correct.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
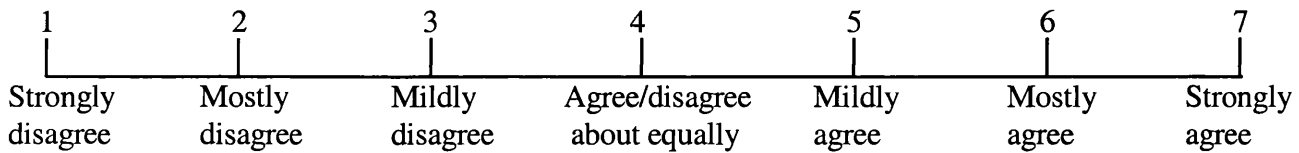
Thank you for your co-operation.

Appendix 6. Causal Belief Questionnaire (Whittle, 1996a).

How much do you agree that the following factors contribute to the cause of any psychological problems that you may be experiencing?

1. Unpleasant events that have occurred in the past.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

2. Difficulty in forming close relationships.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

3. A chemical imbalance inside the brain.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

4. Stress resulting from a recent very unpleasant event.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

5. Conflict with ex-partner following separation.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

6. The body's physical make-up.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

7. Difficulty in coping with daily demands.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

8. Experience of considerable marital conflict.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

9. Difficulties experienced through upbringing.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

10. Stopped taking medication.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

11. Relationship difficulties at work/college.

| 1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

12. Unresolved feelings resulting from the past.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

13. Difficulties in coping with a loss through death or separation.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

14. Being physically ill has made it harder to cope with emotional demands.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

15. Family relationship difficulties.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

16. The body's sensitivity to certain substances.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

17. Unhelpful attitudes held by others to people of a certain class.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

18. The lack of supportive communities.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

19. Family difficulty in adjusting to new living arrangement such as children leaving home.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

20. Unhelpful attitudes held by others to people of a certain age.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

21. Certain genes inherited within the family.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

22. The threat of an unpleasant event such as repossession of the house or redundancy.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

Thank you for your co-operation

Please reply to the following statements about the meetings that you have with this client, by indicating how much you agree with the statements, on the scale provided.

1. This client and I agree about the things s/he will need to do to improve his/her situation.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
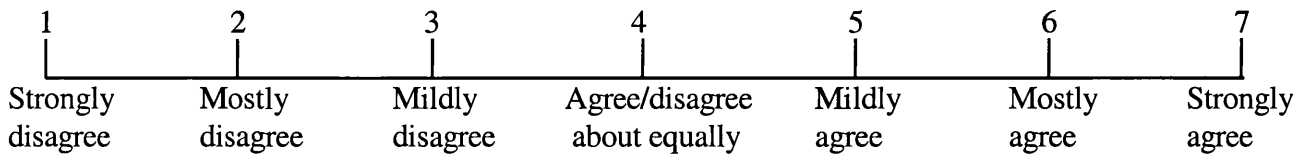
2. What this client doing in these meetings gives him/her new ways of looking at his/her problem.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
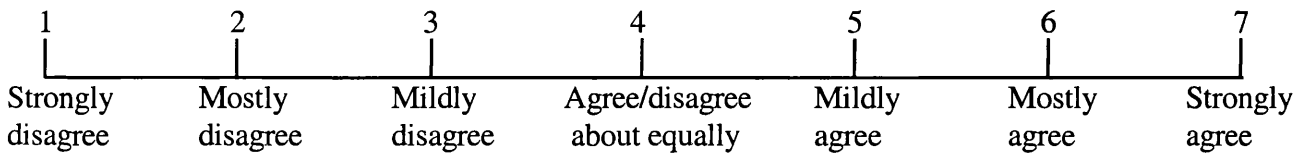
3. I believe this client likes me.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
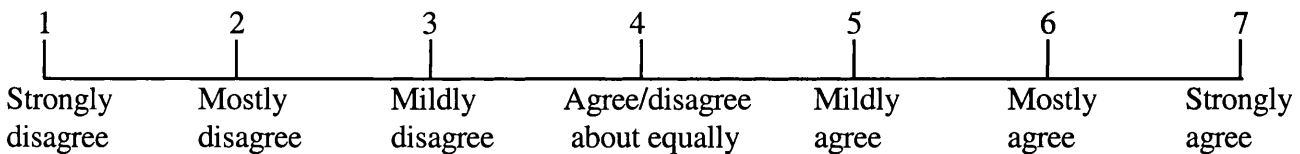
4. This client does not understand what I am trying to accomplish in these meetings.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
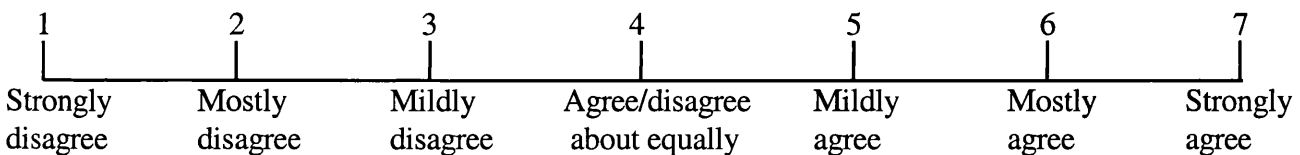
5. This client is confident in my ability to help him/her.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
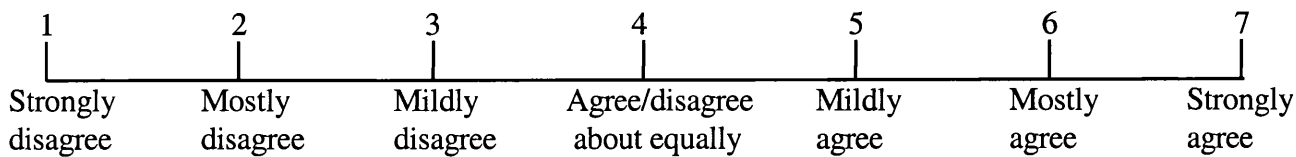
6. This client and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
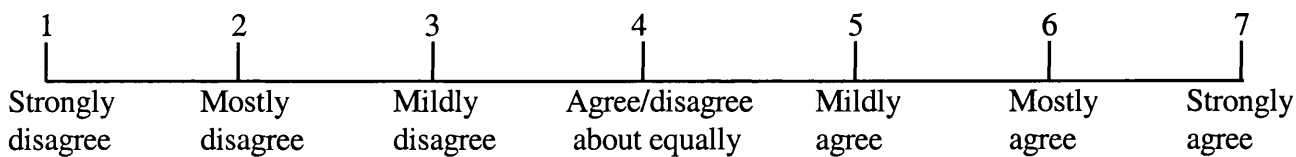
7. I feel that this client appreciates me.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
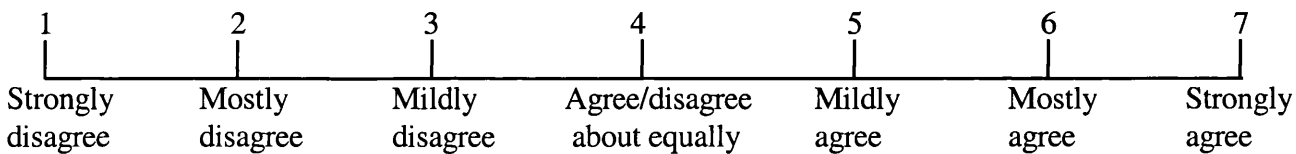
8. We agree on what is important for him/her to work on.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
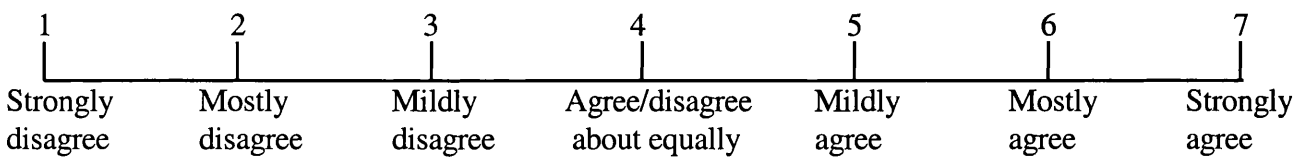
9. This client and I trust one another.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
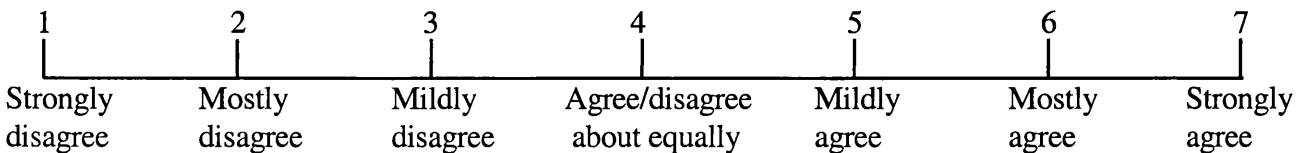
10. This client and I have different ideas on what his/her problems are.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
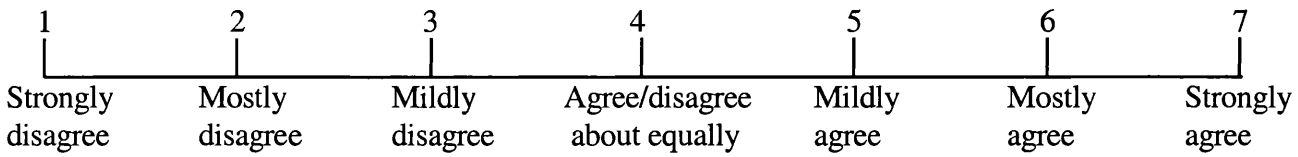
11. We have established a good understanding of the kind of changes that would be good for him/her.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
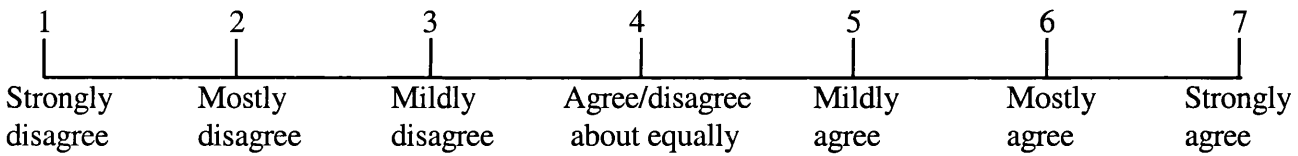
12. I believe the way we are working with his/her problems is correct.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree
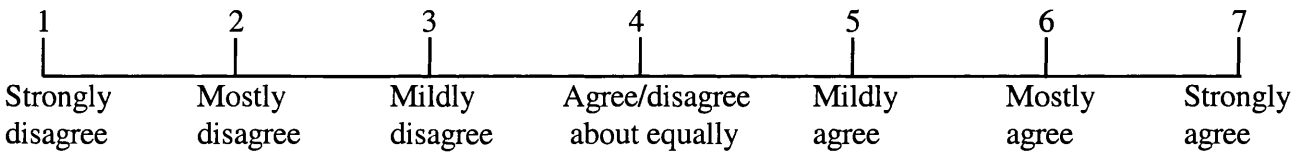
Compliance

Please rate this client's compliance with anti-psychotic medication, using the scale below.

1	2	3	4	5	6	7
Complete Refusal	Partial Refusal	Reluctant Acceptance	Occasional Reluctance	Passive Acceptance	Moderate Participation	Active Participation
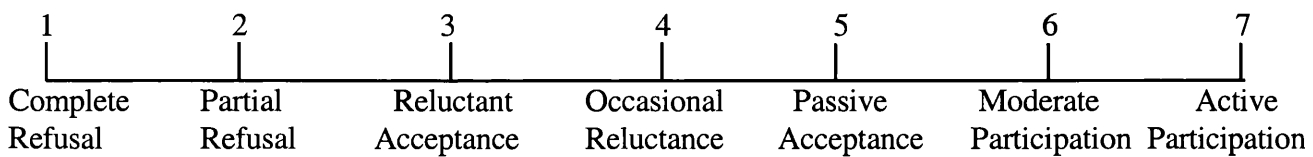
Please rate this client's compliance with non-medical treatments, using the scale below.

1	2	3	4	5	6	7
Complete Refusal	Partial Refusal	Reluctant Acceptance	Occasional Reluctance	Passive Acceptance	Moderate Participation	Active Participation
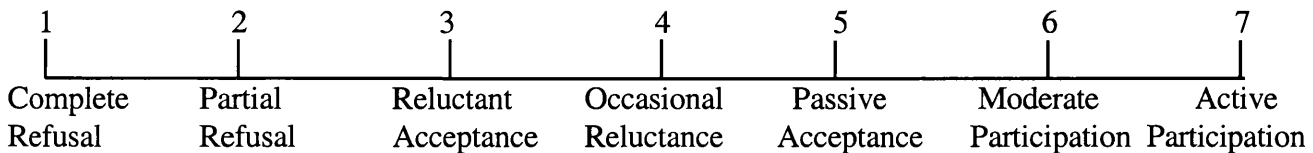
Appendix 8. Causal Belief Questionnaire (Whittle, 1996a).

How much do you agree that the following factors contribute to the cause of any psychological problems this client may be experiencing?

1. Unpleasant events that have occurred in the past.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

2. Difficulty in forming close relationships.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

3. A chemical imbalance inside the brain.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

4. Stress resulting from a recent very unpleasant event.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

5. Conflict with ex-partner following separation.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

6. The body's physical make-up.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

7. Difficulty in coping with daily demands.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

8. Experience of considerable marital conflict.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

9. Difficulties experienced through upbringing.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

10. Stopped taking medication.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

11. Relationship difficulties at work/college.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

12. Unresolved feelings resulting from the past.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

13. Difficulties in coping with a loss through death or separation.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

14. Being physically ill has made it harder to cope with emotional demands.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

15. Family relationship difficulties.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

16. The body's sensitivity to certain substances.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

17. Unhelpful attitudes held by others to people of a certain class.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

18. The lack of supportive communities.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

19. Family difficulty in adjusting to new living arrangement such as children leaving home.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

20. Unhelpful attitudes held by others to people of a certain age.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

21. Certain genes inherited within the family.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

22. The threat of an unpleasant event such as repossession of the house or redundancy.

1	2	3	4	5	6	7
Strongly disagree	Mostly disagree	Mildly disagree	Agree/disagree about equally	Mildly agree	Mostly agree	Strongly agree

Thank you for your co-operation

Appendix 9. Guidelines for the Manchester Scale (Krawiecka et al., 1977)

PART 2: GUIDELINES FOR THE USE OF THE FIVE-POINT SCALES

In making these ratings the psychiatrist is expected to use his clinical judgement to make overall assessments about the patients in each particular area. For example, in making the rating for depression the rater should be expressing his own clinical assessment of the severity of depression, based on both the patient's demeanour and behaviour during the interview and the history that the patient has given concerning depression. It should be emphasized that a morbid rating (2, 3, or 4) for depression does not imply that the principal diagnosis made will necessarily be an effective illness.

General rules for the Five-Point Scale

Rating "0" Absent:	The item is for all practical purposes absent.
Rating "1" Mild:	Although there is some evidence for the item in question, it is not considered pathological.
Rating "2" Moderate:	The item is present in a degree just sufficient to be regarded as pathological.
Rating "3" Marked:}	
Rating "4" Severe:}	See individual definitions.

DEPRESSION

This does not only include the actual behaviour observed at interview - dejected pose, sad appearance, despondent manner - but should be a clinical rating which expresses the overall assessment of depression, and the contribution that this abnormality of affect is making to the abnormal mental state being rated. Where there is a discrepancy between depression observed at interview and depressed mood reported as having been experienced in the past week, the rating made should be the greater of the two ratings.

Rating "0" Absent:	Normal manner and behaviour at interview. No depressive phenomena elicited.
Rating "1" Mild:	Although there may be some evidence of depression – occasional gloominess, lack of verve, etc. – the rater does not consider that it is pathological, or takes it to be an habitual trait not amounting to clinically significant depression.

Rating "2" Moderate:	The patient is thought to be clinically depressed, but to a mild degree.
	or
	Occasional depressed feelings which either cause significant distress or are looked upon by the patient as a significant departure from his usual self, in the past week.
Rating "3" Marked:	The patient is thought to be clinically depressed, in marked degree.
	or
	Frequent depressed feelings as described in "2" in the past week, or occasional extreme distress caused by depression.
Rating "4" Severe:	The patient is thought to be clinically depressed in extreme degree. Major depressive phenomena should be present; strongly held suicidal ideas, uncontrollable weeping, etc.
	or
	Depression has caused extreme distress frequently in the past week.

ANXIOUS

In addition to direct evidence of anxiety observed by the rater at interview, this rating should express the rater's view of the contribution which morbid anxiety is making to the mental state under consideration. (There may be some physiological signs of sympathetic over-activity, moist palms, mild tremor, blotchy patches on skin, etc.). Where anxiety is of such a degree that there is associated motor agitation, this will be rated on this key as not less than "3". Where there is a discrepancy between anxiety as observed at interview and anxiety expressed in the previous week the rating made should be the greater of the two ratings.

Rating "0" Absent:	Normal mood at interview.
Rating "1" Mild:	Such tenseness as the patient displays is thought either to be an habitual trait not amounting to pathological proportions or is thought to be a reasonable response to the interview situation.
Rating "2" Moderate:	The patient is thought to display a mild degree of clinically significant anxiety or tension.
	or
	Anxiety sufficient to cause significant distress has occurred occasionally in the past week.

Rating "3" Marked:	The patient is thought to display a marked degree of clinically significant anxiety or tension. He may be apprehensive about the interview and need reassurance, but there are only minor disruptions of the interview due to anxiety. There may be associated motor agitation of mild degree. *or* Anxiety sufficient to cause significant distress has occurred frequently in the past week, *or* anxiety has caused extreme distress for the individual concerned in the past week.
Rating "4" Severe:	The patient is thought to display an extreme degree of clinically significant anxiety or tension. He may be unable to relax, or there may be major disruptions of the interview due to anxiety. There may be associated motor agitation of marked degree, or a fearful pre-occupation with impending events. *or* Anxiety has caused extreme distress for the individual concerned frequently in the past week.

COHERENTLY EXPRESSED DELUSIONS

Rating "0" Absent:	No abnormality detected at interview.
Rating "1" Mild:	Eccentric beliefs and trivial misinterpretations: that bad weather is caused by nuclear tests; superstitions, religious sects, etc.
Rating "2" Moderate:	Over-valued ideas and ideas of reference, or undoubted misinterpretations. Special meanings.
Rating "3" Marked:	Undoubted delusions or delusional; perceptions are described as having occurred in the past month, but the patient denies that he still holds the beliefs at present. *or* Delusional ideas are expressed but they are not strongly held or incorrigible.
Rating "4" Severe:	Undoubted delusions are present and are still held by the patient.

HALLUCINATIONS

The rater must therefore decide whether hallucinations have occurred in the *past week;* if so, whether they are true – or pseudo-hallucinations, and how frequently they have occurred.

Rating "0" Absent: No evidence of hallucinations.

Rating "1" Mild: The hallucinatory experiences reported to the rater are not definitely morbid, hypnagogic hallucinations, eidetic images and illusions.

Rating "2" Moderate: Pseudo-hallucinations of hearing and vision; hallucinations associated with insight – e.g., those following bereavement.

Rating "3" Marked: True hallucinations have been present in the past week but have occurred infrequently.

Rating "4" Severe: True hallucinations have occurred frequently in the past week.

INCOHERENCE AND IRRELEVANCE OF SPEECH

Rating "0" Absent: No evidence of thought disorder.

Rating "1" Mild: Although replies are sometimes odd the abnormalities fall short of those required for thought disorder: it is always possible to understand the connection between ideas.

Rating "2" Moderate: Occasional evidence of thought disorder elicited, but patient is otherwise coherent.

Rating "3" Marked: Frequent evidence of thought disorder, but meaningful communication is possible with the patient.
or
Several episodes of incoherent speech occurs.

Rating "4" Severe: Replies difficult to follow owing to lack of directing associations. Speech frequently incoherent, without a discernible thread of meaning.

FLATTENED, INCONGRUOUS AFFECT

Flatness refers to an impairment in the range of available emotional responses; the patient is unable to convey the impact of events while relating his history, and cannot convey warmth or affection while speaking about those near to him.

Rating "0" Absent: Normal mood at interview.

Rating "1" Mild: The patient may be laconic, taciturn or unresponsive in discussing emotionally charged topics, but the rater considers that this is an habitual trait rather than a sign of illness.

Rating "2" Moderate: Clinically significant impairment of emotional response of mild degree. Definite lack of emotional tone discussing important topics; *or* occasional but undoubted incongruous emotional responses during the interview.

Rating "3" Marked: Clinically significant impairment of emotional response of marked degree. No warmth or affection shown. Cannot convey impact of events when giving history, no concern expressed about the future.
or
Frequent incongruous responses of mild degree or occasional gross incongruity.

Rating "4" Severe: Clinically significant impairment of emotional response of extreme degree; no emotional response whatever elicited.
or
Gross frequent incongruity; fatuous, supercilious, giggling, etc., in such a way as to disturb interview.

PSYCHOMOTOR RETARDATION

Rating "0" Absent: Normal manner and speech during interview. Questions answered fairly promptly; air of spontaneity and changes of expression.

Rating "1" Mild: Although there may be evidence of slowness or poor spontaneity the rater considers that this is either an habitual trait or that it does not amount to clearly pathological proportions.

Rating "2" Moderate:	The rater detects slowness, or lack of spontaneity at interview and attributes this to psychiatric illness: it is just clinically detectable. Delays in answering questions would merit this rating providing that the rater considers that it is part of a morbid mental state rather than an habitual trait of the patient.
Rating "3" Marked:	Psychomotor retardation attributable to psychiatric illness is easily detectable at interview and is thought to make a material contribution to the abnormalities of the patient's present mental state.
Rating "4" Severe:	Psychomotor retardation is present in extreme degree for the individual concerned.

POVERTY OF SPEECH, MUTE

Rating "0" Absent:	Speech normal in quantity and form.
Rating "1" Mild:	Patient only speaks when spoken to; tends to give brief replies.
Rating "2" Moderate:	Occasional difficulties or silences but most of the interview proceeds smoothly. *or* Conversation impeded by vagueness, hesitancy or brevity of replies.
Rating "3" Marked:	Monosyllabic replies; often long pauses or failure to answer at all. *or* Reasonable amount of speech, but answers slow and hesitant, lacking in content, or repetitions and wandering, that meaningful conversation was almost impossible.
Rating "4" Severe:	Mute throughout interview, or speaks only two or three words. *or* Constantly murmuring under breath (prosectic catatonia).

Appendix 10. Open Questions.

Treatment belief questions

Of the treatments that you have experience of, which do believe is the most useful?

For what reason(s)?

Of the treatments that you have experience of, which do you believe is the least useful?

For what reason(s)?

Appendix 11. Demographic data.

Age: _____   How long known:_____

Years since first admission: _____

Ehnicity: _____

Living situation:

    Alone   ☐

    With Family/Friend(s)   ☐

    Semi-supervised hostel   ☐

    Supervised hostel   ☐

    Other (Please specify) _____

Frequency of meetings with Case manager:

    Every 1-13 days   ☐

    Every 14-27 days   ☐

    Every 4-12weeks   ☐

    Less than every 12 weeks ☐

Who administers medication? _____

What is medication?

1. Name _____   3. Name _____

   Dose _____   Dose _____

2. Name _____   4. Name _____

   Dose _____   Dose _____

St Mary's

RESEARCH AND DEVELOPMENT OFFICE

(Mailbox 121) 2nd Floor, Mint Wing, St Mary's Hospital, Praed Street, London W2 1NY

Direct Line R&D: 0171-886 1330/2014 Ethics: 0171-886 6514 Fax: 0171-886 1529

May 22, 1998

Donal Leddy
Sub department of Clinical Health Psychology
University College London
1-19 Torrington Place
London WC1

Dear Mr Leddy

98/X0045 **An investigation into the relationship between therapeutic alliance, insight into illness and medication compliance among a sample of chronically psychotic patients**
<u>R&D NUMBERS MUST BE USED IN ALL COMMUNICATIONS</u>

On behalf of the members I am pleased to say that the above project has now been approved by the St Marys Local Research Ethics Committee. This approval is given on the understanding that the research team will observe strict confidentiality over the medical and personal records of the participants. It is suggested that this be achieved by avoidance of the subject's name or initials in the communication data. In the case of hospital patients, which can be done by using the hospital record number and in general practice, the National Insurance number or a code agreed with the relevant GP.

It should be noted:

- The LREC decision does not cover any resource implications which may be involved in your project.

- The LREC should be informed of any untoward development, amendments or changes in protocol that may occur during the course of your investigations. Please quote the above R&D number in any correspondence.

Chairman's initials

Appendix 13. Client information sheet

Information sheet - please read carefully

What is the study about?

This is a study about people with a diagnosis of schizophrenia, and the help that they are offered.

What am I asking you?

Will you consider helping us in a study that involves examining whether there is any link between

- whether people diagnosed with schizophrenia take their medication as prescribed
- the quality of the relationship that they have with those who care for them
- their beliefs about their psychological problems?

What are the possible benefits?

The possible benefits of this study are that it may help in finding out how best to predict the course and outcome of schizophrenia. This is important, as such information could assist carers in giving the right kind of help at the right time. Anything that helps people with a diagnosis of schizophrenia feel well and safe should be of benefit to patients and their families.

Your involvement in this study will not help you directly now, but may help others in the future. No-one is certain about what makes people more or less likely to suffer a relapse of their illness, and this study may help provide some answers.

What does it involve?

Your name was chosen at random from a list of all the patients being looked after by the Community Rehabilitation Team. Altogether, I hope to interview about 40 patients. If you are interested in helping, I will be asking you to sign a form saying that you agree to take part. Then I will be asking you to fill in some questionnaires with me, a process that should take 45-60 minutes. There would be nothing else for you to do to do after that. Your name will not be attached to the questionnaires, and all your answers would be confidential.

I will also be asking you whether you would be happy for me to talk to some of those people involved in your care, such as nurses or occupational therapists, to fill in similar questionnaires. This is to find out how they explain any problems you may be experiencing, and how they view the working relationship that you both have. Again, neither your name nor theirs would be attached to the questionnaires, which would be confidential.

Risks

There should not be any risks involved in your helping in the study. However, if you feel distressed during or after the interview, please talk to me or your case manager, and we will do whatever we can to reduce any distress, and resolve any problems resulting from the interviews. If you suffer an adverse event or deterioration in health as a result of your participation in this study, appropriate compensation will be paid to you in accordance with the Association of the British Pharmaceutical Industry Guidelines. The amount of compensation payable will take into account the severity and persistence of the injury. A copy of the Guidelines may be obtained from your doctor.

The future

The results of the study will hopefully be published some time in the future. If you want to get in contact with me after your involvement, you will be able to do so through your case manager.

Important:

You are under NO obligation to help in this study, and if you do agree to help, you can change your mind at ANY time. If you do not wish to take part, or if you change your mind after agreeing to take part, your care will NOT be affected in any way.

You can take as long as you wish to make up your mind, and please feel free to ask me any questions about the study. Thank you very much for your time.

Donal Leddy

Clinical Psychologist in Training

Appendix 14. Qualitative data

The codes derived form the qualitative data are presented below, in the categories into which they were sorted in the data analysis presented in Chapter Seven. The terms in parentheses are the particular treatments that the participant was referring to.

Case managers

Helpful aspects

1. Improved functioning

Compliance with depot medication allows clients to function adequately in all areas of daily living activities.

2. Improved access

(Medication) keeps the mental state stable, so you can then provide other treatments, such as day care activities.

I feel that medication plays a very important part in the treatment of mental illness, however it should only be used in conjunction with other types of support - counselling, therapy, structural activities, problem solving etc.

3. Structure

Structure is important in order that clients are not a danger to themselves. They need behavioural boundaries and dynamic space.

4. Presence

(Of long term engagement).You build up trust, the more the patient sees you as an asset, it helps. They recognise a familiar face.

(Counselling) is an opportunity for the client and the counsellor to get to know one another.

5 .Understanding

(Counselling) can identify underlying problems that the client experiences

It helps to express feelings, to talk about problems, and to trust someone. You won't find solutions otherwise. Knowing someone is there makes them feel positive.

6. Symptom management

(Anti-psychotic drugs) Evidence-based medicine, which shows that they can control symptoms

(Respiridone) gets rid of negative as well as positive symptoms.

(CBT and psychotherapy) Helps people to manage their symptoms, such as hallucinations, and delusions. They are able to cope with symptoms better.

7. Participation

(Of psychosocial interventions, problem solving, and family work dealing with EE.) Client and family participation is empowering for the patient and the family. It is educative, it helps in dispelling myths of how person thought of illness

Unhelpful aspects

1. Disorder limitations

(Of psychotherapy) There's no direction, patients have to find their own solutions, which is difficult for clients in stressful situations.

(Regression techniques) could be dangerous, and could open up too many wounds, and the person couldn't rationalise what happened.

(Psychotherapy) Some clients have mild learning disabilities.

(CBT and psychotherapy) can't be done with someone who is too disturbed. They need a little grasp of what you are doing.

In practice, (counselling) is wishy washy, not concrete enough.

2. Labelling

(Of heavy medication)They don't progress, and become labelled chronically ill, which affects those caring for them, who continue with the same medication, because they are "chronic".

3. Abuse

(Behavioural programmes) are more open to abuse, especially when people don't keep up to date.

In theory (counselling) is oppressive, about abuse of power.

4. Mistrust

(Laingian psychotherapy) makes patients non-compliant and antagonistic to medication, projecting their problems on to others.

(Sectioning and forced treatment) backfires. They start distrusting professionals, and turn against everything.

Clients

Helpful aspects of treatment

1. Tranquilising

(Medication) It keeps me stable.

(Sulperide) It calms me down.

(Sulperide) It is a 'leveller'. It makes me more level. Not depressed, and not high.

(Respiridone) I had no problems, it keeps you balanced. It calms you down.

(Medication) Calms me down and relaxes me.

(Medicine) Relieves stress and nerves.

(Being in hospital and medication) Quiet and rest.

(Injections) Calms me.

(Medication) Gives you stability.

(Injections) It keeps you calm.

(Medication) It keeps me relaxed, calm, I'm not anxious.

2. *Instant effects*

(Tablets) Instant effects.

(Prozac). You can feel it working. It gives me a nervous, happy feeling.

3. *Compulsion*

(Injections)With the tablets, I didn't take them every day, but with the injections, I know I

have to take them

4. *Side effects prevention*

(Procycladine) It stops you from being stiff and ill.

(The pills against the shaking) It stops you shaking.

5. *Symptom prevention*

(Tablets) Help prevent a nervous breakdown.

(Injections) I feel very confident, as the voices disappear.

(Injections) They keep me the right way.

(Depot injection) It keeps me out of hospital, with no side effects, and it is not too sedating.

6. *Understanding*

(Talking therapy) It can help you come to terms with unresolved problems, and the causes of

mental illness. Medications deal with the symptoms, not the causes, They are not a cure.

7. *Physiological action*

(Medication) Because the brain is the most important part of the body, because thinking takes place there.

(Medication) All the talking can help, but when you flip into the psychotic state, talking won't help. There is a chemical basis to the psychotic state.

8. Safety

(Coming to the hostel and having the time to get organised). You get to know the options, and not find things so strange.

(Help with benefits) It's very difficult to talk directly to DSS staff and you need money to support yourself, and to have freedom.

(A house with other women) Because I've lived there before, you're not getting pushed around, you live with women who understand.

9. Comfort

(Being in hospital) They are trying to make you better, by taking medication

(All the staff) They try everything to help, they are kind and understanding.

10. Don't know

(Medication) I'm not sure why, it is helpful. It's for schizophrenia

Unhelpful aspects of treatment

1. Poor efficacy

(ECT) The effects didn't last

(ECT) It didn't make any difference.

(Largactil) It didn't work.

(Injections) I don't feel it in myself.

(Some tablets) They don't seem to have any effect.

(Injections) They don't serve the purpose, they have no effect.

(Depot) It don't get anything from it.

(Stellazine) It didn't work. I think it wasn't strong enough.

(Injections) Without it, you feel more yourself.

(Stellazine) It didn't work. I think it wasn't strong enough.

(Procycladine) I've run out, and I don't feel any different.

2. *Frightening side effects*

(Too much medication) It makes you shake, and behave strange.

(Tablets) Makes you hear voices, you can't sleep.

(Depixol) I get bad headaches.

(Largactil) The dribbling, swelling, you see things. There are other side effects.

(Stellazine) All the time I was on it, I was really depressed. It had a lot of side effects.

(ECT/leuchotomy) ECT destroys brain cells, leuchotmies remove parts of the brain, so the long term side effects are quite traumatic. ECT users complain of memory loss.

(Chlozaril) I took it, I couldn't sleep, the sheets were soaking, it made me go blank in the head.

3.*Stigma and stress*

(Hospitalisation) I don't like the place or the people there. It is untidy and dirty

(Hospital) I feel insecure, they're all too busy talking

(Going into hospital) you get involved with some rough characters.

(ECT) I cases too much pain and stress, because they feel that it is dangerous

(Being zonked out on acuphase, & immediate restraint.) It is demoralising. They should take more time to talk people round.

4. *Lack of freedom*

(Going into hospital) On the closed ward, your freedom is restricted,

(Sectioning) You become too institutionalised

(Tablets) Because I don't want to take them everyday, I don't want to swallow them

5. *Agitation*

(Sulperide) It doesn't let you sleep, day time or night time.

(Taking injections) It doesn't help, it makes you worse. Because of the way I was feeling.

The made me nervous and restless all the time.

(Injections) I couldn't sit down, I was pacing up and down, very restless.

6. *Drowsiness*

(Stellazine) It makes you drowsy, slows you down too much.

(Injections) Makes you drowsy

(Chlozaril) It make you sleep all of the time