A STUDY OF THREATENED IDENTITY IN SCHIZOPHRENIA

PORTFOLIO SUBMITTED FOR THE PSYCH.D. CONVERSION COURSE

AT SURREY UNIVERSITY

By Melinda Jane Bunyan
UNIVERSITY OF SURREY, NOVEMBER 1997.
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1. PERSONAL STUDY PLAN

Psych.D in Clinical Psychology: Conversion Programme

Name: Mel Bunyan  
Date of Registration: October 1994  
Registration Number: 3414507

1.1. Overall Aims and Objectives

Prime Aim: To increase academic competence in three areas in order to enhance the services offered by my Department and the Profession.

Prime Objective: To produce a portfolio of Study, Practice and Research demonstrating increased competence in each of these three areas.

To attain greater professional competence in order to increase the contribution of Clinical Psychology to Health Care.

To increase academic knowledge in three areas relevant to the development of services in my Department.

To broaden the areas in which my Department can offer Specialist Services.

1.2. Academic

Aims: To acquire specialist knowledge in three areas:

1. Family Psychoeducation Approaches in Schizophrenia
2. Cognitive Behaviour Therapy Approaches to Psychosis
3. Treatment Adherence

**Objectives:**
To write Critical Academic Reviews in each of the above areas.

To attend training events at the University and as organised by the Clinical Psychology Continuing Professional Development Committee, to update my knowledge in areas relevant to my job.

**Rationale:**
Bounewood Trust is currently involved in considering alternative service models in line with Government targeting of mental health services for those with severe and persistent mental illness. The rationale for the subjects chosen was to provide up to date reviews of the areas of specialist psychological knowledge relevant to this population, in order that my Department could provide specialist input into the Community Mental Health Teams and in my work with the Rehabilitation Team. The areas chosen are all ones in which Psychologists may provide specialist services to those with severe and persistent mental illness or improve the effectiveness of the CMHTs.

Therapeutic or educational work with families has not been developed in my District and was considered to be a possible area of specialist intervention by Clinical Psychologists. A review of current research in this field would provide a resource for the Department in offering this kind of input to the Community Mental Health Teams. Hence my first
Academic Review is in this area.

The second Academic Review concerns Cognitive Therapy for psychosis. This is an important area of development in Clinical Psychology and it would be of value to my Department to have a review of current literature including the theoretical background to current approaches.

The third Academic Review concerns factors and approaches relevant to treatment adherence with particular reference to the application of Health Psychology theories to long-term psychiatric disorders. The rationale for choosing this subject was to provide a review of current psychological theory applicable to the work of Community Mental Health Teams, of which prescription and monitoring of medication is a central concern, allowing Clinical Psychologists to bring specialist theory and understanding to this aspect of care.

**Plan:** Academic Reviews completed:


A Critical Review of the Literature on Adherence to Medication Regimes in Major Psychiatric Disorders and the Application of Theory.
Attendance at Clinical Workshops on
  - Cognitive Therapy for Delusions
  - Paranoia
Attendance at University Workshops on
  - Statistics
  - Expert Testimony
  - Identity Theory
  - Models of Care

1.3. Clinical

Aim
To increase personal professional competence and develop the services offered by my Department and Profession.

To develop the Clinical Psychology service provided to the local inpatient psychiatric unit with particular reference to patients who self-harm.

Objectives
To present a dossier of clinical activity that will describe the Service development and its psychological framework.

To review the literature relevant to the kinds of difficulties presented by patients in acute psychiatric care who harm themselves and who may benefit most from psychological treatment.

To design, implement and evaluate a service based on the literature, specifically designed to improve the service offered to patients who harm themselves.
Rationale

When the psychology sessions available to the acute wards were increased, the kinds of referrals most commonly made were for patients diagnosed with personality disorder, exhibiting self-harming and suicidal behaviours. The ward teams were concerned about the adequacy of the service currently offered and it was felt that developing the psychological service to these patients in particular would be most beneficial.

Although many of these patients were taken into individual therapy by the psychologists, a review of the literature indicated that a group treatment would be a useful adjunct. This would enable skills to be taught in a way that is difficult when working one-to-one. It was also felt that running a structured group treatment, based on the relevant literature, would increase the experience and expertise for working with self-harm within the psychology department.

Plan

To carry out a literature review on areas relevant to self-harm, suicidal behaviour and personality disorder, focusing on treatment approaches.

To design a group treatment based on the literature as an adjunct to current treatment.

To liaise with the ward psychiatric teams regarding the approach being taken and relevant referrals.

To implement and evaluate the group treatment.
1.4. Research

**Aims**

To increase research competence so as to develop the services offered by the Department.

To increase personal competence in assessing factors such as self-efficacy over symptoms and aspects of positive identity with people with schizophrenia.

To increase personal research competence in the use of the SPSS package.

**Objectives**

To develop a research dossier, part of which will be the original MSc. dissertation, that will make increased research competence evident.

To investigate the factors relevant to a positive sense of identity and the function of insight in relation to identity in recovery from schizophrenia.

**Rationale**

Providing both one to one therapy and guidance to other staff in the design and aims of care plans for people with schizophrenia living in the community is a central part of my work in the Rehabilitation team. Within the literature on recovery from schizophrenia, there is recognition of the importance of a positive sense of identity and the therapeutic aim of acceptance of illness without self blame whilst maintaining self-esteem. It would be of great value to investigate the factors relevant to maintaining a positive sense of identity in people with schizophrenia to provide a basis for
Both I and the Rehabilitation service would benefit from investigating the use of new assessment approaches, particularly focusing on psychological aspects. Traditionally, symptomatology and functioning have been assessed to measure change in psychiatric rehabilitation. I believe it would benefit our service greatly to perfect measures of change in psychological factors relevant to the aims of the programme, including perceived stigma, identity and self-efficacy over symptoms, for use as measures of individual outcome and in service evaluation.

I would benefit from increasing my competence regarding use of the SPSS computer package.

**Plan**

To carry out a literature review on the factors important to the maintenance of positive identity and self-esteem in schizophrenia and identity theory.

To carry out a research study investigating the relative impact of factors associated with positive identity in schizophrenia and to investigate the measurement and function of insight in schizophrenia.
2. POST-QUALIFICATION CONTINUING PROFESSIONAL DEVELOPMENT
(since qualification in October 1991)

2.1. Courses and Workshops Attended

Clinical Psychology Continuing Professional Development Committee Study Days on

Formulation

Utilising Family Therapy Techniques in Individual Therapy (I)

Developing the Internal Supervisor

The Psychology of Care

Sexual Abuse

Research Design in Clinical Practice

Cognitive Therapy for More Complex Problems

Family Therapy Techniques (II)

Clinical Psychology Observed

Outcomes in Therapy

Neuropsychological Testing in Psychosis
Creative Interventions in Family Therapy

Bournewood Trust Internal Courses on

Management Development

Handling Face to Face Violence (BAC)

University of Surrey (Doctorate Conversion) Courses on

Identity Process Theory

Quality Audit in Mental Health Services

Expert Testimony

Models of Care

Statistics

Using SPSS

Courses Organised by Other Agencies on

One Day Conference on Schizophrenia and Long Term Care

Study Day shadowing Consultant Clinical Psychologist in Rehab. Service at another hospital

Community Care and New Patterns of Working: The Psychologist's Role in
Consulting to the Changes

One Day Conference on Current Developments in Psychiatric Rehabilitation

Two Day Conference on Alternatives to Mental Hospital and The Care Programming Approach

Lectures on Cognitive Approaches to Delusions and Manic Depression

2.2. Supervision:

Supervised practice for two years post-qualification, until Chartered (1991 to 1993).

Regular participation in peer supervision group with fellow Clinical Psychologists, since qualification.

Regular attendance at a “Ballint Group” (multi-disciplinary group exploring psychodynamic concepts in Clinical Practice, led by a Consultant Psychotherapist) for one and a half years post qualification.

2.3. Involvement in Higher Level Work:

“Project Manager”, from 1992 until 1993, for the Rehabilitation Assessment and Training Centre:

- this was a new project providing day, residential and outreach care for people with severe and persistent mental health needs

- the role of project manager entailed both day to day management (i.e.
staffing, budget, etc.) and developing the approach to patient care and philosophy of the service

- design, implementation and reporting of outcomes of service and client satisfaction with service to Senior Managers and Purchasers

**Member of the Commissioning Team** which designed and opened a new nursing home for people with very severe and persistent mental illness (who would otherwise have remained in hospital)

- continuing input as the team psychologist in both day to day care of residents and the assessment of new residents

- leading a number of service evaluation projects, including assessment of the overall functioning of the home and assessment of client satisfaction with the service.

**Co-ordinator of Psychiatric Rehabilitation Team,** from 1992 onwards, with responsibility for ensuring that policy and procedure are implemented, reviewing procedure and policy and representing team views to Management and Purchasers.

**Manager of Psychology Service to the In-patient Psychiatric Unit,** from 1995 onwards. This has included supervision of other psychologists working with individual clients, implementation of staff support groups and staff teaching and supervision programmes on psychological issues. Plans for a more formalised debriefing system (following violent incidents) is under discussion, currently debriefing is offered on an informal basis (to individuals and staff groups).
CLINICAL PROJECT:
DESIGN AND IMPLEMENTATION OF AN INTERVENTION
FOR PATIENTS WHO HARM THEMSELVES
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1. INTRODUCTION

This clinical project was developed in the context of expanding the psychological service offered to an acute psychiatric unit, which involved the author (referred to as psychologist 1 in the text) and another psychologist studying for a BPS Certificate of Equivalence (referred to as psychologist 2), supervised by psychologist 1. The project was designed in response to a growing number of referrals by the acute psychiatric teams, for whom current treatment options seemed unsatisfactory.

These patients were characterised by frequent deliberate self-harm and overdosing, with multiple, often frequent hospital admissions. They tended to have a diagnosis of personality disorder (often borderline personality disorder (BPD) –see Appendix I for criteria) or recurrent depression. The teams reported feeling unsatisfied with current treatment approaches and many felt that admissions were often counterproductive, because they reinforced self-harm rather than coping, and that psychological intervention should be the main approach.

2. AIMS OF THE PROJECT

2.1 To increase the knowledge base within the Psychology Department of literature relevant to the problems presented by these patients and recent developments in treatment approaches.

2.2. To provide a knowledge base available to other staff within the unit regarding the problems presented by these patients and recent developments in treatment approaches.

2.3. To improve the service provided to these patients by designing, implementing and evaluating a new intervention model based on the psychological literature.
3. LITERATURE REVIEW

The literature on suicide, parasuicide and deliberate self-harm (DSH), including areas of particular relevance to BPD, were reviewed to provide depth of understanding for the intervention (a summary is given in Appendix II). To summarise, the literature suggests that interventions aiming to reduce suicidal behaviour need to involve developing rewarding short-term routines and long-term goals to combat hopelessness, as well as developing problem-solving skills, especially the generation of alternative solutions. Negative self-evaluations need to be addressed, leading to more realistic expectations. The ability to regulate and tolerate aversive emotional states, especially anger, may need to be developed. Regarding DSH, the literature suggests that interventions need to focus on either reducing emotional tension, or developing skills and beliefs allowing it to be tolerated. Contingencies reinforcing DSH, both intrapersonal and interpersonal, may also need to be altered. The main areas of innovation in treatment are reviewed below.

TREATMENT DEVELOPMENTS

The development of psychological treatments with this client group may be particularly relevant as there is evidence that drug treatments are largely ineffective (Morgan, 1979) and that prescribed drugs may be used to overdose. A number of treatments have been developed over the last few decades, details of which are given below.

3.1. PROBLEM-SOLVING APPROACHES TO PARASUICIDE

A small number of treatment studies have been completed using a problem-solving approach. For example, Patsiokas & Clum (1985) compared problem-solving therapy with cognitive restructuring (Beck, 1976) and a non-directive treatment control (10 sessions of each), to a small sample of hospitalised suicide attempters. Hopelessness and suicidal intent were reduced in all three conditions, but the problem-solving group performed better on personal problem-solving. Similarly, Lerner & Clum (1990)
compared problem-solving therapy with supportive therapy for groups of students exhibiting suicidal ideation. The problem-solving therapy was rated more highly following treatment and resulted in less depression, higher problem-solving self-efficacy, slightly greater problem-solving ability and marginally less suicidal ideation, at three month follow-up.

Judging the success of treatments depends on the definitions of good outcomes used; increasing the length of time between episodes and reducing other associated variables may be valid goals. The results of treatment studies may be contaminated by spontaneous remission, however. To prevent this from contaminating their study, Salkovskis et al (1990) used a sample of twenty people at high risk of repeating parasuicide as measured by Buglass & Horton's (1974) criteria (including diagnosis of sociopathy, previous psychiatric treatment, use of alcohol and not living with a relative, previous suicide attempts and using antidepressants in an attempt). Twelve of these people received problem-solving therapy over five sessions. The rest made up a "treatment as usual" control group, although it is unclear what form this took. The experimental treatment demonstrated a short-term effect of lengthening the amount of time between attempts; also there was an enduring reduction in hopelessness, depression, suicidal ideation and target problems at one-year follow-up. Differences in the frequency of repeated attempts did not endure at eighteen-month follow-up, however, and the authors suggest that a longer intervention may be necessary. These results are encouraging, particularly considering the brevity of the intervention.

3.2. SCHEMA-FOCUSED COGNITIVE APPROACHES TO PERSONALITY DISORDER

Recently, it has been recognised that traditional cognitive-behavioural therapy may be unsuccessful with personality disorders. A number of authors have expanded the theory and therapy to take account of the difficulties of personality-disordered individuals in devising schema-focused cognitive therapy (Layden et al, 1993; Beck et al, 1990; Young, 1990). It is hypothesised that working on automatic thoughts and dysfunctional beliefs is inadequate. The route of the problem of personality disorder is viewed as being
at the deeper level of schemas, referring to the content of fundamental, unconditional core beliefs about oneself and the world. Meaningful work with BPD patients is aimed at the level of schemas. It is assumed that childhood trauma and adversity causes the existence of maladaptive schemas, as development is distorted and developmental tasks incomplete. Maladaptive schemas may lie dormant but be activated by life events, with overwhelming negative emotions ensuing. BPD patients may demonstrate many behaviour patterns aimed at keeping schemas dormant and the therapy aims to help them to deal with the negative feelings when schemas are activated and to reduce their avoidance behaviours which themselves become maladaptive, including DSH. Dependence, emotional deprivation, lack of individuation, abandonment, mistrust, unlovability and incompetence are proposed as the common contents of schemas in BPD (Layden et al, 1993). Due to their development in early childhood, it is assumed that some schemas are not language-based and require therapeutic responses in other sensory modalities, including imagery, tone of voice, physical comfort etc. Whilst therapy entails the identification and challenging of certain core schemas, some methods are borrowed from gestalt therapy (Perls et al, 1973).

Generally, there has been little empirical testing of these approaches. Davidson & Tyrer (1996), however, assessed an intervention based on the approaches described by Beck and colleagues and Young. They report outcomes for eight patients with antisocial or borderline personality disorder, in the form of single case studies; all except one improved on some measures.

3.3. DIALECTICAL BEHAVIOUR THERAPY FOR BORDERLINE PERSONALITY DISORDER

An intervention, similar in some aspects to schema-focused approaches, has been devised by Linehan and colleagues, specifically aimed at patients with a diagnosis of BPD. Previous attempts at psychosocial treatment with this population have generally met with limited success (Pope et al, 1983). The treatment approach is based on Linehan's biosocial model of BPD (Linehan, 1993) which proposes that people who later develop BPD may be temperamentally vulnerable children who grow up in what is
described as "invalidating environments". This refers to environments in which the child's expressions of their mental experiences are met with trivialising, denying or punishing responses by caregivers. Environments in which child abuse occurs are viewed as intrinsically invalidating of the child's needs. It is proposed that the person then develops with the following areas of difficulty:

1. Emotional Dysregulation

This is viewed as the primary problem, leading to emotional overreactivity, periodic depression, problems of anger control and anger expression, due to the failure in learning to label, describe, tolerate and trust their own emotional experiences. The BPD patient is conceptualised as both emotionally vulnerable and deficient in emotion modulation skills. Some are assumed to become emotionally avoidant and emotion-phobic in consequence.

2. Interpersonal Dysregulation

The person is viewed as developing chaotic and intense relationships, due to difficulties with emotional awareness and communication, and fear of abandonment.

3. Behavioural Dysregulation

Extreme and problematic behaviours, including DSH & suicidal behaviours, are assumed to develop as attempts to cope with or escape from the difficulties with emotion regulation, compounded by difficulties in current relationships. Suicidal and impulsive behaviours are seen as maladaptive solutions to difficulties with communication and emotional experience.

4. Cognitive Dysregulation

Experiences of depersonalisation, dissociation or delusions are assumed to develop in response to emotional stress, in the absence of other emotion modulation skills.

5. Dysregulation of the Sense of Self

Consequent to the primary difficulty with emotional awareness and difficulties trusting emotional experience, the individual is assumed to develop difficulty maintaining a sense of self, characterised by pervasive feelings of emptiness.

The treatment, named Dialectical Behaviour Therapy (DBT), has a double focus. First, a behavioural problem-solving approach is used to focus on improving problem-solving ability, generating alternative strategies, clarifying and managing contingencies.
The emphasis remains on the observable present throughout. Second, the dialectical aspects of the person's experience and of the therapy are taken into account. This consists of an emphasis on balancing acceptance and change; this may involve helping the client to accept things as they are in order to facilitate change, in part by not invalidating their own feelings. The treatment takes place over one year and is carried out by specifically trained therapists, combining weekly individual therapy with group therapy and crisis telephone contact. The aims of DBT are the reduction of suicidal behaviour, behaviour which interferes with therapy and with quality of life, and their replacement with skilful interpersonal, emotion regulation, distress tolerance and mindful behavioural responses. Importantly, the agenda for an individual session is set according to the overall goals; therefore, if there has been a suicidal act between sessions, then the situation is analysed in detail and the behaviour analysed functionally, with alternative solutions discussed.

In an outcome study (Linehan et al, 1991), forty-four subjects diagnosed with BPD and having had at least two incidents of parasuicide in the previous two years (at least one in the eight weeks preceding therapy), were assigned to DBT or treatment as usual (TAU). The latter, for some of the subjects, included psychotherapy. Results of this study showed a significantly greater reduction in parasuicidal episodes over the year for the DBT group. By the end of the year only 35% of the DBT group compared to 60% of the TAU group were still exhibiting parasuicidal behaviour. Over the year, 96% of the TAU group had an episode of parasuicidal behaviour, compared to 64% of the DBT group. DBT subjects also had significantly fewer days in psychiatric hospital and less serious suicide attempts when they did occur. These findings were generally maintained at one year follow-up (Linehan et al, 1993). In considering why this and other problem-solving approaches should be successful where other therapies have failed, MacLeod et al (1992) conclude that very detailed analysis of behaviour is the most crucial component. This strategy offers the individual more choice points between impulse and action, as well as counteracting the tendency to both encode and retrieve overgeneralised memories of events. Further, this detailed analysis may provide opportunities for the reattribution and reconstrual of events.
3.4. EMPHASIS ON EMOTIONS IN TREATING BORDERLINE PERSONALITY DISORDER

A new emphasis on emotions in BPD is evident in both the schema-focused and DBT approaches. These are based on evolutionary/biological theories of emotion.

A number of investigators have demonstrated that certain emotions, distinguished by common facial and gestural expressions, are generalised amongst humans and are biologically adaptive responses that reflect survival needs and promote survival-oriented problem-solving (Arnold, 1960; Ekman, 1972; Gray, 1982; Izard, 1977; Panskepp, 1982; Tomkins, 1962). Certain "primary" emotions are seen as hard-wired and as motivating adaptive behaviour (Lang, 1985; Leventhal, 1982, 1984), including fear, anger, disgust, surprise, sadness and joy (Ekman, 1972; Ekman & Friesen, 1975; Greenberg & Safran, 1989). Basic emotions are seen as fleeting (Buck, 1984). Primary emotions are distinguished from secondary emotional responses, which viewed as indirect reactions and maladaptive, blocking adaptive problem-solving, such as showing anger when afraid, hopelessness in response to negative expectations etc. (Greenberg & Safran, 1989).

Greenberg & Safran, in a number of studies, promote an emotional focus within existing therapeutic models, using emotions as allies in the change process rather than undesirable aspects to be avoided or extinguished. They suggest that processing of specific emotional experience can lead to the emergence of new and adaptive problem-solving (Greenberg & Safran, 1981, 1984a, 1984b, 1987a, 1987b; Safran & Greenberg, 1982a, 1982b, 1986). Five processes of change are delineated:

1. acknowledging previously unacknowledged emotional responses to increase awareness of adaptive response information
2. evocation & intensification of emotion to motivate new behavioural responses
3. emotional restructuring
4. accessing state-dependent core beliefs
5. modifying maladaptive emotional responses

Further, Gottman & Katz (1990) suggest that there are four emotion-regulating activities:

1. inhibit inappropriate behaviour related to strong affect
2. self-regulate physiological arousal associated with strong affect
3. refocus attention in the presence of strong feelings
4. organise oneself for action in relation to non-mood-dependent goals.

Greenberg & Safran (1987a) suggest that the therapist encourages emotional processing by directing the client's attention to inner experience in the present. As such, it has much in common with schema-focused cognitive therapy (Young, 1990; Beck & Freeman, 1990) and with experiential approaches (Perls et al, 1973; Rogers, 1951). Recent developments in therapy with BPD indicate a new emphasis on emotional processing and emotion modulation.

4. THE INTERVENTION

4.1. PRINCIPLES OF THE TREATMENT APPROACH

The treatment approach designed for this intervention was based on the literature on psychological factors associated with parasuicide, DSH and BPD. As DBT (Linehan 1993) seemed to be the most cohesive approach to these behaviours in patients fitting the criteria for BPD, some of its principles and approaches were incorporated.

As it was impossible for the therapists to be formally trained in DBT and because there were crucial differences in the treatment model, however, it is not claimed that this intervention was DBT. The intervention was shorter than DBT, lasting eight months. Telephone contact was not available to patients, not all patients were in the same kind of individual therapy and the group therapists also conducted individual therapy with some but not all of the patients. Importantly, Linehan (1993) warns against diluting the model and not attaching the same expectations of treatment success, in terms of reduction of suicidal behaviours and use of services, to treatment models which do not include all the components assumed to be critical in the DBT model. It was felt, however, that in the absence of alternative treatments for this population and within the realities of an NHS setting characterised by shortage of time and resources, it was worth devising a simpler and shorter intervention as an adjunct to existing treatment. Certainly, the same claims for expected clinical outcomes were not made.
A group treatment was chosen for the same reasons as in DBT; that is, it is difficult to teach skills in individual therapy with patients who experience frequent emotional crises. Clinical experience indicated that those crises need to be discussed in detail in individual sessions, lack of attendance to them being experienced by the client as rejection or indifference on the part of the therapist. The group structure was proposed as a means of facilitating, supporting and reinforcing positive changes, as well as a vehicle for generating alternative solutions to individual problems through sharing experiences. Further, it was felt that the experiences and process available in group therapy may have extra benefits in relation to shared emotional experiences, the experience of universality, installation of hope etc. (Yalom, 1995). Consequently, although the group was focused on skills training, shared experience and emotional expression was also encouraged; the time-table of teaching and exercises was not totally fixed but partly responsive to the issues and feelings brought by the group members.

The idea was to provide a focused, time-limited group aimed at developing skills specifically to reduce self-harming and suicidal behaviours. This aim was explicitly stated to group participants. The ethos of the group was to provide an experience that was validating of emotional experiences but actively did not condone the use of self-harm as a means of regulating these experiences. The group focused on the 'here and now': although reference was made to the origins of current emotions, self-images and beliefs in childhood experiences, the details of these experiences were not specifically discussed. The ethos of the group was on balancing acceptance and change, and on considering the consequences of behaviour, rather than value judgements, particularly regarding self-harm itself.

The model was faithful to traditional cognitive-behaviour therapy in terms of requiring the explicit commitment of participants to a collaborative relationship aimed at promoting skilful responses, based on detailed analysis of behavioural and cognitive patterns, and requiring their active participation in within-session and homework tasks. This was achieved through a combination of teaching, group discussion and exercises.

The model differed from traditional cognitive-behaviour therapy by its emphasis on emotional awareness, developing trust in one's own emotions and the validation of
emotional experience. Here, reference to biological/evolutionary theories of emotion was made, deviating from the traditional cognitive-behavioural model which tends to see emotions as products of cognitions. Consequently, the group may be described as an "emotionally-focused intervention" (Greenberg & Safran, 1989). Links between primary and secondary emotions were explored, along with self-evaluations linked to emotions and mood-dependent core beliefs about the self. One aim was to increase awareness of primary emotions and their functions, in order to promote self-validation of emotional experience and exploration of more adaptive coping responses stemming from primary emotional experiences. A further aim was to increase skills in tolerating painful emotional experiences, whilst reducing maladaptive mood-dependent behaviours.

4.2. PROCEDURE

After reviewing the current literature on DSH, parasuicide and treatment approaches for BPD, the intervention approach was designed. Dr. A. MacLeod (Senior Lecturer - Royal Holloway College, University of London) was asked to supervise the group process and intervention, and agreed to provide regular supervision sessions.

Information about the proposed intervention was given to other professionals within the Trust and procedures for communication and dealing with emergencies agreed. Referrals were requested. Once referrals had been received, a number of patients were assessed by clinical interview and a group of possible participants were identified. Standardised measures were administered to each.

The group was carried out in the form of weekly sessions lasting one and a half hours each, including a brief coffee break. The group continued for thirty-three sessions.

Teaching sessions were carried out with nursing staff from the acute psychiatric wards on the following areas:

1. Sexual Abuse - Sequelae, Theories and Treatment Issues
2. Theories of Suicide, Parasuicide and DSH
3. Approaches and Issues to Treating Suicidal Behaviour and DSH.
Following completion of the group intervention, repeat measures were taken. Two weeks after the last session of the group, satisfaction questionnaires were sent out to all participants, to be returned anonymously.

4.3. GROUP PARTICIPANTS

Participant 1

A woman in her 30's, mother of two, with a psychiatric history dating 10 years. She was initially diagnosed with postnatal depression, but the diagnosis developed over the years to personality disorder with mood swings and anger control problems. She had nine admissions (including 6 months on a locked ward in the year preceding the group), with a history of angry outbursts and violence to hospital staff, police, and threats to kill her ex-husband and a Consultant Psychiatrist. Her history of DSH included frequently cutting her legs, medication abuse and two overdoses (in the 6 months preceding the group).

Background:

She reported witnessing violence between her parents and experiencing physical abuse and emotional rejection by her mother.

At the Start of the Group:

DSH consisted of weekly incidents of cutting legs, two recent overdoses (but called for help herself). She was going through divorce and separation from her children, living alone for the first time in her life. She had also been banned from the local psychiatric unit due to her violent behaviour and routine admissions were dealt with by a forensic unit in a neighbouring district.

Other Treatment:

She was receiving support from a Social Worker (SW), a Community Psychiatric Nurse (CPN) and a Community Support Worker (CSW). She was in individual therapy with Clinical Psychologist 1 and attended a community resource centre for weekend support (from about half way through the intervention).

Participant 2:

A woman in her 50's, living alone, with a 30 year psychiatric history. She was diagnosed with personality disorder (described as inadequate, emotionally
unstable/impulsive, dependent). She had been admitted more than 15 times, due to depression, social isolation and DSH, cutting her body often in a frenzied way. At least six overdoses were recorded (but she called for help herself). She had been treated in a therapeutic community for one year.

**Background:**

She reported sexual abuse during childhood by a family member and traumatic grief following the abuser's death. She also reported emotional rejection by her mother.

**At the Start of the Group:**

She was harming herself by cutting approximately twice a week, with frequent periods of active suicidal intent.

**Other Treatment:**

She was attending the Day Hospital and had regular Art Therapy sessions.

**Participant 3:**

A woman in her late 40's, with a psychiatric history of 4 years including five admissions. She was diagnosed with recurrent depression characterised by suicidal ideation. She had three serious overdoses in the past, leading to protracted spells in general hospital.

**Background:**

She reported being abandoned by her mother and brought up by other family members, who tried to hide her true identity. She reported sexual abuse by another family member. She married and coped well until incidents at work triggered re-experiencing of feelings from childhood.

**At the Start of the group:**

She presented with frequent periods of active suicidal intent and attempts to overdose, walk under trains etc..

**Other Treatment**

She was attending the Day Hospital and had individual sessions with a Clinical Psychologist 2. (Although she did not present with frequent DSH as such, it was felt that she would benefit from this treatment approach).
Participant 4:
A woman in her early 20's with a three-year psychiatric history, including four admissions. She was diagnosed with personality disorder with obsessional features and periods of depression. She had overdosed once and presented with frequent, serious DSH by burning skin with boiling water, matches, iron etc.. She reported periods of active suicidal intent and of flashbacks to childhood sexual abuse sometimes resulting in attacking her partner.

Background:
She reported severe sexual, emotional and physical abuse throughout childhood, perpetrated by her mother and others.

At the Start of the Group:
DSH was weekly but had stopped two weeks before the group commenced. She was doing voluntary work and living with her partner.

Other Treatment
She was attending the Day Hospital and had weekly sessions with Clinical Psychologist 1.

Participant 5:
A woman in her early 30's with a two-year psychiatric history, including six admissions. She was diagnosed with personality disorder and presented with depression. She had taken six overdoses and frequently harmed herself, including cutting, burning with cigarettes etc. There were also incidents of uncontrolled anger leading to violence to others and damaging property.

Background:
She reported physical abuse and rejection by her mother during childhood, but had great difficulty describing and communicating her experiences.

At the Start of the Group:
She was an in-patient, following a recent overdose, presenting with twice weekly DSH.
Other Treatment:
Individual therapy had been tried but she refused or was unable to speak to the Clinical Psychologist 2.

4.4. MEASURES
Measures were taken at the assessment stage, before the group commenced and at the end of the group. The measures used were as follows:

1. Social Problem-Solving Inventory - Revised (SPSI-R) (D’Zurilla & Maydeu-Olivares, 1994)
2. Assessment of Problem Severity and Effect on Role Performance (see Appendix IV)
4. Beck Scale For Suicide Ideation (BSS) (Beck & Steer, 1991b)
5. Satisfaction Questionnaire (see Appendix V).

4.5. CONTENT OF GROUP TEACHING
The areas covered were as follows:

1. PROBLEM-SOLVING AND ALTERNATIVES TO SELF-HARM
Building commitment and motivation to change through the non-judgemental consideration of the consequences of harming oneself or not

   -this approach is similar to motivational interviewing and entails analysis of the pros and cons of behavioural choices.

   Behavioural analysis of events and patterns leading to self-harm, through detailed diaries

   -the aim was to develop an understanding of the patterns of thoughts and emotions occurring between a triggering event and the act of self-harm (from clinical experience, people often describe the triggering event and the self-harm as if there were no process of mental events between them. and often seem to lack awareness of the process of events between them)
-to analyse the triggers for self-harm for the individual.
Identification of possible alternative coping strategies to self-harm.
Generating commitment to trying alternative strategies.
Analysis of success, i.e. the urge to harm not carried out, an alternative coping strategy carried out or a triggering event coped with in a different way, through diaries. Successes were “shaped” through reinforcement in the group of even partial success.
Prediction of impending triggers likely to lead to self-harm and planning of alternative responses.
Identification of individual difficulties i.e. emotion tolerance problems, problems in self-evaluations etc., from analysis of the diaries.
Emphasis on breaking the normal chain of events evident in the diaries, to avoid self-harm.

2. EMOTIONS
Developing knowledge about the nature and experience of emotions, through teaching and discussion of diary material
- distinguishing primary from secondary emotions and the association of secondary emotional reactions with judgements about primary emotions
- developing knowledge about the triggers, functions and ways that emotions may be expressed
- developing skills to promote positive emotions, by introducing positive activities into daily lives
- gradually increasing sense of control over emotions and experience of positive feelings being created both in and outside the group
- developing skills to reduce emotionally relevant stimuli that set off secondary reactions or perpetuate emotions.

3. AWARENESS AND FOCUSING ON MENTAL EVENTS
This section was aimed at:
-developing an awareness of the nature of states of mind in which emotions take over from reasoned responses, leading to mood-dependent behaviours

- developing skills in awareness of, labelling and describing internal mental events. This was carried out through teaching and group discussion. The rationale for developing these skills was:

1. Naming and describing mental events in itself can be a containing and calming process

2. Conscious awareness of mental processes seems to allow for more conscious choice about how to react to them and allows for conscious self-instruction.
   - distinguishing beliefs, emotions, physical sensations and action urges.
   - developing skills in accepting the experience of these events non-judgementally, through teaching about emotions and group discussion.

The aim was for group members to develop a greater ability to tolerate the experience of problematic feelings without action. This was achieved through teaching about emotions, discussion and shared experience in the group and practice, which was reinforced within the group. A further aim was for participants to expose themselves to emotions previously avoided.

4. COGNITIVE RESTRUCTURING

This section included:
- identification of beliefs about self or about emotional reactions leading to self-harm

- re-evaluation of those beliefs in relation to teaching on emotions and in relation to recognition of invalidating childhood experiences.

Group leaders and group members questioned others’ interpretations of the meanings of events in their lives or self-evaluations that lead to self-harm (usually self-blame, self-disgust etc.). Alternative interpretations were suggested and discussed.
5. RELATIONSHIP SKILLS

These included:
- identifying relationship between DSH and experiences in relationships
- identifying personal difficulties with relationship skills i.e. assertiveness.

Teaching and exercises in specific relationship skills included:
- recognising when demands are unbalanced
- assertiveness skills
  - saying no
  - holding on to a point of view
  - resisting pressure
  - opening a discussion
  - making a request
  - communicating one’s needs etc.

4.6. GROUP PROCESS

Aims: The primary aim of the group was to reduce self-harming behaviour. One of the central methods was the problem-solving approach to self-harm taken throughout, consisting of the non-judgemental analysis of the consequences of any behaviour and the alternatives for the individual within their own terms. This involved fostering a collaborative relationship with the group members in which their own responsibility for their behaviour was stressed. Further, the facilitation of discussion and sharing of experiences was aimed at broadening views and reducing extreme beliefs and behaviour. Repeated teaching, practising and detailed behavioural analysis was aimed at changing negative patterns and replacing them with more skilful responses.

Main Aims of Section One (Sessions 1 to 8):

For group participants:
- to engage in a collaborative relationship with group leaders, committing themselves to the aim of stopping harming themselves
- to understand the model of self-harm and that responsibility for self-harm remains with them
- to develop "mindfulness" skills, including observing, describing and participating without self-consciousness; one-mindfully, effectively and non-judgementally
- to explore alternative coping strategies to self-harm
- to begin to use their observation skills to develop a better understanding of the patterns of events leading to self-harm.

Session 1: 7 attended

Introductions were made and ground rules decided:
- 8 weekly sessions initially, then a break
- commitment to learning and change
- missing 2 sessions would necessitate a review of attendance
- confidentiality, homework etc.

The model of self-harm was explained, that the basis of DSH lies in painful feelings and problems that are difficult to solve. The approach that would be taken in the group was clarified, including that
- it is up to them to solve their own problems
- we are not telling them life is worth living as it is but that we are aiming to improve things
- the emphasis is on developing skills.

Reactions to this model were elicited: most described experiences of being seen as attention-seeking, feeling poorly understood etc.

A description of the skills that would be taught in the group was given.
Homework: something like smell/taste/touch of to bring or describe next week.
Session 2: 6 attended

Review of homework:

Group members seemed to find the idea amusing and interesting. A few brought in things that were perhaps “too” significant, e.g. a photo of children that she was separated from. Others brought in things like a ring, a teddy bear and a plant. The group leaders brought in coloured stones.

"Mindfulness" skills were explained, e.g. taking control of your mind, what you are thinking, feeling etc. (Mindfulness Handout 2: “Taking Hold of Your Mind, ‘What’ Skills” (Linehan, 1993 –p.111).

The differences between being in a state of mind overwhelmed by emotions and one in which one has awareness and choice were discussed. Experiences of being taken over by emotions were elicited, especially relating to self-harm; members of the group expressed helplessness regarding certain emotional states.

This led to an unexpected discussion of the negative consequences of self-harm e.g. clothes, relationships, perceptions of others, and a recognition that motivations may be different in different states of mind. This helped make sense of mindfulness, i.e. skills that make alternatives to self-harm available when emotions are strong.

Reasons for learning to observe and describe mental events were explained and observation exercises were carried out, e.g. noticing the feeling of one’s hand on rough cloth and then smooth wood.

Homework: observing self and experiences at a chosen time.

Session 3: 7 attended

Homework review: group members reported varied experiences in completing the homework, some found it difficult to focus on the details of experience. The principles were explained and rehearsed again.

Group “potato race” exercise (an example of having to focus one's mind on just one thing) was carried out.

Participants thought this exercise was hilarious and that the psychologists
should be the patients instead of them. They also recognised the point of the exercise regarding having only one thing in your mind.

States of mind and examples of when we do things without awareness were discussed further. Group participants gave their own examples, such as driving, housework, smashing things up and, for some, self-harm.

Identifying thoughts, feelings, sensations etc. was discussed, using examples, e.g. the thoughts, emotions, physical sensations in response to being in ward round but not feeling brave enough to say what one had wanted to the doctor.

Homework: self-awareness exercises at a chosen time or situation.

Session 4: 5 attended

Homework review: Group members reported mixed success.

One said she had been in bed all the time so there was no way to observe mental events. We debated whether she could observe the sensations/experience of being in bed, but she insisted that she needed a particular time or marker to do this. We suggested that she could do the observation exercise when she went to the toilet.

The group seemed to find this funny and bizarre and the tension in the discussion was broken. We tried to use this as both meeting her resistance to the exercise and implicitly as an example of a problem-solving approach.

Awareness exercises were carried out in the group, e.g. noticing a shape that they liked in the room, noticing what thoughts enter their minds as they look around the room (we tried to work gradually from observing more tangible, sensation experiences to more abstract thoughts and emotions).

Distinguishing between what we think and what we "know" (facts and judgements) was described. An exercise in describing a squashed tomato and an old banana was carried out (i.e. they debated what we could say as a fact about the banana, e.g. brown, old, soft, versus what was judgement, e.g. tasty, inedible etc.). (Mindfulness Handout 3: “Taking Hold of Your Mind, ‘How’ Skills (Linehan, 1993 –p.113)).

The distinction between describing events and making judgements in interpersonal situations was clarified. The distinction between observed consequences and judgements
was made clear. The unwanted consequences of self-harm (e.g. scars, other people's prejudices) were discussed.

Experiences of invalidation, leading to difficulties in accepting emotional experiences, were volunteered by participants (e.g. parents who said they should be grateful not angry etc.).

Homework: observing mental events at a chosen time or situation.

Session 5: 5 attended

Homework review: Thoughts (beliefs/judgements), sensations, emotions and action urges were distinguished. Difficulties distinguishing thoughts from emotions were discussed.

The rationale behind learning these skills was explained, i.e. that distinguishing what is happening can lead to change, e.g. accepting a painful emotion more easily, rethinking interpretations that lead to DSH etc.

Awareness exercises were carried out and exercises in distinguishing mental events, through the presentation of participants' examples. Having an emotion but not having to act in order to get rid of that emotion was emphasised and therefore that self-harm need not be "inevitable", if certain emotions are present. This lead to a discussion of times when they had successfully diverted themselves from DSH and a discussion of the expression of anger (often they had carried out destructive acts instead of DSH).

Homework: observing mental events at a chosen time or situation.

Session 6: 5 attended

Homework was reviewed and awareness exercises practised.

Emotions that participants thought they should not feel, e.g. anger, fear and sadness, were discussed. Related negative self-evaluations leading to self-harm were identified, such as "I should be better than this", "I should be grateful not angry", "I have no right to be angry", "everyone else copes without feeling like this".

These beliefs were not specifically challenged by the group leaders at this stage, because to do so seemed too threatening. The challenge was implicit in the way group participants themselves discussed them.
New ideas for strategies to help with DSH were introduced and discussed, mainly focusing on distraction e.g. doing something physically active, absorbing or pleasurable. (Distress Tolerance Handout 1: “Distracting” (Linehan, 1993 –p.166)).

Homework: practising distraction strategies.

Session 7: 5 attended

Homework review: Emphasis was placed on finding strategies that work for the individual, rather than that all strategies should work for everyone (participants tended to give up altogether if they had not found those tried out immediately useful).

We explicitly stressed that self-harm tends to be a very powerful release of feelings and that no other strategy would be likely to match this, and that in part we were suggesting to them that they tolerate more of the painful feelings self-harm released them from. This point had to be stressed repeatedly, as participants often said that a strategy had not worked because they still felt distressed or still had an urge to harm themselves.

Awareness exercises carried out.

More strategies for DSH were given and discussed (Distress Tolerance Handout 2: “Self-Soothe” (Linehan, 1993 –p.167)). Participants identified ones they have used or could use.

Two incidents of DSH presented by participants were discussed, including identifying the main triggers, links with self-evaluations, sequence of external and mental events (e.g. one example was a chance meeting with ex-husband, with feelings of sadness and anger, then hatred, thoughts of “I can’t cope”, the urge to beg him to stay, self-harm as coping strategy).

Participants discussed their anger regarding recent news reports about child sexual abuse. Alternatives to DSH were discussed, focusing on "self-soothing".

Homework: 1. list of strategies given and participants asked to identify ones they could use

2. asked to begin filling in a diary of incidents of DSH (see Appendix III).
Session 8: 5 attended

One person's diary discussed in detail, introducing a more detailed diary for homework. Examples for filling in the diary were completed on the black-board. The rationale for the diary was presented, i.e. as a means of finding out what works for them and keeping a record of their successes. Using the diaries to cope was encouraged, i.e. by asking whether, looking back, they see any other way of coping, asking for suggestions from other group members etc. Ratings of the urge to self-harm were made with any incident noted in the diary and incidents where the urge had not led to actual self-harm were heavily reinforced within the group.

Participants expressed anger again regarding prominent media reports of child sexual abuse. They reflected on experiences of injustice and difficulties with anger, “just world” ideas were discussed.

An awareness exercise “Washing-up as Contemplation” was used to demonstrate "one mindfulness" (Linehan, 1993 –p.175) and with bubbles to demonstrate observing mental events without attempting to alter or hold onto them etc. Teaching on observation and description of mental events and mindfulness was reviewed, summarising:

- painful feelings
- invalidation
- difficulty coping with feelings
- ‘emotion mind’ and ‘reason mind’
- mindfulness and what it is for
- labelling and description of emotions
- judgements and tolerance of emotions

This seemed to lead naturally to a commitment to identifying new strategies.

Each person picked out about 5 alternative strategies to DSH each, wrote them on a card and a commitment to try them was elicited

  e.g. one person focused on practical activities such as “phone a friend”, “play loud music” or “go for a walk”, another focused on self-instruction and self-soothing such as “remembering that people do love me” and “touch a piece of soft material” etc..
When asked what they would like in the subsequent sessions, they identified anger and accepting an unjust world. Topics to be covered in subsequent sessions were explained, including balancing emotions, problem solving etc..

**Break of Three Weeks**

**Aims of Section Two (Sessions 9 to 17):**

For group participants:
- to develop an understanding of the nature and function of basic human emotions, including anger, sadness, fear etc..
- to understand the relationship between primary emotional experiences and secondary reactions to them, relating to negative self-evaluations.
- based on this understanding;
- to develop their ability to tolerate and accept primary emotional experiences, without perpetuating or avoiding them
  - to challenge secondary reactions to them
  - to reduce avoidance of painful experiences
  - to reduce panic and the belief that it is necessary to “get rid” of painful emotions by harming oneself.

**Session 9: 5 attended**

Diaries and incidents of DSH were discussed in detail, along with which coping strategies worked.

The group said goodbye to one member who was starting a college course that clashed with the timetable of the group. There had been no warning that this would happen. She had been studying on a course which did fit in with the times of the group but had not been managing the work well. She appeared distressed and had not wished to attend this session at all. She did not speak within the group and left at tea break. Other group members appeared to feel
anxious and overwhelmed by this, especially because she sat without speaking or making eye-contact. Group members seemed to feel helpless. We tried to manage the situation by expressing our own feelings about her leaving the group and prompting others to do the same. At that moment it seemed best to model a way of identifying and expressing uncomfortable feelings, whilst moving things forward for the group. We felt it most important to preserve the comfort of the group for all concerned, including that member, in case she was able to come back (which she did) and therefore we intervened gently, allowing some degree of bearing the discomfort whilst trying to contain it within tolerable limits.

Primary and secondary emotions were described and examples given:
- depressed about depression
- shame about anxiety
- guilt about anger and jealousy.

Triggers to emotions and associated brain and body changes were discussed. The group was presented with the following ideas:
- emotions come and go
- emotions can be self-perpetuating i.e. by triggering memories of similar experiences etc.


Session 10: 3 attended (one member explained her absence the following week as due to spending time in bed, this could have been a reaction to emotional discomfort the week before)

Diaries, successes with coping strategies, primary and secondary emotions were reviewed.

One member expressed strong suicidal urges:
- the trigger identified was the experience of rejection by family, leading to
negative self-evaluations

- other participants disclosed having cut ties with punishing relatives to protect themselves from rejection.

This seemed to be an important moment in the group especially for one member, for whom most admissions/overdoses had been triggered by experiences of rejection. The discussion in the group offered both support but also the possibility of alternative ways of dealing with the family. Her story was met with empathy but also by hopeful challenge by the group who had all struggled with similar emotions.

This lead to disclosure by all group members of abuse and invalidation in past and sadness about childhood experiences, also expression of feelings regarding the group itself, i.e. of safety and comfort.

An exercise was introduced of bringing a positive experience to mind and describing positive feelings.

We were surprised by how well they were able to do this after discussing such painful areas. We felt it was especially important to close the subject well and to leave with something more positive in mind.

Homework: DSH diaries.

**Session 11: 3 attended** (different person missing this week due to holiday)

Diary review: sequences of events leading to DSH and coping strategies were discussed.

An exercise to bring recent experience of anger to mind was introduced. One disclosed an experience of loss of control of anger (leading to harm of another) and fear of losing control was acknowledged by all. Disclosures of rejection by care givers leading to anger were made. Triggers for anger were identified i.e. rejection, loss etc., and feelings associated with anger were discussed.

A role-play debate was carried out, arguing for and against being angry and expressing anger (those with most difficulty accepting and expressing angry feelings were asked to argue "for" and vice versa). The group responded very well to this exercise and came up with many points on either side.

Session 12: 2 attended
Diary review: Predicting trigger situations and preparing coping strategies was emphasised.

Teaching on anger continued, covering:
- the functions of anger
- the fight or flight response (requested by one participant)
- the issue of anger being difficult to accept
  i.e. - past invalidation
  - fear of losing control
  - negative self-evaluations.

Both gave recent examples of anger leading to appropriate action.


Session 13: 4 attended
One member disclosed that they stayed in bed the previous week and missed the group; bed as a coping mechanism was discussed, including the pros, cons and possible consequences.

We took this opportunity to demonstrate a problem-solving approach i.e. analysing the pros and cons of sleeping or not sleeping all day as a means of coping, as opposed to judgements about it. This seemed to locate the decision about coping back with participants.

Diary review: two were grieving the deaths of friends and one expressed suicidal ideation. The experience of sadness was discussed.

Areas covered in previous session (i.e. anger) were explained for those who had missed it. The ‘fight or flight’ response plus avoidance was described again (at members’ request).

The purpose of anger was discussed:
i.e. organising action, protest at injustice etc..

The idea of emotions as self-validating was introduced.

Homework: DSH diaries.

Session 14: 4 attended

Diary review: One member expressed suicidal thoughts relating to grief, support was given by other members and alternative coping strategies were discussed.

Sadness was discussed, giving examples of the following:

- describing/labelling
- triggers
- interpretations
- feelings
- expression.

The issue of being sad about something you hoped for or something you never had, was raised by participants, e.g. "a good mother".

This seemed to be an important moment of validation for one member who had always felt she could not grieve her relationship with her mother because her mother was alive.

Functions of sadness were identified by participants, including:

- to contrast with happiness
- to signify what is important to you
- a necessary part of attachment
- to enable people to feel empathy
- part of the process of grieving and adjustment to loss.

They had great difficulty with this initially, viewing sadness as unnecessary and painful, but then gradually the list emerged.


Session 15: 4 attended
Diary review: Two participants reported suicidal thoughts.

The work on sadness was reviewed, which brought out feelings of sadness and loss underlying their suicidal thoughts. We called upon their previous commitment not to act on these urges and planned alternative coping strategies for time alone.

Session 14 and 15 seemed important for one member who first described feelings of sadness about separation from her children (in individual session).

Fear was discussed, including:
- describing/labelling
- triggers
- feelings
- interpretations
- expression
- ‘fight or flight’ response and avoidance.

The issue of fear of other emotions was brought up by group participants, especially anger and sadness, leading to avoidance of triggers and conflict situations.


**Session 16: 3 attended** (one person admitted to locked ward)

Diary review:

One person discussed having been admitted for 10 days but without harming herself, leading to a discussion of the function of self-harm to express needs and ensure care. Two "confessed" to having purposefully harmed themselves to ensure care in the past; one member acknowledged once taking an overdose because she feared that people would expect her to be better and get a job otherwise; she had not felt she could communicate her needs or wishes in any other way.

The way that services respond to crises was acknowledged by the group leaders i.e. that threatened or actual self-harm is often the only way to get help or protection from
services. The possibility of communicating one’s needs and ensuring a response without self-harm was discussed.

Shame was discussed, including:
  describing/labelling
  triggers
  feelings
  interpretations
  expression.

Participants brought up the issue of feeling shame in response to perceptions of being abused, deceived, trusting and being betrayed.


Session 17  3 attended (one member remaining in locked ward)
Diary review: One member reported a week without DSH since the group began. Positive coping strategies were identified including the use of appropriate help-seeking and small targets.

The list of pleasant events was discussed (Linehan, 1993 –pp.157-159); participants added their own and chose the ones they liked. We compared and contrasted different preferences. The need to increase pleasant events in life and the effects on mood were discussed. Choosing one positive activity per day, plus setting small daily goals and noting achievements was recommended. Participants discussed their own examples.

Homework: 1. Choosing one pleasant activity to try each day
   2. Identifying any future goals for pleasant events/activities/achievements to bring into own life in future, to be discussed in following group.
Aims of Section Three (Sessions 18 to 22):

For group participants:
- to experience and understand that they have the ability to create positive emotions.
- to develop skills and habits in creating and noticing positive experiences and identifying hopes for the future.

Session 18: 3 attended (participant who was in hospital able to attend but another member did not in order to avoid her; these two, who had been friends, “fell out” regarding the way they had used each other’s support, especially regarding self-harm. This was known through individual sessions and worked on there, rather than in the group).

Review of pleasant events, activities and future plans: positives were identified e.g. painting nails, seeing flowers, seeing children, getting out of cooking, reading magazines.

Review of daily goals: effects on mood were discussed.

Several found it difficult to identify ideas for goals for the future but were encouraged by the rest of the group.

Session 19: 3 attended

Diary review: We returned to a detailed discussion of diaries, identification of coping strategies, goals and pleasant activities.

The reasoning behind creating positive feelings was reiterated.

Session 20: 3 attended

The rationale and practicalities of creating positive feelings was discussed again, with participants examples.

A problem-solving approach was used to work through obstacles to positive activities.

Coping strategies were revised.
Session 21: 4 attended

Mindfulness skills were revised through exercises.
The discussions of the nature of emotions were revised.

Session 22: 4 attended

Judgements versus observations were revised.
Anger and sadness were revised.
Coping over the Xmas break was discussed.

Xmas Break 3 weeks

Aims of Section Four (Sessions 23 to 33):

For group participants:
- to recognise the kinds of negative patterns in relationships which create negative feelings and relate to self-harm.
- to recognise their own difficulties in communication in relationships.
- to develop and practise assertiveness and communication skills.
- to identify and challenge the negative beliefs and self-evaluations underlying difficulties with assertiveness.

Session 23: 5 attended (the person who had left several weeks ago returned)

The impact of the break was discussed; participants said they had missed the group.
The effects of expectations/disappointments on emotions were discussed i.e. Christmas.
Diary review: One person had been admitted for 6 days over New Year, without DSH, and she felt that the admission was well handled. Another had frequent incidents of self-harm that week, was readmitted to the Day Hospital, and was feeling a failure. The others encouraged her to accept help and not to judge herself badly for her difficulties.

Positive activities were reviewed, obstacles and lack of commitment challenged.

A new topic was introduced: identifying difficult situations in relationships
Participants discussed their reactions to such difficulties, e.g. withdrawal/hopelessness.

**Session 24: 5 attended**

Diary review: One member’s refusal to eat was recognised as self-harm and discussed, with other members volunteering the likely consequences for her.

We had planned to work on relationship skills but, during tea-break, participants had been discussing getting worse “consciously” at times, because “if you get a little better people expect you to get completely well”.

We treated this as an opportunity for a problem-solving exercise; all chose “explaining their fears to others” as the most sensible solution but felt it was difficult to implement. DSH and suicide were treated as possible solutions but none of the group members criticised suicide as a coping mechanism and said that they had not committed suicide only because it was too difficult to do successfully.

-We refrained from arguing this point, which was probably an omission. With hindsight, we could have called upon their previous commitment to trying to find alternatives. I think we were shocked to experience so rigid a pro-suicide argument at this stage.

Homework: Identifying two situations successfully handled and two unsuccessfully handled from asking for something, opening a discussion, holding on to a point of view, saying no etc.

**Session 25 5 attended**

Diary review:

- several incidents of self-harm and violence to property were discussed
- commitment to change and validation of anger were discussed.

Homework review:
- successes and failures in interpersonal situations were discussed
- the idea of attending to relationships by 'balancing demands/responsibilities with ones own priorities/wishes was introduced
- participants generated examples of the effects when relationships are unbalanced and seemed to strongly recognise these kinds of problems.

   Surprisingly, the main subject then generated was their experience of demands from services:
   - "to be cheerful"
   - "to be responsible with medication"
   - "to get better".

   Recognition was also demonstrated of
   - difficulties regulating demands leading to "blow ups", shutting off and cutting all ties, self-harm, overdose etc.
   - too few demands leading to emptiness and hopelessness.

   It was suggested that interpersonal skills are needed to balance 'shoulds' and 'wants'
   i.e. asking for something
   starting a discussion
   making a request
   saying no
   resisting pressure
   keeping hold of your point of view.

   We experienced difficulty getting them to talk about personal relationships, although difficulties in these relationships were frequent triggers to DSH. It seemed to be a threatening subject and may have been deflected by the attack on "demands" from services.

   Homework: (as before) to look for situations that successful with and situations that are difficult over the week, plus Interpersonal Effectiveness Handout I (Linehan, 1993 – p.115).
Session 26: 5 attended

Diary review: One person encouraging the others to follow her in asking her local chemist not to sell razor blades to her and to get rid of ones she had at home. Participants discussed keeping tablets as an "escape route", versus creating the temptation to use them. This lead to a discussion of whether DSH and suicide are "inevitable". 

Homework review: Situations in which they asserted themselves well were identified; participants mainly focused on requesting help from services. The "bill of rights" (Powell, 1992 – p.51) was introduced and met with a lot of silence and thinking. Participants chose “taking responsibility for others’ problems”, as an area for discussion. They began to discuss this in absolutist terms: the issue of choosing when to use rights and when not to, was introduced by the therapists.

Relationships seemed a very touchy issue and this was a very difficult session.

Homework: Identifying which situations are difficult and what stands in the way of using their ‘rights’ in relationships.

Session 27: 5 attended

Diary review: Two people discussed using DSH/overdosing as a means of influencing others, i.e. as a means of avoiding conflict and as a means of getting one’s needs for care met (one person admitted to taking an overdose to get her husband to return). The other two people discussed the urge to harm themselves in order to keep others at a distance, in one case to feel safe from sexual attack by mutilating her body. Other group members challenged the thinking behind this and suggested other interpretations of why someone might be attacked sexually.

This was a very powerful session with painful issues tackled. We felt it had to be handled delicately and tried to end the session by identifying alternative ways in which someone might experience a sense of control in such a situation, by suggesting whether other means of keeping a distance or feeling safe could be found.
Problem-solving exercise were carried out on ways to feel safe from attack.

Session 28: 4 attended
The timing of the ending of the group was discussed.
Diary and homework review: Dealing with interpersonal situations and exercising assertiveness rights were revised.
The issue that participants noticed was the right not to feel responsible for others’ needs and introduced the scenario of when someone turns to you and threatens DSH or suicide.
This was almost surreal for the psychologists because a lot of what they were describing sounded very much like themselves but they did not seem to be aware of this. We did not comment on this because it seemed far too threatening. This could be interpreted as an unconscious communication about the ending of the group.
Emotional reactions and boundary issues were discussed. Problem-solving exercise were carried out regarding possible responses. Obstacles and cognitions regarding boundary issues were challenged, e.g. “I must always be available to help a friend”, “I should always be able to solve someone else’s problems”.

Session 29: 5 attended
Interpersonal effectiveness exercises were reviewed, each person suggesting challenges to non-assertive responses. Different situations that make assertive behaviour more difficult for each person were identified, i.e. dealing with authority figures or emotionally significant others.
Beliefs underlying non-assertive behaviour were identified and challenged, e.g. “saying no is rejecting someone”, “it is bad to put your needs first” etc.
Carrying out one piece of assertive behaviour e.g. make a request.

Session 30: 5 attended

Aggressive versus passive versus assertive behaviour was discussed, and the pros and cons of each. Examples of different situations in which each are used were generated. Participants identified situations in which to decide to tolerate rather than assert i.e. “lost causes” (for several this was with parents). Coping with rejection was discussed, i.e. if the relationship feels like a lost cause and that you will never get what you need from it, working towards acceptance.

Homework: carrying out assertive behaviour as chosen in the group.

Session 31: 3 attended

Homework review: Examples of assertive behaviour carried out over the week were reviewed; successes, feelings and beliefs were described.

Feelings about the ending of group were discussed and subjects they wished to discuss again before the end were identified; assertiveness and self-evaluations were chosen.

Session 32: 5 attended

A review of the assertiveness homework and revision of assertiveness in general was carried out; all the teaching points were reiterated.

The group carried out a problem-solving exercise about the consequences in life if either passive, aggressive or assertive behaviour were used. Obstacles to assertiveness were discussed further and difficulties with negative self-evaluations were identified as the main problem. These evaluations were identified and analysed.

Feelings about the ending of group were discussed again.

Session 33: 5 attended

Participants gave the psychologists presents and everybody spoke about what they would miss about the group. Future plans and hopes were discussed, along with successes and changes that participants had been able to make in the group.
Participants expressed many positive feelings about being with the other members of the group, i.e. feeling safe and supported enough to bring up painful subjects.

The "Washing-up as Contemplation" exercise was repeated.

The psychologists summarised the main approaches to DSH taken during the group and expressed their hopes for the participants in the future.
### 5. RESULTS

Results of the Interpersonal Problem-Solving Inventory -Revised: Pre- and Post Treatment:

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<th>Participant 1</th>
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(Higher scores may be positive or negative depending on the subscale).
As is shown in the table above, scores on the SPSI-R form a complex array. All participants showed gains in some areas but also some areas of deterioration. Participant 1 showed deterioration in both positive and negative problem orientation, solution implementation and impulsivity improved however. Participant 2 improved on positive problem orientation but not on negative problem orientation, with a slight improvement on practical problem-solving skills (generation of alternative solutions, decision-making, solution implementation and verification) and reduction in impulsivity. Participant 3 improved on nearly all scales. There was little change evident on the scores of participants 4 and 5, except improvements in decision-making for the former and in practical problem-solving and impulsivity for the latter.

**Results of the Beck Hopelessness Scale: Pre- and Post Treatment:**

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<tr>
<th></th>
<th>Pre-treatment</th>
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<tbody>
<tr>
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<td>Participant 5</td>
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(Higher scores indicate greater hopelessness).

(Scores between 9 & 14 are “moderate”, over 14 are “severe”, maximum score is 20)

The group members seem to score highly compared to the data provided by Beck et al (1985): in their samples, those with recurrent episode depression (n = 72) scored highest with a mean score of 10.37 (s.d. 5.70). The scores for group members may be greater because they were chosen for the group on the basis of a history of severe depressive episodes and serious suicide attempts.

As the table above shows, differences in the scores on the BHS before and after the group varied between participants. Only two showed improvement (2 & 3), although this was clinically very significant for participant 3. Two showed increased hopelessness at the end of the group (4 & 5).
Results of the Beck Scale for Suicide Ideation: Post Treatment Only:

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(Higher scores indicate greater suicide risk).
(There are no cut-off points, maximum score is 38).

Compared to the original normative sample (Beck, Steer & Ranieri, 1988), the scores of group members are generally higher: the inpatient sample group (n = 50) mean score was 15.63 (s.d. 7.83), the outpatient sample group (n = 55) mean score was 11.23 (s.d. 6.5). These were both groups with mixed diagnoses, however, not specifically chosen because of suicidal intent, as had the sample in this group. As the table above shows, only participant 3 demonstrated a clinically low level of suicidal intent on this measure.

Results of the Personal Problem Scale: Pre- and Post-Treatment:

<table>
<thead>
<tr>
<th></th>
<th>Severity of Problem</th>
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<th>Interference with Work</th>
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<thead>
<tr>
<th></th>
<th>Interference with Leisure</th>
<th>Interference with Relationships</th>
<th>Interference with Day to Day Chores</th>
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<td>Pre</td>
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<td>Participant 1</td>
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<td>Participant 5</td>
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(Higher scores indicate greater difficulty, except for ability to cope).

As the table above shows, scores on the personal problem scale did not alter greatly between the beginning and the end of the group. In some cases the definition of the problem changed for the participant, so in fact they are rating a different problem at the second stage. This will be discussed later.

**Client Satisfaction Measure:** (see Appendices V and VI)

Four out of the five questionnaires sent were returned. All responders rated the group as “very useful” and all stated that the extent to which they had obtained what they wanted from the group was “very much”. Regarding approaches they found most useful, one participant ticked them all, whereas others ticked a variety. All approaches seemed to appeal (including “doing homework exercises”!).

Comments regarding what was found useful in the group included the seriousness with which self-harm was treated and focusing on the positives, however small. The supportiveness of the group and the degree to which participants’ experiences did not seem to be shocking to the psychologists were commented on. Learning about emotions and the effects of depression as well as learning specific coping strategies were valued. Regarding areas for improvement, suggestions included challenging more and being stricter with participants about using their diaries properly. It was also suggested that further work could be done on recognising different states of mind and on trying to be more aware of things that trigger self-harm.
Overall, it seemed that participants rated the group highly and felt that they had gained something from it. Many very positive comments were made (details are given in Appendix VI).

6. PROGRESS OF INDIVIDUAL MEMBERS

Participant 1:

She participated in the group with great enthusiasm although her attendance was poor at times, mainly due to low phases. Initially, she was challenging, i.e. convinced that it was impossible to alter emotions, that her anger leading to self-harm and aggression was a “chemical reaction” and therefore out of her control. She seemed to challenge the group leaders at times and generated many useful discussions but almost seemed to be trying to “catch us out”. She also challenged other members in a very honest and genuine way, e.g. when she suggested that another member, who claimed that she could not resist using razor blades, not buy them. It did seem that she benefited from the group in terms of learning practical skills and setting up ways of protecting herself from situations leading to self-harm. She also seemed to benefit from being in the group and developed greater sensitivity to others, after initial insensitivity. She has been able to maintain attendance at several community facilities for some months now, without behavioural problems threatening the placement and is no longer banned from the acute unit; the experience of the group may have contributed to this amongst other interventions. She has not harmed herself for more than three months (at the time of this report) and seems to have improved her communication with services such that, although she has still been admitted during crisis periods, this has not followed acting out behaviour. One issue that seems particularly important is that she seemed to develop a recognition of her underlying sadness about losses and traumas in her life which previously had been covered by anger and aggression.

She defined her problem as “manic depression” and “self-harm” at the start of the group, and as “depression” and “suicidal-homicidal tendencies” at the end of the group. Regarding the results of the standardised questionnaires, no significant improvements
were found. Her level of hopelessness and suicidal intent was generally high, and problem-solving did not appear to improve except in the area of impulsivity.

**Participant 2:**

She exhibited very entrenched patterns of self-harm and a very strong identity and life-style as a psychiatric patient. We suspected from the start that she would not improve much in the group and this was the case. Her resistance to trying alternative strategies was present throughout the group and she remained intensely dependent on services. It seemed that this dependency would have been threatened by too much improvement in self-harm. Despite this, self-harm decreased in frequency during the group and she went through slightly longer periods without harming herself than previously. She may have benefited slightly from reinforcing the issue of communicating with services rather than acting out, which the rest of her team were also promoting. She expressed a wish that the group would go on forever.

She defined her problem as "self-harm" including "overdosing, cutting, burning, scalding and induced vomiting" at the beginning of the group, and added the connection between this and depression due to sexual abuse as a child at the end of the group. Regarding the results of the measures, she scored as the same or slightly better on all aspects of problem-solving. Hopelessness was slightly improved, although coping with the problem remained the same generally, and suicidal risk remains significant.

**Participant 3:**

She seemed to benefit most from recognising that her self-harm/suicide attempts were often in response to difficulties in relationships and the self-evaluations she made consequent on this. She used the group to consider her own behaviour with great candour and bravery, such that she was able to admit how she had used it to influence others' expectations of her. In conjunction with reconsidering her beliefs about herself consequent on very destructive early experiences, she was able to develop greater assertiveness and to alter the patterns in some destructive relationships. She was not admitted to hospital during the time of the group and was discharged from the day
hospital and from individual therapy shortly after the ending of the group, and now manages in the community without harming herself.

Initially, she described her problem as “I have lost all faith in myself and look upon myself as being worthless and incompetent”. At the end of the group she had redefined the problem as “I have a fear of being forced to seek paid employment”. Regarding the results of the pre- and post-group measures, both hopelessness and problem-solving showed significant improvement. Although ratings of coping with the problem remained the same, except in the area of interfering with everyday chores, this is difficult to interpret because her definition of the problem changed significantly. Our impression is that she was able to define the problem underlying her suicide attempts more accurately during the group, as a fear of being forced to seek paid employment. This seemed to help her to minimise its effect on some areas of her life and to take more appropriate action to help with it.

**Participant 4:**

She seemed to benefit from all aspects of the group and particularly took up the mindfulness skills, finding these useful in containing flashbacks, and self-soothing, focusing and self-instruction strategies. She also developed a clearer view of how her negative evaluations in relation to early traumas created the urge to harm herself and challenged these with the help of the group, but still has great difficulty with this. She was able to recognise and express anger about her childhood experiences during the group, for the first time, which had an impact on her ability to assert herself. She experienced quite a severe relapse just after Christmas following the involvement of Social Services and the police in her family of origin, which destabilised her greatly and necessitated admission to the locked ward as her behaviour was extremely disturbed, including attempting to harm herself. Subsequently, she was able to return to the community and is able to contain her urge to harm herself for periods of months at a time. It is generally felt, however, that due to the severity of her emotional difficulties, she would benefit most from a period of intensive treatment in a specialist psychotherapy
unit. At the moment, she is not keen to pursue this and continues to experience periods of very disturbed behaviour.

At the start and the end of the group, she defined her problems as “anxiety leading to self-harm” and “feelings of inadequacy”. She did not show improvement on any of the pre- and post-group measures. Problem-solving remained the same, except for an improvement in decision-making. She expressed feeling slightly more hopeless and rated herself as the same on coping with her problems. Suicidal ideation remained high.

**Participant 5:**

She talked in the group and became engaged in the treatment approach, which she had not done in individual therapy. Unfortunately this was disrupted by her return to college in the middle of the group, so she missed a lot of the teaching and practice. She had particular difficulties with observing and describing her experiences and was just beginning to improve when her attendance was disrupted. She identified her own difficulties with coping with other people’s expectations of her, such that she used self-harm to protect herself when she feared their expectations were too high. She also recognised a pattern of trying to meet all expectations, not managing and then overdosing to escape the situation. After this group, she went on to a full time placement in a therapeutic community, run completely through group therapy. It seems likely that her attendance in this group helped her develop insight into her need for intensive treatment, her ability to engage in treatment and her commitment to this, as it was the only structured treatment she engaged in at all.

She defined her problem as “harming myself – cutting, taking tablets, burning myself etc.” at both the end and the beginning of the group. The results on the pre- and post-group measures demonstrate no significant improvements. Problem-solving and coping with the problem remain about the same, she rated herself as slightly more hopeless and suicidal ideation remained high.
7. DISCUSSION

The aim of providing an intervention which specifically addressed the needs of some of the patients who had most frequently self-harmed and required hospital admission was achieved. Not all but a number of these patients were successfully engaged in the group and continued their commitment to the treatment for many months.

This intervention was intended to comprise some of the approaches known to be most effective in treating suicidal urges and DSH. The aim was to include aspects of problem-solving approaches along with developing a future orientation. An emphasis on analysing self-evaluations and cognitions relevant to self-harm was made. A central feature was developing an understanding of emotions, in order to facilitate the development of skills in regulating and accepting the emotions which underlie self-harm. The style of intervention was also important; the psychologists attempted to model validation, problem-solving through the analysis of consequences and a non-judgemental stance throughout.

As was noted, a number of patients dropped out quite early in the group. This was not unexpected, as we knew it might be difficult to engage some patients in a group in which a commitment to reducing self-harm was so directly and explicitly required. In this sense the group was quite challenging, especially with the detailed analysis of incidents of self-harm requiring patients both to give an account of themselves and to allow others to comment on it (although this was only really carried out from section 2 of Group Process onwards). Although commitment to change was discussed and assessed at interview, and some patients were excluded from the group due to lack of commitment, some patients were perhaps not ready to tackle their difficulties directly. Others found it difficult to work in a therapy group and continued successfully with individual sessions.

Regarding outcome for those who did complete the group, it seems that all of them benefited from the intervention to some extent. One patient in particular managed to cope without day-care, group or individual therapy following the group and has not been re-admitted. One other patient went onto an intensive therapy environment and participation in the group seemed to play a major part in developing her willingness and ability to
make use of such treatment, as it had been very difficult to engage her in any treatment previously. It seemed that the group helped to develop her insight into her needs, confidence about being accepted by others and her experience of relating and the usefulness of therapy. Other patients seemed to gain from learning in the group but remained long-term patients, continuing to require a variety of supports and therapy. One issue may be offering the intervention earlier in their hospital careers, before rigid patterns of service use have been established. As this was the first time that such an intervention had been tried, we included most of the most well known and “difficult-to-treat” patients with this type of problem. Although this is true of DBT, this group was only one addition to ‘treatment-as-normal’, rather than a complete package.

On reflection, we felt that the combination of structured teaching and responding to the issues brought up by or the mood expressed by group members was effective. It also seemed to facilitate a very interactive style. At all times we tried to relate to the group and maintain their experience of being validated, except regarding the use of self-destructive behaviours. The balance of the group seemed delicate, as if participants could be easily alienated, or the credibility of the leaders lost, which would have detracted greatly from the teaching. The initial sessions of describing the approach, with the focus on painful emotions and problems that seem insoluble, was especially important in setting the scene and creating engagement. Participants seemed surprised and encouraged by this, which was immediately reflected in disclosures of personal experiences. Also, starting with teaching on “mindfulness” seemed most useful because it provided a less personal emphasis to begin with which diluted the intensity of the group, until people became more used to it, whilst teaching skills that were the building blocks for the rest of the group. Participants seemed to enjoy this part of the teaching and the group leaders used it to introduce some unusual exercises, which were both engaging and disarming.

It often seemed as if participants expected us either to tell them off or to tell them which behaviours were right and wrong. They seemed surprised by the approach we did take, which was always non-judgemental and involved analysing the possible consequences for the individual. This had the effect of increasing individual responsibility for actions and decreasing the possibility of polarisation between staff and
patient regarding self-harm, which was a prominent feature for many of them, as well as increasing our credibility.

The issue of painful feelings seemed to be the most accessible for these participants and the sessions on emotions seemed to have the most impact. The issue of problems that were difficult to solve seemed only to be tackled indirectly. None of them seemed to conceptualise their difficulties in this way but all recognised great difficulties in either tolerating, controlling or accepting their own emotions. This part of the intervention was both empathic and validating but also challenging.

One of the indicators of the success of the group seemed to be the degree to which members were willing to discuss underlying thoughts and motives. Some of the underlying motives for self-harm such as reducing others’ expectations of them and attempting to maintain relationships were discussed with a sometimes brutal honesty. Also, the negative consequences of self-harm were never brought up by the group leaders, only by the participants themselves.

Rigid arguments pro-suicide, however, created some of the most difficult moments to deal with in the group. One way of dealing with this would have been to call upon participants’ previously stated commitment to find alternatives to suicide; at times, we felt that the commitment might not have been forthcoming and would have left us with a confrontation. Also, beliefs about the “inevitability” of self-harm, i.e. that ‘you can put it off but it will still happen eventually’, were some of the most difficult. We tended to use analogies to try and challenge these ideas. We noticed, however, that some of these issues came up when sadness was being discussed and focusing on the underlying feelings was sometimes more fruitful rather than arguments about logic. Often ideas about tolerating feelings were some of the most difficult to teach, in that self-harm had generally been used to get rid of feelings. So this idea was anathema to the participants but perhaps the most important idea to impart.

On reflection, it seemed that we should have continued to practise the mindfulness skills at every session to ensure learning and to demonstrate the continuous need to use these skills. Also, being stricter with participants about filling in their diaries could have been useful, in order to reinforce commitment and analysis of patterns relating to self-
harm; partly, this was a difficulty with time. We also felt that participants needed more work specifically on their negative beliefs about themselves. These were central for several of them, underlying their patterns of self-harm, and we felt that there had not been enough time to work through them. This may have been quite a difficult area to approach in the group though. We also felt that we would need to work more with other staff to back up what we were teaching in the group, which had sometimes been met with suspicion and misconceptions. One of the most difficult tasks seems to be breaking the cycle of reinforcing self-harm through hospital care etc. and no doubt requires a whole team approach.

The results of the questionnaire measures taken before and after the group are generally disappointing. It is also possible that the problem-solving approach might have been more effective if it had been carried out more explicitly; we used opportunities as they arose to demonstrate it. Participants could have benefited from specific work on increasing understanding and motivation to face problems head-on, using the problem-solving method to achieve this. This omission is probably reflected in the overall lack of change and the inconsistency on the Social Problem-Solving Inventory (Revised). Hopelessness did not generally improve. It is possible that this was influenced by feelings about the ending of the group, as most patients with these kinds of problems have great difficulty with separations and feelings of abandonment. More within-session measures might have given information about whether the group had any impact on hopelessness when it was in progress. The area that was not directly measured was participants’ emotional understanding and tolerance, although this had been central within the group and seemed to have the most impact on participants. This might be quite a difficult area to measure but could be useful in future investigations. The desired main effect remains the reduction of self-harming behaviour: this was achieved with the majority of patients.

The participants expressed a high degree of satisfaction with the group, as did the referring teams. Further groups may be carried out in the future following the success of this intervention, although it depends on having a number of patients with similar needs at the same time, who are willing to attend a group. A modified version (shortened) is being
considered for outpatients. We have also requested to do the full DBT training but financial constraints are likely to inhibit this. As this is likely to be the case in many other Trusts, it does seem useful to continue research on smaller scale intervention packages than DBT. Longer term follow-ups would be useful to assess whether gains in self-harming behaviour are maintained.
8. REFERENCES


MacLeod, A.K. & Tarbuck, A.F. (1994). Explaining why negative events will happen to oneself: Parasuicides are pessimistic because they can't see any reason not to be. *British Journal of Clinical Psychology, 33*, 317-326.


Appendix I: Diagnostic Criteria for 301.83 Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behaviour covered in criterion 5.

(2) a pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation

(3) identity disturbance: markedly and persistently unstable self-image or sense of self

(4) impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behaviour covered in criterion 5.

(5) recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour

(6) affective instability due to a marked reactivity of mood (e.g. intense, episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

(7) chronic feelings of emptiness

(8) inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)

(9) transient, stress-related paranoid ideation or severe dissociative symptoms.

Appendix II: A Literature Review of Psychological Issues Associated With Suicide, Parasuicide and DSH:

1. Definitions

The literature on three categories of behaviour is of interest: completed suicide, attempted suicide and deliberate self-harm (DSH). There is considerable debate, however, regarding categorisation and definition of these behaviours.

There is some evidence that the demographic characteristics of those who complete suicide are dissimilar to attempters but also of an overlap between suicide and parasuicide (MacLeod, Williams & Linehan, 1992). The most significant known risk factor for suicide is a previous incident of parasuicide and, although only 1% go on to commit suicide within one year of the attempt, this represents a hundred times the risk compared to others (MacLeod, Williams & Linehan, 1992).

Some have attempted to distinguish parasuicide from DSH by the presence of conscious suicidal intent (e.g. Dulit et al, 1994). Several studies have shown that there may be suicidal thoughts concurrent with self-harm for some (Gardner & Gardner, 1975; Jones et al, 1979; Pattison & Kahan, 1983). Hence, Walsh & Rosen (1989, p. 10) argue that lethality is the dimension along which DSH can be distinguished from parasuicide and define DSH as "deliberate, non-life-threatening, self-effected bodily harm or disfigurement of a socially unacceptable nature".

2. Borderline Personality Disorder, DSH & Suicide

Most importantly for acute psychiatry, a particular relationship between borderline personality disorder (BPD), DSH and suicide attempts has long been recognised; recurrent suicidal or self-harming threats or acts are diagnostic criteria of BPD in both ICD-10 (World Health Organisation, 1992) and DSM-IV (American Psychiatric Association, 1994) (see Appendix V for criteria). Shearer et al (1988) found rates of DSH as high as 80% in a sample of female in-patients diagnosed with BPD. Parasuicidal
behaviour is particularly prevalent among this group (Clarkin et al., 1983; Cowdry et al., 1985).

Within BPD there seems to be a relationship between DSH and suicidality. Dulit et al. (1994) found that borderline patients who mutilated themselves more frequently (five times or more) were more likely to have attempted suicide and had higher levels of chronic and acute suicidal ideation. They suggest a greater risk of suicidal behaviour amongst frequent self-harmers. No data on completed suicides is given though, leaving the relationship of these factors to actual suicide unclear. Several long-term follow-up studies do give rates of completed suicide in borderline patients, ranging between 3% (McGlashan, 1986) and 9% (Stone, 1987; Paris et al., 1989). Factors associated with actual suicide were previous attempts, higher educational attainment and age (Paris et al., 1989). Similarly, Shearer et al. (1988) found that increased lethality and intent of suicide attempts in people with BPD was associated with the number of previous attempts, the 3rd decade of life and a concomitant eating disorder.

3. Psychological Theories of Suicide and Parasuicide

Recently the psychological processes underlying suicide and parasuicide have been investigated. Initially, research focused on the relationship with life events, which have consistently been shown to be good predictors of suicide, suicidal ideation and attempts, in terms of both the quantity and perceived impact of the events (e.g. Paykel, Prusoff & Myers, 1975). Despite the strong relationship between suicide and life events, much of the variance is left unexplained. The question arises as to why some become suicidal in response to life events whereas others do not.

3.1. Cognitive Factors

The expansion of cognitive theories of emotion led to exploration of the cognitive factors in suicidal behaviour. Suicidal people demonstrate greater field dependence (Levenson, 1972), cognitive rigidity (Patsiokas, Clum & Luscomb, 1979), dichotomous
thinking (Neuringer, 1967) and negative attitudes to self/life (Wetzler, 1976). These findings have not led to therapeutic models, however.

Depression is significantly associated with suicidal behaviour but cannot account for it (Baumeister, 1990). The most important factor that has been found to mediate between depression and suicide is "hopelessness".

3.2. Hopelessness

Hopelessness has been shown to predict a repeat suicide attempt within six months (Petrie, Chamberlain & Clarke, 1988) and actual suicides up to ten years later (Beck, Brown & Steer, 1989). Hopelessness is more strongly associated with suicidal intent than is depression per se (see Weishaar & Beck, 1992, for a review).

MacLeod, Rose & Williams (1992) found that suicidal individuals demonstrate a deficit in positive anticipation of both short- and long-term goals, indicating that a lack of both rewarding short-term routines and long-term plans are important components of hopelessness. It has been found that parasuicidal subjects do not anticipate negative events but are less able to think of reasons why they would not occur. Thinking of reasons why negative events would not happen reduced their experience of hopelessness, suggesting an important area for intervention (MacLeod & Tarbuck, 1994).

3.3. Problem-solving

Researchers have attempted to investigate the psychological processes underlying hopelessness. Initially, a stress-diathesis model was proposed, in which cognitive rigidity, defined as an inability to identify problems and solutions adequately, was seen as the mediator between life stress and suicidal behaviour. Subsequently, the model has been refined, principally by Schotte & Clum (1982, 1987), who propose a stress-diathesis-hopelessness model. Specifically, individuals who are deficient in the capacity for flexible, divergent thinking, lack the ability to develop alternative solutions necessary for adaptive coping when faced with life stress. Problem-solving deficits combined with life stresses have been found to produce hopelessness in many studies (e.g. Schotte & Clum, 1982, 1987; Orbach et al, 1987; Asarnow, Carlson & Guthrie, 1987; Rotheram-
Borus et al, 1990). As Schotte & Clum (1987) propose, difficulties in generating solutions to problems become a major handicap in the context of the increase in life events: if the person is unable to think of solutions to the problems generated by these events, they are at risk of becoming hopeless and suicidal.

3.4. Self Evaluations

Resolution of problems may not be all that is required, however. Sakinofsky et al (1990) found that repetition rates of suicide attempts were the same (16%) at three month follow-up between a group of subjects who had resolved their presenting problems and a group who had not. The "resolvers" who repeated remained similar to the "non-resolvers" who repeated on other measures of social and psychological functioning, including feelings of powerlessness and internally-directed hostility. This indicates the need for broader interventions, focusing on emotional regulation and self-appraisal.

Similarly, Baumeister (1990) proposes that one of the causes of suicide is an attempt to "escape from self", when the person experiences an unbearable state of mind or terrible situation; these are in fact the reasons most commonly stated by suicide attempters. He suggests that the person experiences setbacks in their life due to events or too high expectations or both. The disappointment is attributed to the self, leading to negative self-appraisals. An aversive state of high self-awareness develops in which the person becomes acutely aware of him/herself as either guilty, unattractive, inadequate or incompetent. In an attempt to escape from this, the person retreats into a state of numbness which Baumeister terms "cognitive deconstruction". This state can escalate, leading to suicide as a final attempt at numbness. "Cognitive deconstruction" is conceptualised as a shift to less meaningful and integrative forms of thought in response to aversive affective states. In this state, it is hypothesised that thinking will be characterised by concreteness, cognitive rigidity and a short time focus. Although Baumeister finds support for this theory from cognitive research and from epidemiological studies of high rates of suicide/parasuicide in societies valuing individual success, this theory remains speculative.
3.5. Anger and Hostility

Researchers have found that suicide and parasuicide are related to certain affective states. Whilst both parasuicide and suicide are significantly related to depressive states, the former has been most commonly associated with anger (e.g. Litman, 1974) and the latter with apathy or a lack of anger (e.g. Virkkunen, 1976). Both before and after an attempt, parasuicides have been shown to be more angry, hostile and irritable compared to controls (e.g. Richman & Charles, 1976; Paykel & Dienelt, 1971), with relationships characterised by hostility, demandingness and conflict (e.g. Taylor & Stansfield, 1984). Furthermore, BPD is characterised by anger dysregulation (Gunderson, 1984). It can be concluded that parasuicides may experience difficulty in regulating emotional states, particularly anger. As MacLeod et al (1992) point out that viewing parasuicide as a manipulative act or an act of punishment towards others may be fallacious: anger may turn quickly into apathy leading to a suicide attempt, or parasuicide may represent an attempt to regulate the experience of anger. Regulation may be through distraction, sleep or biological changes produced by cutting or overdose, for individuals who find the experience of anger painful and intolerable.

4. Factors Associated with Deliberate Self-harm:

DSH usually takes the form of cutting, burning, interfering with wound healing etc., and may become habitual (Morgan, 1979; Favazza & Conterio, 1989). DSH is less well understood and researched than suicide/parasuicide: theories are sparse and unelaborated, partly because the functions of DSH may vary between individuals (Favazza & Conterio, 1989).

Again, the issue of DSH in BPD is relevant. Tantam & Whittaker (1992), however, suggest that DSH is as much a function of disturbed situations and disturbed relationships as of character disturbance, and argue that the triggers may be different to the maintaining factors. They suggest DSH may be triggered as a form of self-help to signal an intolerable situation characterised by feeling trapped and neglected, drawing on evidence that DSH occurs in caged primates, solitary prisoners and adolescents in dysfunctional families, but may be maintained by other factors.
A number of psychological factors are related, including traumatic childhood experiences, dissociative experiences and dysfunctional relationships, shedding some light on the development of DSH.

4.1. Sexual Abuse

There is strong evidence linking sexual abuse with DSH. Romans et al (1995), in a random community sample of 252 women, found that almost all who engaged in DSH reported experiences of childhood sexual abuse, although not all of those who reported abuse engaged in DSH. They also report a "dose effect": more intrusive (i.e. forceful) and frequent sexual abuse was related to more severe DSH. Beitchman et al (1992) suggest force as the link between sexual abuse and DSH. DSH was also associated with overdosing and repeated abusive relationships in adulthood. In a review of the literature, Yang and Clum (1996) found evidence of a link between early childhood trauma and suicidal behaviour. Sexual abuse in childhood has also been found to be a strong predictor of DSH in BPD (Stone, 1987; van der Kolk et al, 1991), with rates of reported sexual abuse in in-patients with BPD range between 40 and 86% (Bryer et al, 1987; Ogata et al, 1990; Shearer et al, 1990; Stone, 1981; Wagner & Linehan, 1994).

4.2. Dissociation

Dissociation has been suggested as a mediating factor between sexual abuse and DSH in BPD. Dissociation may be defined as pathological failure to integrate thoughts, feelings and memories into a coherent unified sense of consciousness (Demitrack et al, 1990). In a study of 60 BPD in-patients, DSH was associated with higher levels of dissociation, independently of sexual and physical abuse (Brodsky et al, 1995). Dissociation was also associated with depression and increased use of services. Therefore dissociation has been associated with abuse history, frequency of DSH, depressive symptoms and severe psychopathology. The authors suggest that DSH may function to control dissociative experiences. The question remains, however, as to whether DSH reduces the discomfort of dissociation or whether both are defences against intolerable self-images and body distortions deriving from abuse.
4.3. Interpersonal Relationships

Alternatively, van der Kolk et al (1991) assert that although abuse may trigger DSH, it is maintained by lack of secure attachments. Similarly, Yeomans et al (1994) found that DSH in BPD in-patients was associated with depression, unstable interpersonal relationships, difficulties with intimacy and sociability, resentment, hypervigilance and paranoia.

5. The Functions of Deliberate Self-Harm (DSH)

Theories of the function and genesis of DSH can be categorised into four areas:

5.1. Emotion

Reduction of tension is one of the most common reasons that patients give for DSH (Favazza, 1989). Many authors have observed that a sudden intrusive urge to harm may occur in response to mounting anxiety, agitation or anger due to a sense of existing in an intolerable situation, and that psychological relief from these feelings follows DSH (Shneidman 1980; Pao, 1969; Pattison & Kahan, 1983). As such, DSH has been viewed as a means of reintegrating of the psychological state (Walsh & Rosen, 1989). Leibenluft et al (1987) highlight the function of self-mutilation to relieve dysphoria, often in response to feelings of failure, separation and loss.

Similarly, psychodynamic theories of DSH, although generally diverse, have a common underlying theme of the experience of very early loss (Kafka, 1969; Friedman et al, 1972; Pao, 1969; Asch, 1971). Threatened loss is proposed as triggering archaic feelings leading to mounting tension, to which DSH provides the reduction and return to a normal mental state (Walsh & Rosen, 1989).

5.2. Cognition

It has been proposed that certain beliefs are necessary for DSH to occur. Walsh & Rosen (1989) summarise these as follows:

1. self-mutilation is acceptable
2. One's body and self are disgusting and deserving of punishment
3. Action is needed to reduce unpleasant feelings and bring relief
4. Overt action is necessary to communicate feelings to others

(Walsh & Rosen, 1989 -p.156).

This is supported by the finding that, in a study of adolescents, body alienation was the factor most predictive of DSH (Walsh, 1987).

Similarly, Young (1990) proposes early maladaptive schemas ("unconditional beliefs about oneself in relation to the environment" -p.9) as the underlying dysfunction in personality disorders, such as beliefs that one's emotional needs will never be met, one will always be abandoned or abused etc. DSH is conceptualised as a means of numbing psychological pain when early maladaptive schemas are triggered and is conceptualised as a schema avoidance behaviour.

5.3. Reinforcement Contingencies

It is proposed that DSH may be internally, negatively reinforced by the reduction of tension. It is also proposed that it may be externally both negatively and positively reinforced by the reduction of conflict/criticism and the attention and care of others respectively (Walsh & Rosen, 1989).

5.4. Biological

Although tentative, several explanations of the biological underpinnings of DSH have been offered. The opiate system (e.g. Wilier et al, 1981; Richardson & Zaleski, 1983), dopaminergic dysregulation (e.g. Goldstein et al, 1986; Goldstein & Mellor, 1988) and the serotonergic system (e.g. Thoren et al, 1980; Goodman, Price & Charney, 1989; Coccaro et al, 1987) have been implicated. Evidence regarding the biological underpinnings of DSH remains preliminary (Winchel & Stanley, 1991) and has not led to successful interventions in all cases.
### Appendix III: Homework Diary:

<table>
<thead>
<tr>
<th>Date and Time or trigger</th>
<th>Situation</th>
<th>Feelings Sensations Thoughts etc.</th>
<th>Urge to Harm Self (0-10)</th>
<th>Coping Strategies Tried</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix IV: Assessment of Problem and Effects on Role Performance:

Please summarise your main problem as clearly as you can:

1. How long have you had this problem?

2. How severe is the problem?
   - 0 1 2 3 4 5 6 7
   - not at   moderately   very
   - all severe severely severe

3. How well do you cope with the problem?
   - 0 1 2 3 4 5 6 7
   - not at   moderately   very
   - well well well

4. To what extent does your problem interfere with:
   a). work?
      - 0 1 2 3 4 5 6 7
      - not at   moderately   very
      - all much

   b). Leisure?
      - 0 1 2 3 4 5 6 7
      - not at   moderately   very
      - all much

   c). Relationships?
      - 0 1 2 3 4 5 6 7
      - not at   moderately   very
      - all much

   d). Day to day chores?
      - 0 1 2 3 4 5 6 7
      - not at   moderately   very
      - all much
Appendix V: Satisfaction Questionnaire

1. How useful did you find the group? (please circle)
   Not at all  Quite  Very
   Useful  Useful  Useful
   1  2  3  4  5

2. To what extent did you achieve what you wanted from the group? (please circle)
   Not at all  Somewhat  Very much

3. Which of the following did you find most useful about the group? (please tick)
   Learning new skills
   Doing exercises in the group
   Hearing what the Psychologists had to say about things
   Hearing what other group members had to say about things
   Telling other people about yourself
   Doing homework exercises
   Ideas for coping strategies
   Learning about emotions etc.

4. Please say 3 things you found useful about the group:

5. Please say 3 things you thought could be improved:

6. Please add any other comments you would like to make:
Appendix VI: Comments from the Client Satisfaction Questionnaires:

Please say 3 things you found useful about the group:

"I learnt to look at myself honestly"
"I learnt to analyse what I was going through"
"I had help learning to cope"

"that self-harm was treated seriously and not looked on (as by some professionals) as attention-seeking"

"that quite often, when discussing the week/s, it was pointed out to us, that we had coped well and that self-harming had not taken place for a longer period, as we had distracted ourselves, one does not register this at times"

"It was very reassuring to know that I was not the only one to feel this way about myself, the whole group was very supportive"

Please say 3 things you thought could be improved:

"I am not sure whether it would be helpful to challenge what we say at times, i.e. if someone says something which is rather "cloud cuckoo land" and not reality? Or would it make people feel unsafe?"

"different states of mind"

"more on awareness of triggers to self-harm"

"everything was fine"

"people could have been made to use their weekly diaries more strictly"

Further comments:

"I was very interested in learning about emotions and the way depression effects our thoughts and feelings, and found this a great help"

"I would like the group to carry on, maybe have breaks, then a sort of 'topping up' session now and then. This may help people to keep motivated in taking action to prevent self-harm"

"it was a brilliant group, very helpful and extremely supportive by all"

"it felt quite important to me that the group was run by yourselves. As (no disrespect to Day Hospital staff) it felt more important than an ordinary group. That is it is an important issue which needs addressing in a serious manner. There was never any feeling..."
of what any of us clients said, was shocking—it all seemed to be accepted in a matter of fact way"
ACADEMIC REVIEW ONE:
FAMILY PSYCHOEDUCATION APPROACHES TO
SCHIZOPHRENIA: A CRITICAL REVIEW OF THE LITERATURE
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1. INTRODUCTION

The past decade and a half have witnessed the proliferation of psychosocial intervention models, aimed at families with a schizophrenic member. 'Psychoeducation' is one of the main developments and has been defined as "the use of educational techniques, methods and approaches to aid in the recovery from the disabling effects of mental illness or as an adjunct to the treatment of the mentally ill, usually in the framework of another on-going treatment approach" (Barter, 1984, pp. 183-191). Lam (1991), in reviewing studies of psychoeducation, cites the underlying assumptions to be that schizophrenia is usefully described as an illness, that families are not implicated in the aetiology but the burden of care is acknowledged, and that the educational intervention is part of a treatment package. Most studies describe interventions consisting of weekly or fortnightly meetings with families, for up to two years, although six to nine months is more common. The overall stated aims are to reduce the likelihood of relapse and to promote social functioning for the patient.

2. WHY NEW INTERVENTION STRATEGIES WERE SOUGHT

The motivation to seek alternative treatment strategies arose partly due to the failure of medical 'cures'; 30 to 40% of people with schizophrenia relapse despite medication (Leff & Wing, 1971; Johnson, 1976). Increasingly, the emphasis has moved away from finding cures for the disorder and towards finding strategies for coping with the disabilities it generates. Recognition of the severe level of burden in families coping with a schizophrenic member has highlighted the families' own needs and motivated attempts to alleviate their suffering (Gibbons et al, 1984; MacCarthy, 1988). This has become more pertinent with the deinstitutionalisation movement, leading to further burden on families: approximately half of patients with schizophrenia live with relatives (Brugha et al, 1988). Kuipers and Bebbington (1985) argue that relatives are an important community resource with needs of their own. Hatfield (1987) suggested that clinicians should resist seeing families as merely an inexpensive resource in the care of schizophrenic patients and respond to their most frequent request for more information.
The family had been a central focus in earlier psychoanalytic and systemic interventions with schizophrenia, which viewed the family as causal in the development of the illness and aimed for 'cure' through the alteration of pathological interaction patterns (e.g. Bateson et al, 1956; Lidz et al, 1965; Palazzoli et al, 1978). Some of the underlying reasons for developing new approaches were a shift in philosophy and theory, moving away from approaches which implied that family patterns cause the illness and an increasing reliance on more psychobiological explanations for the disorder (e.g. the vulnerability-stress models of schizophrenia (Zubin & Spring, 1977; Neuchterlein & Dawson, 1984). Second, earlier approaches were no longer deemed acceptable because they failed to acknowledge the level of burden on families and the needs of families themselves, identified in the studies of family burden (see Kuipers, 1992 -for review). Third, an emerging view is that successful intervention strategies have not arisen from these earlier approaches (McFarlane, 1991). Recent studies have aimed to find effective interventions that support rather than blame families and may be seen as based in more general social and political changes in attitudes towards families with a schizophrenic member. A further impetus was the influential work on expressed emotion, providing a theoretical basis for developing new strategies.

3. THE FINDINGS ON EXPRESSED EMOTION

Of central importance in the development of family psychoeducation was the work on "expressed emotion" (EE). Importantly, there is evidence that the risk of relapse is greater for patients returning to families rated as high on a measure of EE, especially with frequent contact (Vaughn & Leff, 1976; Brown et al, 1972). EE, defined as "a measure of the quality of social interaction between carer and patient" (Bebbington & Kuipers, 1994 p.707), consists of a composite including 'hostility', 'emotional over-involvement' and 'critical comments'. EE has been found to be predictive of prognosis in a range of physical and psychological disorders (e.g. Flanagan & Wagner, 1991). Psychophysiological assessment has borne out the proposition that high EE increases arousal in schizophrenic patients (Sturgeon et al, 1984; Tarrier et al, 1988). In a review article, Bebbington and Kuipers (1994) conclude that the evidence for the value of EE in
predicting relapse is overwhelming and that both EE and medication have an independent effect on relapse. Further, they suggest that the literature tentatively supports a protective function of contact with low EE relatives. How EE varies over time and its effect on coping mechanisms is not yet known, however (Kuipers, Birchwood & McCreadie, 1992).

Two aspects concerning EE are pertinent to interventions with families. First, evidence for attentional deficits and impairments in the regulation of arousal in schizophrenia (Neuchterlein & Dawson, 1984) suggest a need to reduce the intensity, quantity and complexity of stimuli in the environment (McFarlane, 1991). In line with the stress-diathesis model, family psychoeducation may aim to reduce the level of stress in the environment; a vague, complex or emotionally-charged environment, as in high EE households, may create information overload for a schizophrenic patient characterised by difficulties in information processing and arousal regulation, leading to the recurrence of positive symptoms. Second, the development of high EE may relate to attributions. Brewin et al (1991) found that relatives measuring highly on hostility and criticism, tended to make attributions of the patient's behaviour as personal to and controllable by the patient. This suggests that if relatives believe that the patient has control over their illness and behaviour, they are more likely to be hostile and critical. Helping relatives to understand that patients have a real illness and limited control over their behaviour may help to attenuate their criticisms (Vaughn & Leff, 1981), hence the emergence of educational approaches. There is evidence to suggest that relatives have most difficulty accurately attributing negative symptoms or socially disruptive behaviour to the disorder (Creer & Wing, 1975; MacCarthy, 1988). Hence the view emerged that if relatives understood schizophrenia better, this could make attributions more accurate, reduce EE and improve outcome.

4. THE DEVELOPMENT AND EFFECTIVENESS OF EDUCATIONAL INTERVENTIONS

In a review, Lam (1991) assessed the effectiveness of educating families about schizophrenia. In the six studies included, education about diagnosis, symptomatology,
aetiologies, outcome and medication was conducted, in interventions ranging from one to six sessions. These approaches can be distinguished from 'psychoeducation' in that the packages did not contain specific teaching and practice of psychological techniques for coping or specific psychological interventions aimed at therapeutic change, apart from teaching about schizophrenia. The teaching is aimed at helping families understand schizophrenia better, in order to reduce self-blame or blaming the patient.

First, knowledge of the illness was usually increased, especially during a first admission. Early teaching may be useful, before views become entrenched but caution must be taken because diagnosis may still be uncertain. Generally, families are found to be more receptive following a recent crisis (McGill et al, 1983: Berkowitz et al, 1984; Barrowclough et al, 1987; Smith & Birchwood, 1987; Abramowitz & Coursey, 1989). Second, education alone had little effect on the relatives' beliefs about illness, although optimism was often higher (Berkowitz et al, 1984; Smith & Birchwood, 1987; Cozolino et al, 1988; Abramowitz & Coursey, 1989) and self-blame, stress and burden slightly reduced (Smith & Birchwood, 1987; Cozolino et al, 1988; Abramowitz & Coursey, 1989). It is not clear whether these improvements remained over time. Third, no data on whether education alone had any effect on relapse rates was available in these five studies: the study by Tarrier et al (1988) does provide comparative data, indicating that there were no improvements in relapse rates in education-only groups. Different approaches to providing education had little difference in effectiveness, except that face-to-face was better than postal contact (Smith & Birchwood, 1987). The literature indicates that educational interventions may serve as useful preliminary and engagement stages to further interventions, and as providing the basic knowledge necessary for developing problem-solving skills (Lam, 1991).

Smith and Birchwood (1987) also argue that provision of knowledge may help relatives feel less helpless, whereas MacCarthy (1988) argues that relatives have a moral right to this knowledge. It has been noted that families frequently request more information about the disorder and educational approaches at least meet this need (Hatfield, 1987).
Although this intervention style is termed 'educational', issues concerning teaching methods have not been addressed and the literature makes no reference to adult teaching models (e.g. Freire, 1970; Knowles, 1978). This casts some doubt on the validity of Barter's (1984) definition in that "educational techniques, methods and approaches" may be an overstatement; education about schizophrenia seems to be the central component but there is scant discussion of relevant techniques and methods to imparting this knowledge to families.

5. THE DEVELOPMENT OF PSYCHOEDUCATIONAL INTERVENTIONS

What is apparent in the literature is that education about schizophrenia is usually only an entry point to more complex interventions. Kuipers (1991), for example, stresses the importance of education in allowing a dialogue and trusting relationship to develop between carers and professionals, rather than just learning facts. This may elucidate why psychologists should suddenly be casting themselves in an educational rather than a psychotherapeutic role. It seems likely that educational interventions provide an entry point into discussion with families by providing what families themselves are requesting, without the implication of blame that 'therapy' entails. From this, however, emerges a confusion of definitions and terminology, as well as difficulties in distinguishing 'psychoeducation' from other kinds of interventions.

A central notion underlying the family psychoeducational approach is that families "can be trained to create an interactional environment that compensates for, and may partially correct, the functional disability in one member" (McFarlane, 1991 -p. 364). Here the boundary between psychoeducation and therapy becomes less clear. From this definition, psychoeducation can be seen as a therapeutic intervention aimed at positive change, but from a different standpoint to family therapy interventions in which the family may be viewed as causal in the individual's illness. Based on this assumption, a number of intervention studies have been completed.

Despite the variation in approaches, De Jesus Mari and Streiner (1994), in a meta-analysis, have extracted a summary of the objectives commonly used to achieve these aims. First is building up an alliance with relatives. Second is a reduction in adverse
family atmosphere, burden and stress. Third is to increase the family’s capacity for effective problem-solving. Fourth is to decrease expressions of guilt and anger. Fifth is to develop realistic expectations for the patient’s performance, balancing improving social functioning against the risk of relapse. Sixth is to develop appropriate limit-setting. Last is to make fundamental changes to the family’s beliefs.

Although there is some variation between studies, the therapeutic approach taken in family psychoeducation may be conceptualised as a problem-focused coping approach (Lam, 1991). As such, coping theory (Lazarus, 1966) provides further theoretical underpinnings. Folkman (1984) defines coping as the "cognitive-behavioural effort to master, reduce or tolerate" the demands created by "the stressful transaction" (p. 842). In psychoeducational approaches, it is assumed that the family gains the basis for reassessing stressors through education regarding schizophrenia. The support of therapists and other families may help to reduce arousal which interferes with problem-solving ability and realistic expectations help families to know when to accept rather than try and change what is happening (Lam, 1991). These expected gains have not yet been studied specifically and little is known about the process of change.

In terms of the therapeutic approaches to change that have been developed, Kuipers (1991) provides a useful summary of the kinds of methods developed from the EE research and their application. It is suggested that, in order to reduce criticism and promote accurate attribution, carers may be provided with a model to explain negative symptoms/disruptive behaviour. Realistic expectations of patients are required to increase acceptance and allow for building hope/optimism when only small gains are made. In order to reduce over-involvement, the patient's adult features are emphasised alongside highlighting the carer’s need for an independent life, giving permission and thus reducing guilt. The complexity of this balancing act between care and overcare is stressed, with special attention paid to not implying blame on the family. The emphasis is also on practical problem-solving, without minimising the problems faced. Collaboration between family and clinician is stressed, in both tolerating unusual solutions and recognising what is not soluble. Intervention style focuses on enhancing communication between patient and relatives and valuing everyone's views equally.
Emotional processing is part of the therapeutic aim (Rachman, 1980; Raphael, 1986), acknowledging the need for expression of negative emotions. Group interventions are recommended to promote sharing and reassurance, whilst reducing isolation, criticism and stigma. Kuipers (1991) suggests that one of the most important aspects of this kind of intervention is the development of a collaborative and open relationship between clinicians and families, which can facilitate other interventions.

6. CRITICISMS OF THE PSYCHOEDUCATIONAL APPROACH

Despite the positive claims made for family psychoeducation, the model has been criticised mainly by proponents of family therapy approaches. Gingerich et al (1992) suggests that the model has gone too far in sacrificing all psychodynamic interpretations in favour of psychoeducation; they suggest that therapists need to use all their psychotherapeutic skills and to balance gaining knowledge with the family's need to express complex feelings. Further, they suggest that what we do not know about schizophrenia must also be explained and that a family's uniqueness requires acknowledgement. Johnstone (1993) criticises family psychoeducation programmes heavily on several counts. She argues that the emphasis on the illness model of schizophrenia and on medication as an all-encompassing solution may be an overstatement excluding other models, and psychoeducators are accused of supporting the dominant ideology of psychiatry. There is a growing body of opinion in psychology which questions the very basis of schizophrenia as a 'disease concept' (Bentall, Jackson & Pilgrim, 1988), such that the content of teaching packages is a contentious issue. There is a danger of reinforcing the 'sick-role'. The stated aim of not attaching blame to the family may be a double message, the implicit message to the family being that their behaviour does worsen schizophrenia (Johnstone, 1993). Several authors have noted that separation and overinvolvement are often the key issues for families (e.g. Berkowitz, 1984) and Johnstone concludes that the psychoeducation model may not provide a deep understanding of these issues or fundamental change. An important issue raised by Hogarty et al (1987) is that the skills acquired do not prepare people to live independently. As most people living with a schizophrenic relative find it stressful and
ultimately wish that the person live away from home (Hatfield, 1987), strategies that promote the patient's independence from the family and their ability to separate may be more important (Halford & Hayes, 1991).

In fact, the dichotomy between family therapy and psychoeducational approaches may be less stark than it first appeared: similarities can be drawn between the concepts of EE and 'enmeshment' or 'double-bind' in family therapy (McFarlane & Beels, 1983). Burbach (1996) suggests that with increasing sophistication in this field, the two theories may integrate. The strengths of the psychoeducation approach are that it is practical and produces demonstrable treatment gains. Concepts drawn from family therapy, however, may add much to an understanding of the theoretical underpinnings as the model develops; some integration is already evident in the literature. Further, much of the psychoeducational work seems to include a broader intervention style than the name implies, including wider use of therapeutic skills and acknowledgement of emotional issues (e.g. see Kuipers, 1991 -described above). Again, the problem seems to be in terminology and in stating exactly what is meant by psychoeducation.

7. EVIDENCE FOR THE EFFICACY OF PSYCHOEDUCATIONAL INTERVENTIONS

The efficacy of psychoeducational interventions is well documented. Lam (1991) included five studies in which families were randomly allocated to either a psychoeducation or control condition in his review. Regarding the primary aim, significant differences in relapse rates were consistently found at nine months to one year follow-up; 6-23% rates of relapse were found in the treatment conditions, versus 40-53% rates in the control conditions (Leff et al, 1982, 1985, 1988, 1990; Falloon et al, 1982, 1985, 1987; Hogarty et al, 1986, 1987; Tarrier et al, 1988, 1989). In most studies employing a six to nine month intervention however, the differences in relapse rates had tended to diminish by two year follow-up (Leff et al, 1982, 1985, 1988, 1990; Hogarty et al, 1986, 1987; Tarrier et al, 1988, 1989). Thus, relapse is postponed rather than prevented (Kuipers, Birchwood & McCreadie, 1992). The model used in these studies appears to be similar to an acute/cure model in which the patient is expected to recover.
following a short period of intensive treatment. These results suggest that a longer term care model is required in which families would be offered help more continuously, in order to maintain their progress. Overall, these studies provide some evidence for increased social functioning in the patient and improvements in EE were also found. Lam (1991) concludes that there is an interactive relationship between changes EE rates, increased social functioning and relapse rates.

More recently, De Jesus Mari and Streiner (1994) completed a meta-analysis of family intervention studies which included educational sessions as a central component of the intervention, although other aspects of the interventions varied in content and style of delivery (the studies analysed were Goldstein et al, 1978; Leff et al, 1982, 1885; Falloon et al, 1982, 1985; Hogarty et al, 1986, 1987; Tarrier et al, 1988, 1989; Vaughn et al, 1992). In their assessment of treatment effectiveness, they found that psychoeducational family interventions were moderately successful at a nine month follow-up for those who complete the course. Taking drop-out rates into account, however, they found that approximately two to five patients have to undergo the intervention in order to prevent one relapse in a nine-month follow-up period and that successful outcomes were only really demonstrable for those living in high EE households. Despite this, they did not find a clear relationship between changes in EE status and family interventions.

There is also some evidence that psychoeducational approaches may be cost effective. Falloon et al (1985) consider that their intervention costs 20% less than treatment-as-normal, over a two year period, whereas Tarrier et al (1989) made a saving of 27%. Of course, cost-effectiveness is a secondary consideration to treatment success.

8. SOME CAVEATS REGARDING OUTCOMES

8.1. Engaging Families:

The problem of refusal and drop-out rates in psychoeducation has increasingly been recognised. Difficulty engaging families in this type of programme is common in many studies. Smith and Birchwood (1990) quote non-engagement rates of between 14 and 35% in the six studies they considered. Several possible reasons are suggested. First, that some families are approached during the patient's first admission, when they may still be
unconvinced of an 'illness' diagnosis and may be expecting a 'cure'. Other authors, however, have found that families are more amenable to intervention following a recent relapse (McCreadie et al, 1991; Tarrier, 1991) and that earlier intervention is more successful (McFarlane, 1991). Second, families may feel threatened and blamed by being included in a treatment package for their relative. Tarrier (1991) highlights a number of reasons that prevent families from participating, including poor health, lack of resources (financial/practical), lack of understanding of the risk of relapse and pessimism about the future. This highlights the need to foster partnership between families and professionals, with an emphasis on negotiating the goals and priorities of treatment, and the need for flexibility. Offering education first may enable them to see the possible benefits of the intervention; this requires ensuring that 'front-line' professionals have accurate information regarding schizophrenia (Smith & Birchwood, 1990). An assessment of the family's perception of the illness may need to be carried out at the early stages to ensure that a clash of views with the professionals does not lead to withdrawal by the family (Tarrier, 1991). It is generally agreed that the family's experience of burden needs to be acknowledged, to prevent feelings of being blamed. It is not clear from the literature how disagreements between family and professionals about models and explanations of schizophrenia are dealt with. An interesting area for further research may be to assess the reasons why some families drop out of the programmes and whether this does relate to disagreement about the material being taught.

8.2. Model Programmes:

Most of the studies discussed have been carried out by research centres and may therefore be considered as "model programmes" (Bachrach, 1980, 1982). How they may be integrated into routine clinical practice is worthy of further consideration. Smith and Birchwood (1990) comment, "psychosocial interventions represent complex and time-consuming procedures which require careful planning of mental health resources when attempting to integrate them into existing psychiatric management" (p.654). They also point out that 'grass roots' interventions may not meet the high standards set by published interventions, indicating that quality assurance is an issue. Alternatively, the claims made
for probable outcomes must be stated modestly. They emphasise the need for training and continued supervision of front-line professionals. Similarly, McCreadie et al (1991) found little change in the EE status of families taking part in their intervention study in a normal NHS setting, and suggest that a lack of staff expertise may be part of the reason. Relapse rates were reduced, however, and high levels of satisfaction were expressed by relatives. Further, McFarlane et al (1993) assessed a model for disseminating the family intervention approach into ordinary clinical practice. Intensive training and supervision over two years were offered to the clinicians involved and training of administrators to support implementation.

8.3. Possible Confounding Factors:

Despite the wealth of positive evidence regarding the success of family interventions, most outcome studies to date may be criticised for being confounded by increased contact with and between professionals in the treatment conditions (Johnstone, 1993). This could be the active ingredient that accounts for their effectiveness. The positive effects of community services emphasising closer liaison and contact are well known (Stein & Test, 1980; Hoult et al, 1983). A study by Kottgen et al (1984), using a psychoanalytic approach, clarifies this issue; the outcomes are worse in the treatment condition despite levels of contact comparable to other studies, suggesting that the active ingredient in psychoeducation programmes is not the level of contact with and between therapists alone. Total contact with services and high expectation of treatment effectiveness have not been ruled out as influential factors, however. De Jesus Mari and Streiner (1994) also found improvements in medication compliance with this approach. There is evidence, however, that the decrease in relapse is not a consequence of this alone (Hogarty et al, 1986). The question arises as to what the active ingredients are.
9. THE FINDINGS ON 'ACTIVE INGREDIENTS' AND SUCCESSFUL INTERVENTION STYLES

9.1. Active Ingredients:

Only one study has attempted to answer this question. Tarrier et al (1988, 1989) attempted to assess the 'active ingredients' of psychoeducational approaches by comparing a "symbolic" versus an "interactive" approach (Barrowclough & Tarrier, 1987); the teaching content in each approach is equivalent (including information about schizophrenia, stress management, goal setting and strategies for change) but the latter entails active participation in role-playing, guided practice, record keeping etc.. No differences in outcome were found between the two, although both were superior to education alone or treatment-as-usual.

Whilst reviewing the intervention studies, Lam (1991) identified the common components of successful intervention strategies. First, all emphasise developing a genuine working relationship with families, offering a non-judgmental therapeutic stance and the opportunity for each member to express their feelings. Second, structure and stability are offered, with the therapists often being available during emergencies, enabling them to work on firmer boundaries at critical times. Third, the focus is on the current problems and practical solutions or coping strategies. Fourth, family therapy concepts are used to help make interpersonal and intergenerational boundaries firmer. Fifth, cognitive restructuring offers a model for reattributing the patient's behaviour and the family's own feelings, to reduce guilt and blame. This gives the family permission to attend to their own needs. Sixth, a behavioural approach is used including assessing strengths and needs, agreeing realistic goals, setting priorities, breaking goals into small steps, task assignment and review. Last, improvements in communication are emphasised, including the need for clear, simple and specific requests and the need to take responsibility for one's own feelings rather than speaking for each other. These factors appear to be useful components of family interventions and fit with models of healthy family patterns (McFarlane, 1991). Until studies comparing outcomes with different combinations of these components are carried out, the active ingredients of family psychoeducation approaches will not be identified.
9.2. Group versus Individual Approaches:

The efficacy of group versus single family approaches is also an issue. Successful results have been demonstrated for working with individual families (Falloon et al, 1985) and for relatives' groups (Hogarty et al, 1986). The latter appears to be the preferred model in the literature. McFarlane (1991) has suggested that a group approach may add the opportunity to promote network building and social support amongst families. His model is based partly on the assumption that difficulties in making and maintaining changes are a function of isolation and ignorance, rather than an indication of pathology. In a comparison study (McFarlane et al, 1993), group treatment lead to lower relapse rates than single family treatment. Group therapy may be a powerful vehicle for change, by providing opportunities for shared experience, altruism, instillation of hope etc., in accordance with Yalom's (1995) conceptualisation. Alternatively, Soloman et al (1996), in a controlled trial, found greater increases in specific self-efficacy following individual family rather then group education sessions, which the authors attribute to individually-tailored information.

10. CONCLUSIONS

In conclusion, the literature provides strong evidence that family psychoeducational interventions can help to postpone relapse in schizophrenia and to some degree promote social functioning. Engaging families is a particular difficulty and time-limited interventions may not be enough to maintain gains. The most successful models are not wholly based on EE or education, but encompass broader issues including building social support between families, practical coping skills and developing clear communication and relationship boundaries. Care is needed to ensure that the model is not too restrictive and reinforcing of the sick-role: the family's overall development, including possible separation, merits consideration. Currently, the theoretical underpinnings of the model are sparse, indicating the need for more theoretical analysis in this field. The model has developed on the basis of empirical research rather than being theory-driven, leaving something of a mixture of methods and approaches of which the crucial elements are not yet known. Knowledge about the specific mechanisms related to successful outcomes,
measures of family need and change are lacking. In particular, the extent to which change in EE is sufficient to account for outcomes remains unclear. With regard to implementation into routine clinical practice, particular attention should be paid to staff training and supervision, if the model is not to become 'diluted'.

Terminology requires attention: 'education' has not adequately encapsulated the broader therapeutic approaches being developed, leading to the term 'psychoeducation'. The interventions categorised under this title, however, seem to vary in the degree to which they are primarily educational, emphasise developing coping skills through training and practice, or deal with emotional and developmental issues through a more general therapeutic process. Some reasons for this difficulty in definition seem to derive from need to distinguish new interventions from earlier family therapy approaches, the main premise of which was the causal role of the family in schizophrenia, and the need to engage families by presenting interventions that do not imply blame.
11. REFERENCES


ACADEMIC REVIEW TWO:
COGNITIVE BEHAVIOUR THERAPY APPROACHES TO
PSYCHOSIS: A CRITICAL REVIEW
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1. INTRODUCTION

This review is concerned with therapeutic approaches aimed at the content of psychotic symptoms. A distinction must be made between approaches that tackle dysfunctional cognitive processes directly (e.g. "cognitive rehabilitation of schizophrenia", Brenner et al, 1992) and those aimed at the content of cognitions, although there is some overlap between the two (Alford & Correia, 1994). The former are beyond the scope of this review. Until the 1980's, there was a dearth of individual psychological approaches to psychosis. Bellack (1986) attributes this to clinicians' misconceptions of schizophrenia, as "biological", too severe, medically treatable, or not an entity at all. Recently, however, impressive developments have occurred in the domain of cognitive approaches. A "family" of cognitive interventions has emerged (Birchwood & Shepherd, 1992).

2. THE RATIONALE FOR DEVELOPING PSYCHOLOGICAL THERAPIES FOR PSYCHOTIC DISORDERS

The rationale for devising therapeutic approaches to positive symptoms is well established: despite the success of neuroleptic medication, residual positive symptoms of psychosis represent a significant problem (Curson et al, 1985, 1988). Side-effects of and non-compliance with long term medication are added concerns (Tarrier, 1992). Positive symptoms may cause severe distress and are associated with low self-esteem and suicide (Drake & Cotton, 1986; Caldwell & Gottesman, 1990), and poor social functioning (Birchwood et al, 1990; Shepherd et al, 1989). Many personal accounts express the terror which can be associated with acute psychosis and fear of relapse; moderate PTSD symptoms may follow relapse in 30 to 40% (McGorry et al, 1994 -quoted in Fowler et al, 1995, p.11) and the incidence of anxiety and depression is high in people with psychotic disorders (Barnes et al, 1989; Siris, 1991).

Thus, evidence of such severe distress and unmet need led to a new emphasis by clinical psychologists on developing individual therapeutic approaches to psychosis.
Further support came from patients' own accounts (e.g. Ruocco, 1989) and from survey data (Farrell & Coursey, 1989), describing the importance of therapy to the well-being of the individual. The development of cognitive-behavioural therapy (CBT) for psychosis, however, was preceded by and arose from the development of behavioural interventions (see Hemsley, 1986 - for review). Also, consistent evidence was found that people with psychosis actively attempt to cope with symptoms by using behavioural and cognitive strategies, including relaxation, reducing attention to symptoms and socialising (Falloon & Talbot, 1981; Brier & Strauss, 1983; Cohen & Berk, 1985; Carr, 1988). Importantly, this literature dispelled the assumption that people are passive recipients of their symptoms, and supported the possibility of direct intervention and the active role of the patient in managing their own difficulties (Carr, 1988). This led to the development of approaches designed to supplement the individual's own coping strategies (see Tarrier et al, 1990, 1993a & 1993b).

3. THE DEVELOPMENT OF COGNITIVE THEORIES OF PSYCHOSIS

Two developments in the conceptualisation of schizophrenia provided further impetus for the application of CBT theory and practice in this domain. First, criticism of the explanatory power of the purely biological disease-entity model (Boyle, 1990), dominant in psychiatry, led to the increasing popularity of a biopsychosocial model of schizophrenia, that is the vulnerability-stress diathesis model proposed by Zubin and Spring (1977) and developed by Neuchterlein and Dawson (1984). The model differentiates an underlying vulnerability to psychosis, which is a relatively permanent enduring trait, from temporary symptomatic periods triggered by environmental stress. Thus, the inclusion in this model of the issues of stress and therefore coping opened the way for the application of cognitive theory concerning the interpretation of events by the individual.

Second, the development of CBT for psychosis was catalysed by a shift in theory and research towards focusing on symptoms rather than syndromes. The core of the debate which emerged is whether psychosis is best conceptualised as on a continuum with
normal experience or as a discrete illness that is qualitatively different from normal experience.

The argument that psychotic symptoms are on a continuum with normal experience derives from evidence that they have a less clearly unitary relationship with the "illness" category of psychosis than might be thought. There is evidence that hallucinations occur in a range of pathologies and their incidence and interpretation differs across cultures (Bentall et al, 1994). About 2% of normals have been found to experience hallucinatory voices (Tien, 1991). Hallucinations increase with anxiety (Slade, 1972) and fluctuate with levels of arousal (Cooklin et al, 1983); environmental factors, such as white noise or sleep deprivation, can induce hallucinations in normals (Margo et al, 1981). Since Strauss (1969), delusions have been conceptualised as on a continuum with normal beliefs, rather than a discrete entity, and fluctuation even in "fixed" delusions is recognised. It has long been recognised in social psychology that normal processes of belief formation are prone to bias, including the fundamental attribution error (Nisbett & Ross, 1980), the tendency to seek evidence confirming existing beliefs (Tversky & Kahnemann, 1974) and that the processes underlying normal judgements and beliefs often lie outside awareness (Nisbett & Wilson, 1977).

These developments led to an emphasis on assessing individual symptom formation, rather than disorders as a whole. Conceptualising psychotic symptoms in this way has allowed the application of theories of normal cognitive processing to the experience of psychosis and the emergence of intervention strategies, as well as providing a more normalising rationale for patients. Links with a rising political debate can be seen which criticises the traditionally dominant medical model of schizophrenia on theoretical grounds (Bentall, 1990) and in relation to individual rights, forging a new position for psychologists in the domain of psychosis.

Despite this, throughout the literature reviewed, the vulnerability-stress diathesis model of schizophrenia prevails, and schizophrenia often seems to be uncritically accepted as a pathological category of human experience. Despite expressing dissatisfaction with this model (Bentall, 1990; Bentall, Jackson & Pilgrim, 1988), identifying a category has been suggested as useful to avoid referring to a fragmented set
of phenomena. Clements and Turpin (1992) argue that the vulnerability model of schizophrenia has the potential to integrate data from many domains; for example, attempts to integrate cognitive and neurological theories are beginning to develop (Hemsley, 1986, 1993; Frith, 1987, 1992; Frith & Done, 1987). Unfortunately, this creates a lack of clarity at times regarding the model of psychosis which underpins the cognitive therapies being described.

Within the symptom approach, theories and interventions have emerged for both hallucinations and delusions. These will be discussed in turn.

4. COGNITIVE MODELS OF HALLUCINATIONS

Bentall and Slade (Bentall & Slade, 1985; Bentall, 1990) have attempted to integrate current knowledge regarding hallucination formation to provide a cognitive model. The most important findings are evidence, albeit equivocal, of an association with 'subvocalisation' (Green & Preston, 1981; Inouye & Shimizu, 1970) and the inhibitory effects of concurrent verbal tasks (Bentall, 1990; Frith, 1992; Heilbrun, 1980; Hoffman, 1986). Bentall, Haddock & Slade (1994) claim that a consensus has emerged that hallucinations occur when private mental events are not attributed to the self, so that self-generated experiences are mislabelled as alien or external (Hoffman, 1986; Frith & Done, 1987). This model asserts that discriminating between self-generated events and external events is a metacognitive skill and is partly a function of the characteristics of the events being discriminated and the expectations/beliefs of the individual (i.e. "top-down" cognitive processes). It is argued that the experience of hallucinations is influenced by fundamental beliefs about possible mental events and causal agencies that operate in the world. The central hypothesis is that hallucinations constitute an error of judgement and is supported by experimental evidence that hallucinators are more likely to perceive speech in "white noise" (Bentall & Slade, 1985) and to attribute self-generated words as words heard externally (Bentall, Boker & Havers, 1991). It is suggested that hallucinations serve a reinforcing, anxiety-reducing function, by allowing the individual to attribute unpleasant thoughts, worries or feared intentions as alien to the self. The
suggested focus of therapy, therefore, is helping patients to find ways of attributing mental events to themselves.

This model may be criticised for ignoring the meaning of voices to the individual. Benjamin (1989) found that people with hallucinatory experiences form meaningful and coherent relationships with their voices and that they may vary in the degree to which the voices are experienced as attacking and hostile, or approving and even helpful. This may depend on the congruence between the content of the voices and self image, influencing the individual's tendency to engage with or ignore voices. Assessment of the meaning and significance of the voices is crucial before planning interventions (Chadwick & Birchwood, 1994; Fowler, Garety & Kuipers, 1995).

Two strands of theorising regarding psychotic symptomatology may be defined; 'deficit' models focus on cognitive deficiencies, whereas 'motivational' models focus on the meaning and function of symptomatology for the individual. The need to integrate the two in formulating treatment approaches and the dangers of oversimplification, including the reattribution of voices to the self without recourse to the emotional meaning of this, is becoming increasingly evident in the literature (Chadwick & Birchwood, 1994; Fowler, Garety & Kuipers, 1995; Chadwick, Birchwood & Trower, 1996).

5. INTERVENTIONS FOR HALLUCINATIONS

Attempts to use CBT techniques for treating hallucinations fall into three categories, distraction, focusing and anxiety-reduction (see Slade & Bentall, 1988 -for review). Positive results have been achieved with both distraction and focusing techniques. The benefits of distraction techniques seem short-lived (Nelson et al, 1991), presumably because the underlying disorder is not addressed. Fowler and Morley (1989) used focusing to help patients see the connections between voices and situational/emotional factors, to relabel hallucinatory experience as perceptual disturbance and to reassess their beliefs about voices. In a set of five single case experiments, mixed results were achieved. The authors concluded that beliefs about the voices may require modification first, and that voice content may relate to anxiety and
depression pre-dating their emergence. Depression, anxiety, poor motivation and self-esteem are noted as important, suggesting a broader focus for interventions than symptom reduction alone.

Haddock, Bentall and Slade (1996) report preliminary results from a study comparing distraction with focusing techniques. The latter entails first identifying and monitoring the physical characteristics of the hallucinatory experiences both within and outside of sessions, comparing them with ordinary mental experiences in a non-threatening atmosphere. The content is then monitored along with associated thoughts, feelings and beliefs. A formulation of the meaning and function of the voices is developed. If an illness interpretation is rejected by the patient, then reactions to hallucinations are addressed; responsibility for their own reactions to hallucinations is attributed to the individual and addressed as a worthy area for change. The authors report that some patients are able to reattribute the voices as internal mental events, whereas some learnt that their thoughts about their voices, rather than the voices themselves, were the cause of their distress. The preliminary results of their follow-up study indicate that both distraction and focusing produce positive gains in frequency of voices experienced, the level of distress caused by voices and disruption to daily life due to voices. Self-esteem, however, increased slightly with focusing but decreased slightly with distraction, and although the changes are small, they may be especially significant with patients who already have very low self-esteem and are at risk of suicide. Although the follow-up is short and the patient groups were small, the results of this study suggest that both CBT approaches can work and that focusing may also promote self-esteem; the authors attribute this to the concern shown to the individual's daily thoughts and worries during the process of therapy. The authors conclude, however, that approaches combining distraction and focusing may be beneficial in that the former can help the individual gain a sense of control over hallucinations.

Chadwick and Birchwood (1994) provide the most detailed exploration of the nature of auditory hallucinations indicating the extent to which voices are often experienced as omnipotent and omniscient, such that the individual feels overpowered. They stress that beliefs about voices not voices themselves are the source of distress, and
the need to assess the meaning, identity and purpose of voices and their perceived benevolence or malevolence for the individual, along with the degree to which the individual engages with or resists the voices. Chadwick et al (1996) have developed a CBT approach to voices, firmly based in the cognitive models of Ellis (1962; 1994) and Beck et al (1979). Ellis' (1962) "ABC" (Activating events, Beliefs, Consequences) model is used as the framework for exploring the individual's distress. Voices may be classified as A's, distress as C's, mediated by beliefs about voices as B's. Essentially, the approach is to treat beliefs about voices as delusions, explaining them to the client as a way of making sense of the distressing experience of hallucinations. This formulation facilitates a collaboration between client and therapist to explore the beliefs about voices and weaken conviction, leading to reduced distress. A central aim is breaking free from a sense of the voices' omnipotence by beginning with coping mechanisms that create a sense of control; attributing voices to self is deemed too threatening by these authors. Success with this approach has been demonstrated with single case studies and further clinical outcomes are awaited.

6. COGNITIVE MODELS OF DELUSIONS

A central theoretical issue is whether the occurrence of delusions is an attempt to explain abnormal perceptual experiences. Maher (1988), a major proponent of this view, describes delusions as the culmination of normal cognitive processes but in the presence of unusual perceptual experiences. However, anomalous perceptual experiences are not always present with delusions (Chapman & Chapman, 1988) and Maher ignores the question of why abnormal experiences may be present for some but not others. It may be useful to consider whether delusions have formed to explain unusual experiences if these experiences are present in any individual case.

As with hallucinations, psychological models of delusions include cognitive deficit and motivational/emotional aspects. The most purely deficit model is the social learning theory of delusions (Cameron, 1959; Beck et al, 1990). This essentially states that skills deficits such as difficulty understanding the intentions of and interacting with others may
lead to the formation of paranoid suspiciousness which, when met with rejection from others, leads to further isolation and lack of opportunity to disconfirm beliefs. Significantly, a cognitive deficit in understanding the intentions of others is considered the precursor. An understanding of the sequence of events and the process of social interactions leading to delusions is suggested as an essential part of assessment (Fowler et al, 1995). There is also experimental evidence of cognitive deficits (or biases) related to delusions; persecutory delusions have been found to co-exist with biases in attention to and recall of threat-related stimuli and a tendency to attribute negative events externally (Bentall & Kaney 1989; Bentall, Kaney & Dewey, 1991; Kaney et al, 1991). Deluded patients are also found to ignore disconfirming and to focus on confirming evidence, although whether this process, which also occurs in normals, is accentuated in deluded patients is unclear (Kahnemann et al, 1982). Evidence has been found for a relationship between delusions and a tendency to focus on current stimuli rather than past learned regularities (i.e. likely interpretations based on past experiences of similar stimuli), decision making characterised by rapid processing, overconfidence and cognitive simplicity (see Garety & Hemsley, 1994 -for summary).

With regard to motivational/emotional issues, delusions have been proposed as a defence against unwanted feelings. Based in psychoanalytic theory, Zigler and Glick (1988) argue that persecutory delusions constitute a defence against depression by attributing the blame for negative experiences onto others. Similarly, Neale (1988) argues that grandiose delusions constitute a 'manic defence' to protect the individual from threat to self-image.

It may be argued, however, that a dichotomy between delusions defending against unwanted feelings and those making sense of experiences is spurious (Garety, 1991) and most theories are now converging to take both aspects into account (Garety & Hemsley, 1994; Chadwick & Birchwood, 1994; Fowler, Garety & Kuipers, 1995; Chadwick, Birchwood & Trower, 1996). Most importantly for CBT, these theories highlight the importance of both cognitive and motivational factors in the development of delusions.

Evidence from the cognitive literature supports this formulation: Lyons et al (1994) found that individuals experiencing persecutory delusions demonstrated a highly
defensive style, scoring highly on a measure of self-esteem but also on depression, and demonstrating a style similar to depressives on an unobvious attribution task. This suggests that paranoid delusions protect the individual from underlying low self-esteem that is difficult to access directly. Similarly, Kinderman (1994) found that deluded individuals endorse a high number of positive words as relevant to themselves but experience interference with positive and negative trait words on a Stroop task. Further, Bentall & Kaney (1996) found that although people experiencing paranoid delusions endorsed positive words to describe themselves, they demonstrated rigid and perfectionist attitudes for evaluating their self-worth. Regarding the evidence for biases in recall and attributional processes, it is argued that the attentional biases are not global but rather represent more momentary adjustments in information processing functioning to avoid threat to self-image and to reduce the gap between perceived and ideal self, before a gulf which could trigger depression occurs (Bentall, Kinderman & Kaney, 1994). These findings suggest underlying negative self-schema which the delusions protect the individual from experiencing consciously.

Garety and Hemsley (1994) formulated a theory of delusion formation which proposes a dynamic interplay between information-processing disturbances and emotional distress, and constitutes a convergence of defect and motivational models. They hypothesise that delusion formation relates to the judgmental biases described above. Along with Maher (1988), they also suggest that if information is ambiguous, arrival at an explanation may reduce anxiety and puzzlement. This implies that therapeutic change requires attention to multiple factors (Garety & Hemsley, 1994) and some clients may not engage in symptom reduction approaches because of emotional issues (Fowler et al, 1995). Similarly, Penn et al (1997) argue that processes involving the person's view of themselves in relation to the world and to others underpin the deficits observed in schizophrenia. They propose that biases in social-cognitive processes rather than in cognitive processes per se are necessary to create the difficulties observed.

From a schema-focused cognitive perspective, Chadwick et al (1996) have developed a model of delusions emphasising the importance of core beliefs about the self and others (person evaluations) originating in early experience (Beck et al, 1983), relating
to attachment and autonomy issues (Blatt & Zuroff, 1992). They hypothesise that person evaluations influence delusion formation via the interpretation of experiences. Their most important contribution concerns the distinction of two types of paranoia (Trower & Chadwick, 1995). From clinical experience and exploration, they suggest that paranoia may be divided into persecutory and punishment types. "Poor me" paranoia consists of beliefs in persecution by others experienced as unjust and associated with anger and righteous indignation. They hypothesise that this derives from positive evaluations of self and negative evaluations of others, obscuring an underlying negative evaluation of self which lies outside awareness. This fits with the evidence from the cognitive literature described above. "Bad me" paranoia is characterised by beliefs about being punished by others, experienced as just and characterised by fear, shame and guilt. They hypothesise that this type of paranoia relates to a negative evaluation of self and low self-esteem which is consciously known to the individual. Tentative suggestions regarding the types of early experience generating these vulnerabilities are made but remain highly theoretical.

It may be argued that distinct profiles of cognitive biases in delusions are emerging. What is not clear, however, is whether these biases predate the delusions and contribute to their formation. It is possible that they are state-dependent and contribute to the maintenance of delusions rather than the aetiology (Bentall, Kaney & Bowen-Jones, 1995). Only longitudinal studies would elucidate this.

7. INTERVENTIONS FOR DELUSIONS

Early use of CBT techniques with delusions began with a successful single case study (Beck, 1952), in which logical discussion of delusional beliefs followed a long period of trust and rapport building, which the author felt was intrinsic to the success of the intervention. Watts, Powell & Austin (1973) devised a model of challenging delusional beliefs whilst avoiding "psychological reactance", i.e. strong confrontation that strengthens beliefs (Brehm, 1966), by focusing on least strongly held beliefs first, requiring consideration of rather than adoption of alternative explanations, challenging
the evidence for rather than the belief itself and asking the client to voice opposing views themselves. This method was tested by giving six sessions of relaxation training, followed by six sessions of belief modification followed by six sessions of desensitisation training, for each of the three subjects. Better results were obtained for belief modification than for desensitisation or relaxation. This model has remained integral to most approaches devised subsequently, demonstrating reasonable results with small samples (e.g. Hole, Rush & Beck, 1979; Chadwick & Lowe, 1990; Lowe & Chadwick, 1990).

Most recently, Chadwick and Lowe (1994) report that in a series of 12 case studies, 5 rejected their delusions completely and 10 reduced their conviction, as measured using a modified version of the Personal Questionnaire (Shapiro, 1961; Phillips, 1977; Garety, 1985) which provides statements of symptom intensity endorsed by the individual (described in Chadwick & Lowe, 1990). Generally, acknowledgement by the patient during the early stages that disconfirmation of their beliefs was possible has been found to predict success (Watts, Powell & Austin, 1973; Brett-Jones, Garety & Hemsley, 1987; Chadwick & Lowe, 1990). Drury et al (1996a, 1996b) provide evidence of successful intervention with acute in-patients, versus controls engaged in activities for equivalent time. Positive symptoms were reduced and gains were maintained at 9 month follow-up; whether the activities provided a fair control is debatable, however, and not all other treatment factors were controlled. Sample sizes are small in these studies and general and longer term outcomes are not presented, such as effects on functioning: it is not clear how meaningful any changes might be in the patient's life. Most of the CBT interventions described in the literature focus on the content of the delusions and fail to take account of motivational factors or emotional functions. The lack of success with some subjects may relate to the emotional function of their delusions.

Chadwick et al (1996) suggest that the different types of paranoia they have identified require different emphases in interventions. "Poor me" paranoia requires careful rapport building as these clients may be most difficult to engage and react to any sense of criticism/disbelief. The aim of therapy would be to explore the nature of the delusions and gradually uncover the underlying fears regarding the self. "Bad me" paranoia may be easier to engage. Therapy should begin with developing a recognition of
the underlying negative evaluation of self and challenging it, recognition that this drives
the paranoia and then disputing the paranoid ideas themselves. This fits with findings
from the cognitive research suggesting self-esteem may need to be improved before
delusions can be tackled directly and may be considered as an example of increasing
sophistication in CBT for psychosis.

8. CURRENT THINKING ON THE ELEMENTS OF SUCCESSFUL
INTERVENTION

The literature reveals some consensus on the important elements of successful CBT
with psychosis, described below. Research is needed, however, to elucidate the
"necessary" components of successful intervention.

8.1. Therapeutic Alliance:

In the literature reviewed, developing and maintaining therapeutic alliance is
deemed paramount, with various approaches used to foster a collaborative relationship
within which to explore the client's difficulties: this may be a particularly pertinent issue
in working with people with delusions. There is evidence that failure to form a strong
therapeutic alliance is generally associated with non-compliance, premature termination
and poor outcome (e.g. Eisenthal et al, 1979; Gomes-Schwartz, 1978).

Obstacles to developing an alliance are fear of control by others amongst those who
hear controlling voices, fear of enraging the voices and the transfer of delusions on to the
therapist, especially paranoia. Clear acknowledgement of these issues if they seem to be
arising and stating that the client may cease therapy without question at any time are
suggested (Chadwick et al, 1996; Fowler et al, 1995).
8.2. Providing Alternative Explanations:

Giving information about cognitive biases or perceptual disturbances is implicit in most approaches, as a means of providing alternative explanations for the patient's experiences. Open discussion of psychotic experiences is a common feature which distinguishes CBT from other approaches: this may create some distance from their symptoms for the patient and promote therapeutic alliance (Fowler et al, 1995) and fits with evidence that people who cope well with hallucinations in the normal population discuss them more openly (Romme et al, 1992). Several authors argue explicitly for including explanations of the medical model of schizophrenia (Kingdon & Turkington, 1991), proposing that this is decatastrophising. Many take great pains, however, to avoid the mention of "illness" and the reactance it might create. Stigmatising beliefs about mental illness have an impact on well-being (Birchwood et al, 1993), although the view of the patient as a passive recipient of labelling has been largely discredited and it is increasingly acknowledged that the person may accept or reject their "label" depending on various individual factors (Warner et al, 1989). The model which is growing in popularity is the notion of working within the person's belief system (Fowler et al, 1995). This allows therapy to develop without confrontation, whilst protecting the therapeutic alliance. In line with a symptom rather a disorder approach, the focus is increasingly on the beliefs which constitute the source of the client's distress rather than notions of illness.

8.3. Techniques and Approaches:

Using coping strategy approaches is recommended to gain a sense of control and some stability before other approaches are introduced (Fowler et al, 1995; Chadwick et al, 1996). A major difficulty with CBT for psychosis concerns tackling strongly held but bizarre or unlikely beliefs. Most authors advocate fostering an atmosphere of collaborative empiricism in discussing beliefs, vividly described as the "Columbo technique" (by Meichenbaum, 1986 -discussed in Fowler et al, 1995 p.97), rather than direct challenge. Thought chaining and reaction to hypothetical contradiction may be
used to elucidate the meanings and significance of the belief to the individual (Chadwick et al, 1996). Importantly, the client's distress is the explicitly stated impetus for change rather than "faulty beliefs".

9. AN INTEGRATING FRAMEWORK

Despite evidence that psychoanalytic therapy with psychosis is potentially harmful (Gunderson et al, 1984), to the extent that Mueser and Berenbaum (1990) call for a moratorium on its use, some authors suggest the adoption of principles derived from analysis as a framework for therapy, focusing on the therapeutic relationship and the subjective experience of the client (Waylenksi, 1992). The grieving issues raised by having a debilitating disorder and its effects on identity are addressed (Coursey, 1989). Emphasising the subjective experience of the individual and wider emotional factors complements and provides the framework that may be lacking in otherwise useful cognitive approaches to symptomatology (e.g. Beck, 1952; Fowler & Morley, 1989; Bentall et al, 1994). Issues of process in therapy have rarely been addressed in CBT intervention studies; this reflects the use of CBT 'techniques', rather than interventions tailored to address the client's underlying difficulties and distress.

A more integrative framework for CBT with psychotic problems is developing, however. Fowler, Garety and Kuipers (1995) propose an approach described as 'cognitive-emotional', in that both cognitive deficits/biases and emotional/motivational factors are explicitly acknowledged and addressed. Intervention is based on detailed assessment of the individual's symptoms, the sequence of development, the meanings for the individual and the life style choices made in relation to them, within the context of a sound collaborative treatment alliance. A flexible approach, responsive to current need, is recommended, aiming to progress through the development of coping strategies to reduce distress or triggering of symptoms, towards collaborating to develop a shared model of the nature of the psychotic experiences, and then cognitive interventions for specific symptoms based on this shared understanding. The strength of this model lies in a detailed discussion of the individual's life experiences, leading to a shared view of the
meaning and development of their symptoms, before introducing more challenging strategies aimed at change. The client's own beliefs about and the emotional importance of their symptoms to them can be taken into account, making it easier to predict the likely impact and limitations of change for that individual. Regarding outcomes, Fowler (1992) reports positive results in 9 single case studies of patients with positive symptoms and associated distress, who received an average of 22 sessions of individualised CBT. Further, Garety et al (1994) report positive changes in symptomatology, depression, conviction, preoccupation with and interference with daily life due to delusions in a group of 11 patients, who completed an average of 16 sessions of individualised CBT, compared with waiting list controls. The treatment group was small, however, and an alternative treatment control condition would have been more informative.

Similarly, Chadwick et al (1996) describe an approach to assessment and intervention based on the fundamentals of the theory of CBT provided by Ellis (1962: 1994) and Beck et al (1979). They propose a movement from a symptom to a "person model" (p.175), in which symptoms are understood within the individual's search for meaning and identity. They attend to the impact of early experience on evaluations of self and others, within the framework of a cognitive developmental theory of the person. Again this theoretical perspective elucidates issues of process in therapy through clear formulation of the meaning of symptoms to the individual. Although as yet based on preliminary findings, approaches and process issues are identified for different beliefs, indicating the sophistication of CBT for psychosis. Although they describe informative single case study material, no controlled outcome studies have been completed using this approach.

10. CONCLUSIONS

CBT research has provided some evidence that gains can be made with debilitating positive symptoms. Cognitive theories of symptom formation remain contentious, however, and seem to add little to therapeutic approaches beyond the basic recognition of continuity between biases in normal cognitive processes and those underlying psychotic
symptoms. Broad outcome measures and adequate follow-up are lacking: as yet, whether these interventions have a significant impact on the person's life is unclear. In the original attempts at CBT, the subjective experience and function of symptoms and the emotional impact of change were ignored. Interventions must be led by the needs of the patient rather than the methods available: issues of loss and self-esteem may be paramount and symptom change may be threatening as well as helpful. The context of a strong therapeutic relationship seems to be crucial but may be difficult and time-consuming to develop. Little is known about which patients benefit most from CBT. An integrated model of the different approaches to hallucinations and delusions is only just developing, especially regarding process issues. The danger seems to be the possibility of indiscriminate use of CBT 'techniques', rather than constructive interventions based on careful collaboration with and deeper understanding of the person and their search for meaning. The strength of this field seems to be the application of knowledge about normal psychological processes to elucidate the processes underlying abnormal experiences, both reducing the need to categorise individuals and increasing the scope for understanding and change.
11. REFERENCES


ACADEMIC REVIEW THREE:
A CRITICAL REVIEW OF THE LITERATURE ON ADHERENCE TO MEDICATION REGIMES IN MAJOR PSYCHIATRIC DISORDERS AND THE APPLICATION OF THEORY
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1. INTRODUCTION

The concepts of compliance/adherence have provided a common focus for research in medicine and social science. A shift has occurred from the term "compliance" to its replacement with "adherence", following criticism that it implies compliance as an absolute ideal. As such, "compliance" is tied to the dominance of medicine (Donovan & Blake, 1992). The shift to "adherence" occurred in response to findings that patients may not comply with medical advice for many valid reasons (Peck & King, 1985) and to changing ideologies regarding the patient's rights/needs for information, two-way communications and a sense of control in the treatment situation (Piatkowski & Farnill, 1992).

Non-adherence with medical advice occurs on a large scale (Garrity, 1981; DiMatteo & DiNicola, 1982). As approximately one third to one half of patients do not adhere to advice in all fields of medicine (Ley & Spelman, 1967; Conrad, 1985; Zola, 1981), then non-compliant behaviour cannot be viewed as deviant or abnormal (Donovan & Blake, 1992). Nor is non-adherence a fluctuating occurrence but rather an enduring behaviour (Dunbar-Jacob, 1993).

A number of methodological difficulties in researching this field have been identified. Primarily, adherence is defined differently in different studies and is difficult to measure accurately. Self report is often used but where more objective checks have been carried out, large overestimation has been found unless the person says that they are taking no medication, which is usually accurate (Roth, 1987). Physicians' estimates are as bad; they usually overestimate adherence by some 50% although this improves when they know patients better (Roth, 1987). Pill counts are also unreliable (Babiker, 1986). Studies rarely measure clinical outcome or factors related to outcome (Bartko et al, 1988). Often degrees of adherence are not measured but arbitrary divisions into "compliers" or "non-compliers" made. Piatkowski and Farnill (1992) note several common methodological weaknesses in studies relating to schizophrenia, including the heterogeneity and small size of samples, a lack of prospective studies and the failure to build on previous research findings. With particular reference to schizophrenia, predictor and outcome variables may be confounded as cessation of medication can be an early sign.
of relapse (Curson et al, 1985). Cameron and Best (1987) argued that the majority of compliance literature has not been well grounded in theory.

2. ADHERENCE IN PSYCHIATRIC DISORDERS

In major psychiatric disorders, since the development of the neuroleptics in the 1950's, medication has been heralded as a solution to patient distress and hospitalisation. The efficacy of neuroleptic medication in the treatment of psychoses is presented as unequivocal in the literature (Davis et al, 1980; Baldessarini, 1985). Consequently, many patients are expected to remain on long term medication. The efficacy of maintenance neuroleptic treatment for the prevention of relapse in schizophrenia has been established in a number of studies (Hogarty, 1984; Kane, 1984; Johnson, 1984; Leff et al, 1984). Maintenance neuroleptics lessen the severity of symptoms if a relapse occurs (Bartko et al, 1987). Relatively little is known, however, about their specific pharmacological properties (Cohen, 1988), the time course of their effects and whether the effects are specifically antipsychotic or partly sedative; if this is the case, then the extent of side-effects from antipsychotics may not merit their sole use (Keck et al, 1989). In bipolar affective disorder, it is argued that prophylactic medication is essential to prevent the recurrence of symptoms and hospitalisation (Baastrup & Schou, 1967; Jamison et al, 1979). Total adherence is the implied aim, some authors arguing for this explicitly (Falloon, 1984).

As in all fields of medicine, rates of non-adherence are high in psychiatry. The reported incidence of non-adherence with antipsychotic medication ranges from 11% to 80% (Corrigan, Liberman & Engel, 1990); 48% of patients are estimated to be non-adherent within the first year of treatment and 74% within the first two years (Weiden et al, 1989). Similarly, Van Putten (1975) estimated that some 20 to 30% of patients independently discontinue lithium treatment.
3. THEORETICAL ACCOUNTS OF ADHERENCE

In their review, Leventhal and Cameron (1987) argue that adherence behaviour is multifaceted, requiring considerable theoretical analysis. They describe five major theoretical perspectives that can be discerned from the literature: these are the biomedical perspective, social learning models, patient-practitioner communication models, rational belief models and self regulatory systems theory.

3.1. The Biomedical Perspective

In general medicine, adherence was originally viewed from a "biomedical" perspective, in which disease is seen purely in terms of biological malfunctions, invasion by foreign agents, genetic factors etc.. This is relevant to psychiatry, as biomedical formulations remain central even with evidence of psychosocial correlates (Breggin, 1993). Within this model of adherence, the patient is viewed as the passive recipient of instructions that must be obeyed. Stemming from this view were disappointing attempts to identify the dispositional characteristics of "non-compliant" patients. The model was further discredited by evidence that rates of compliance with medical advice are no better amongst physicians than patients (Blackwell, 1973). Research provided evidence that characteristics of the complaint are more important, i.e. severity, likelihood of improvement etc., and of treatment, i.e. complexity, duration, side-effects etc.. Further, treatment delivery factors were found to be influential, such as shorter delays between referral and appointment, choice of treatment site (Hertroijs, 1974), and continuity of practitioner (Becker et al, 1974). The biomedical perspective is limited by ignoring physician behaviour and the effects of psychological processes.

Within the biomedical framework, a number of barriers to adherence with psychiatric medication can be identified. Medication does not always work. Around 20% of schizophrenic patients experience little or no therapeutic effect from neuroleptics (Corrigan, Liberman & Engel, 1990) and 30-40% of patients treated with depot neuroleptics relapse within two years (Johnson, 1976). The degree to which this lack of effect of neuroleptic medication is due to non-adherence is unclear, however, although
studies of depot medication may be more reliable in which medication is administered by
staff and non-adherence can be partialled out. Further, Brown and Herz (1989) have
found that half of the neuroleptic non-responders in their study either improved or
remained the same when gradually withdrawn from medication. Ineffectiveness may
constitute a rational reason for discontinuation. Buchanan (1992) found that the patient's
own belief that medication had helped was a strong predictor of adherence.

The side-effects of medication also merit consideration. Some patients describe a
changed subjective state after just a few doses of neuroleptics, described as inability to
themselves tried a dose of neuroleptic medication and reported feeling restless, lacking in
energy and anxious. These unpleasant experiences may create a preference for non­
adherence. There is also evidence that some demonstrate a dysphoric response after just a
few doses and that this augurs poor therapeutic outcome (Singh & Smith, 1973; Singh &

The presence of akathisia is a strong predictor of poor outcome (Levinson et al,
1990). In a longitudinal study of neuroleptic non-adherence in schizophrenic patients,
Weiden et al (1991) noted that distress due to akathisia was a predictor of future non­
adherence. Some controversy remains regarding the impact of akathisia on adherence
(Buchanan, 1992); some authors even claim that it increases adherence as the patient feels
that the medication is "doing something".

Complexity and duration of treatment regimes are indicated in relation to non­
adherence in general medicine (Ley, 1982); this is pertinent to psychiatric prescribing in
which polypharmacy and maintenance medication is common. Haynes (1976) found that
the complexity of the regime and the degree of active behaviour change required were
influential. Meichenbaum and Turk (1987) demonstrated that the frequency of dosage
rather than the number of tablets prescribed is the important factor.

In a review of the literature on the influence of side-effects, Awad (1993) argues
that clinicians need to listen to the subjective experiences of patients. The studies cited
above suggest the possibility of predicting which patients will not respond to
neuroleptics. Better premorbid information processing ability (Marder et al, 1984) and
premorbid social functioning (Goldstein et al, 1978) are associated with responsiveness to neuroleptics, along with early signs of symptom relief and the absence of an early dysphoric response. Corrigan et al (1990) argue that long term treatments for psychiatric disorders are aversive because they are stigmatising and create hopelessness. There are currently few studies exploring selective use of medication based on the evidence regarding non-responders in the literature.

3.2. Social Learning Models

A second theoretical perspective to emerge (Leventhal & Cameron, 1987) was based on operant and social learning behavioural models, concerned with the behaviours needed for adherence rather than dispositional factors (Henderson et al, 1979). Attention turned to the stimuli and cues that elicit and the rewards that reinforce adherence behaviour, leading to skills training programmes aimed at shaping and automating adherence through repetition. Some success was demonstrated but only with routine behaviours, i.e. regular but not intermittent pill-taking. It was generally found that the behaviour itself needs to be reinforced rather than just the outcome. High relapse rates are evident and maintenance is problematic. Many authors concluded that there was a need to study the situational, cognitive and motivational processes underlying change.

Cognitive dysfunctions associated with schizophrenia may present problems with learning medication management skills. These difficulties are more closely related to negative than positive symptoms (Bellack et al, 1989; Eckman et al, 1992). Corrigan et al (1994) found that short-term recall and visual vigilance are correlated with the ability to learn medication self-management, whereas the severity of psychotic symptoms was unrelated. They suggest that addressing deficits in short-term memory is a necessary adjunct to skills training packages. Highly structured training, using operant conditioning and learning theory, has demonstrated greater efficacy than purely educational models. Eckman, Liberman and colleagues report success with such a method, the Medication Management Module (Liberman et al, 1986). This consists of a package of training aimed at increasing knowledge of the benefits of antipsychotic medication, self-administration and evaluation, identifying side-effects and skills in negotiating
medication issues. Various cognitive-behavioural techniques are employed, including goal setting, overlearning, positive reinforcement and modelling. Increases in medication knowledge were found compared with controls receiving similar amounts of active, educational attention, and the changes produced were maintained at one year follow-up; the format is adaptable to normal clinical settings (Eckman et al, 1990; Eckman et al, 1992). There are no replications however.

Factors in service delivery, environmental cues and reinforcements also impact on adherence. Long waits before seeing the clinician (Craig et al, 1974; Raynes & Warren, 1971) decrease adherence, whereas systematic scheduling of appointments and appointment reminders increase attendance at clinics (Gariti et al, 1987). Liberman and Davis (1975) turned their clinic into a social hour in which relatives and patients mingled with the psychiatrist over lunch whilst the patients were observed, side-effects discussed etc.. Patients identified as taking their medication through urine testing were given small rewards. This group were significantly better on attendance, adherence and attitudes to medication than controls, and used in-patient services less at one year follow-up, although this approach might seem patronising or intrusive to some and other factors such as level of disturbance may account for the differences found. Continuity of contact with the same practitioner increases adherence (Witheridge & Dincin, 1985; Test, 1990) and this is a feature in the design of successful community outreach programmes. The literature indicates that improved supervision leads to improved adherence (e.g. Goldberg et al, 1977). Buchanan (1992), in a two year prospective study of adherence in schizophrenia, found that compulsory admission was associated with poor adherence at one and two years post discharge and suggests that it may "render the patient antipathetic to further treatment" (Buchanan, 1992 p795). The author notes that changes in the illness may also be related, i.e. changes in insight leading to both non-adherence and compulsory detention.

### 3.3. Patient-Practitioner Communication

Focusing on the practitioner, the communications approach was developed, in which adherence is viewed as effective persuasion (Leventhal & Cameron, 1987),
emphasising the nature of effective patient-clinician interactions. Ley (1977) demonstrated that the message must be organised and well-specified, allowing the patient to process it fully. The patient's level of satisfaction with consultation and doctor is positively correlated with adherence at a level of 0.35 and satisfaction in both psychiatric and medical fields is about 39% (Ley, 1986). Satisfaction with the clinician tends to occur when the patient perceives them as warm, friendly, empathic and concerned (Korsch & Negrete, 1972). Meichenbaum and Turk (1987) found that the clinician's interpersonal skills, including listening, eye-contact and their belief in the efficacy of medication influence adherence. Winefield (1992), in reviewing the research, concludes that combinations of partnership building, friendliness, responsiveness and information-giving are effective. The latter is important to reduce helplessness and increase the patient's sense of the doctor's competence. Adherence is also improved if the clinician provides information on how to carry out the recommendations as well as the recommendations themselves (Leventhal et al, 1965). There are no studies of these factors specifically with psychiatric patients.

What is lacking in this research, however, is an understanding of how information effects attitude change. Information does not always lead to adherence, even when the advice is clearly understood by the patient (German et al, 1982). The acceptance of treatment also depends on the extent to which the patient accepts the health threat and accepts that treatment is worthwhile (Fishbein & Azjen, 1975). There is some evidence for the "vividness effect", in which threat/fear messages increase adherence; it is unclear, however, when this occurs or when threat leads to avoidance (Taylor & Thompson, 1982). Leventhal and Cameron (1987) conclude that information is necessary but not sufficient for adherence, and that motivation to act on the advice is required.

More recently, the focus on therapeutic alliance has been developed. Donovan and Blake (1992) argue that the crucial factor in improving adherence is the development of "active, co-operative relationships" between doctors and patients. They relate success to the clinician being aware of the patient's decision-making abilities, understanding their needs and constraints, and working with them to develop treatment regimes. Corrigan et al (1990) suggest that the clinician takes responsibility for promoting a co-operative
relationship by modelling with their own behaviour, i.e. being receptive to the patient's views and providing explicit feedback about treatment. A positive relationship between therapeutic alliance and adherence has been found (Frank & Gunderson, 1990), which is one of the best predictors of treatment success (Luborsky et al, 1985). Weiden (in Frances & Weiden, 1987) sees the development of a collaborative relationship as paramount with many schizophrenic patients and that those who resolutely resist should be allowed to leave treatment without feeling punished, whilst being aware that the clinician disagrees, thus not damaging future adherence. As such, treatment resistance and denial are viewed developmentally (Axelrod & Palgi, 1990) and need to be worked through in collaboration with the clinician, whilst preserving the patient's sense of autonomy and responsibility. Eisenthal et al (1979) found evidence that adherence is improved if an atmosphere of negotiation is present.

3.4. Rational Belief Theory

From a recognition of the importance of attitudes to adherence, a rational belief theory perspective was developed, the underlying assumption being that human behaviour is determined by logical thought processes. As such, given appropriate information on risks, benefits and consequences of health behaviours, then people would take appropriate health preserving actions. Adherence is seen as the result of a cost-benefit computation (Fishbein & Azjen, 1975; Janz & Becker, 1984). The most popular and widely used is the Health Belief Model (Becker, 1974). Four basic dimensions are delineated as underlying health behaviour: the perceived probability of a threat/perception of vulnerability to a health condition; the perceived severity of health and social consequences; the perceived benefits, efficacy and reasonability of a particular health behaviour; the perceived barriers/impediments to undertaking that behaviour. Research has shown that perceived barriers are the most powerful factor, followed by vulnerability, benefits and severity. This model only accounts for a limited amount of the variance in relation to adherence. From the work of Fishbein and Azjen (1975) it can be seen that perceived social norms of behaviour are also influential. Leventhal and Cameron (1987)
argue that this model is limited by only being concerned with conscious, intentional behaviour at one point in time, rather than accounting for process issues.

Despite its popularity, few studies have tried to assess the utility of the Health Belief Model with psychiatric patients. Mostly, only the relationships between single factors and adherence have been studied, such as fear of recurrence of symptoms of depression and increased adherence to a lithium carbonate regime (Jamison & Akiskal, 1983). Kelly et al (1987), however, assessed the validity of the model in its entirety with a psychiatric population. Their study found that, as with medical patients, people with psychiatric disorders hold clear and identifiable beliefs about their illness. The five measures of health beliefs mentioned above accounted for 20% of the variance in adherence. Barriers to adherence, such as side-effects, were found to be less important in this study than risk of relapse and severity of illness. The authors suggest that the impact of side-effects may diminish for some people. It is suggested that clinicians normally using a restricted range of strategies to influence adherence, need to take all the factors into account along with the individual's stage of recovery.

Beliefs about illness may play a particular role in psychiatry as denial or lack of insight is a common feature of psychosis which has been related to non-adherence by some (Mozdzierz et al, 1973; Bartko et al, 1988) but not by others (Buchanan, 1992; McEvoy et al, 1989a). Much depends on how insight is defined; if, as in Lin et al's study, it is partly defined by the patient's acknowledgement of need for treatment, then no wonder it is correlated with adherence. The danger is that insight has come to mean "agreeing with the doctor". Also worthy of note is the significant impact of stigma (Weiden et al, 1989). It is suggested that refusing medication is one way to assert autonomy for those experiencing feelings of loss of control and passivity regarding their illness (Van Putten, 1974).

Elevated mood has been found to relate to non-adherence with medication in bipolar affective disorder (Connelly et al, 1982; Jamison et al, 1979). Van Putten et al (1976) found that grandiose delusions and positive self-image are linked to non-adherence, as opposed to anxiety and depression. The authors argue that a subset of patients are never fully reconciled to the need for medication and have difficulty
tolerating increased contact with reality. This indicates the need to understand the patient's motives for non-adherence, i.e. escape from stigma or a preference for the psychotic reality. It may be presumed that for some patients there are secondary gains in remaining psychotic. Geisen and Feuer (1984) argue that psychosis constitutes an escape from reality, which may function as a defence against experiences perceived as too distressing to confront. The authors present an interesting perspective, interpreting resistance to treatment as functioning to contain aggression or to resolve dependency needs and separation difficulties through hospitalisation, in the context of dysfunctional family relationships. These issues require further study.

Psychiatric patients on long term medication regimes may fall into a category which is ill-understood in terms of health behaviour theory. Kasl (1975) argues that the Health Belief Model cannot account for the nature of "at risk" status. This requires adherence to treatment in order to reduce risk, a sick-role behaviour, from someone who does not feel sick. The expectations, norms and sanctions involving the individual, the doctor and significant others are potentially quite different from the traditional view of the sick-role (Parsons, 1951; Twaddle, 1972). Kasl proposes the need for modifications of the concepts of health, sickness and the sick-role, to include the "at risk" role (Baric, 1969), which lacks the reinforcements, privileges and feedback seen to be inherent in the sick-role.

An approach derived from the Health Belief Model which is currently popular is the use of motivational interviewing (see Miller, 1983) to explore with the client their attitudes to the advice given and their readiness for change. Rollnick et al (1992) argue that advice-giving about behaviour change is premature if ambivalence has not been addressed and may push the patient into psychological reactance (Brehm & Brehm, 1981). More patient centred approaches have proved useful with smokers (Ockene et al, 1991) and others (Kaplan et al, 1989). A method of brief motivational interviewing has been devised by Rollnick et al (1992), using the stages of change model (Prochaska & DiClemente, 1986) as a basis for assessing the level at which to intervene in brief consultations. This kind of practical approach may be useful in dealing with psychiatric medication adherence, requiring further study.
3.5. Self-Regulatory Systems Theory

The fifth theoretical approach described by Leventhal and Cameron (1987) is self-regulatory systems theory. The individual is conceptualised as an active problem-solver and adherence behaviour as depending on the individual's cognitive representations of illness (Carver & Scheier, 1982; Leventhal & Nerentz, 1983). Leventhal's (1984) self-regulation model identifies three stages of adaptive behaviour in a health episode: first is forming a cognitive representation of a health threat including the causes, consequences and manifestations over time; second is developing coping strategies; third is the stage of gauging success. Leventhal argues that two independent processing systems are involved in the formation of illness representations, comprising episodic and semantic memory, i.e. previous experiences of illness/medical care (schematic memories) and less personal knowledge about the illness (conceptual knowledge). Non-adherence may be conceptualised as a discrepancy between the individual's and the practitioner's perception of the health threat, relating to information from previous experience despite that given by the practitioner, or to the appraisal systems used, i.e. if perceptual cues are used to judge risk, medication may be ceased in remission despite advice to continue for prophylactic reasons. Failure to communicate at any of the three stages potentially leads to non-adherence, highlighting the need for clear guidance on each, including how to appraise the success of the intervention.

This is proposed as an integrative framework for previous models (Leventhal et al, 1992). Several studies found evidence that adherence is determined by perceptions of symptoms and episodic memories for previous illnesses rather than semantic beliefs about the illness per se (e.g. Meyer et al, 1985), indicating that the experience of symptoms is a powerful factor in adherence. Research evidence is lacking regarding the application of this theory, however. The emphasis on the impact of previous episodes and the treatment context may be important in psychiatry, i.e. the way the person's disease history unfolds in the context of care received over time, in that process issues are highlighted.
4. ETHICAL CONSIDERATIONS

Of particular note is the fact that ethical considerations receive scant attention in the literature. Professionals do not always act indefensibly; some continue prescribing doses that are no longer appropriate (Clark & Holden, 1987) and prescribing fluctuates rapidly at times of organisational stress (Gouse, 1984). Seeking adherence to treatment that is ineffective or has adverse effects would be unethical (Haynes et al, 1987). This area requires greater attention in the future, although this process seems to have begun with studies of early intervention.

5. EARLY INTERVENTION

Early intervention studies constitute a promising area of investigation, based on collaborative clinician-patient relationships and a more considered approach to prescribing, with the aim of minimal prescribing and maximum co-operation between clinician and client. Herz et al (1989) were motivated by concerns about tardive dyskinesia to explore the use of intermittent versus maintenance medication by predicting relapse from the identification of prodromal signs in schizophrenia. It was found that medication and crisis counselling could restore most patients to former functioning in less than one month, with limited hospitalisations. Similarly, Falloon (1992) successfully used intermittent stress management, education and medication. In a review, Birchwood (1992) argues that success is demonstrable with this approach but that the value of prodromes in predicting relapse is unknown and requires prospective studies. Further, the predictive nature of the prodrome relates to the individual's baseline, forming a "relapse signature" for each patient, rather than general rules. Good results have been achieved in training prodrome self-monitoring in patients with manic-depressive psychosis, suggesting that the approach is also relevant with this group and requires continued study (Molner et al, 1988; Smith and Tarrier, 1992).
6. CONCLUSIONS AND IMPLICATIONS

The existing theories of adherence have not been widely applied or tested with psychiatric patients, and many research approaches are atheoretical. What can be concluded from the literature is that, as in general medicine, adherence is a serious problem in psychiatry, although this is partly due to either negative effects or a lack of effectiveness of psychiatric medications. Listening to the subjective experiences of the patient seems paramount, particularly to assess early responses with antipsychotic medication. Attention to the complexity of the regime and the cognitive functioning of the individual is also crucial. In order to maximise adherence the literature indicates that the clinician must work from an understanding of the individual's beliefs about their illness, their medication and their motivations regarding both. Similarly, the individual's experiences over time must be taken into account. Close, collaborative relationships between patient and clinician, in which the patient's views and experiences of medication/treatment (including compulsory admission) are closely attended to and treatment is negotiated, are critical for appropriate, effective treatment in psychiatry. This is the growing perspective in the literature reviewed.
7. REFERENCES


RESEARCH PROJECT:
A STUDY OF THREATENED IDENTITY IN SCHIZOPHRENIA
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ABSTRACT

This study explores the impact of schizophrenia on identity at three levels: symptomatology (impairment), performance of everyday roles (disability) and stigma (handicap). Identity process theory (Breakwell, 1986; 1992a,b) is adopted as the central approach for assessing identity in schizophrenia; it provides an integrated framework of previous research, focusing on the processes of identity change in relation to threatened identity. The relevance of considering the experience of psychosis and diagnosis with schizophrenia as threats to identity is discussed. The literature on identity and coping in schizophrenia is reviewed and several strategies for coping identified as being particularly important. These are insight into or denial of difficulties, exaggeration of difficulties and self-efficacy relating to symptoms and disabilities. Measuring identity and insight/denial is explored.

Fifty men diagnosed with schizophrenia living in the community, and staff involved in their care, were interviewed. Their sense of identity and identity change, their views of their symptoms, behavioural difficulties, role-performance, specific self-efficacy, social networks and perceived stigma were assessed. The relationships between these factors were then considered.

High levels of identity change in response to schizophrenia were indicated by the participants. Evidence that schizophrenia can present a threat to identity at all three levels was found, although the importance of different aspects seemed to vary depending on individual meanings. Evidence for varied experiences of positive symptoms was found, with both detrimental and positive effects on identity. The individual’s evaluation of their own role performance, rather than the number of positive roles, had the greatest impact on identity. Stigma was not directly associated with identity, and processes of adjustment to stigma seemed to be indicated. More community-based social networks were associated with increased stigma, less self-esteem and greater insight. No strong, direct relationship was found between identity and insight/denial. Importantly, overall self-efficacy was negatively related to the number of admissions and self-efficacy relating to positive symptoms was associated with higher self-esteem.
The measurement of and the conceptual basis of the identity principles proposed in Breakwell's theory are discussed in the light of the findings of this study. Clinical implications and suggestions for future research are described.
1. LITERATURE REVIEW

1.1. INTRODUCTION

Schizophrenia is a recognised diagnostic category of mental illness in all psychiatric textbooks and has attracted interest from researchers since it's conceptualisation by Kraepelin (1896) and then Bleuler (1911). The accepted view in psychiatry is that schizophrenia is an illness, characterised by a variety of symptoms such as auditory hallucinations, bizarre and irrational beliefs, thought disorder, poverty of affect and social withdrawal. Much research has focused on classification and on seeking biological causes; the medical model of schizophrenia, however, has not gone unchallenged (Bentall, Jackson & Pilgrim, 1988; Bentall, 1990; Claridge, 1990).

Further, it has been argued that the life of a person diagnosed as schizophrenic cannot be viewed solely from the point of view of the course of the "illness" but that his or her development depends on a range of social and biological influences other than the "disease process" (Ciompi, 1980a -p.240). Similarly, Winnicott (1971 -p.66) argues that theories which divorce the subject from "the problems of ordinary living and the universals of development in a given environment" must be viewed with suspicion. The occurrence of long-term mental illness may be construed as a stressful life event for the person concerned (Hatfield, 1989) and increasingly, research has also focused on the nature of individual reactions to schizophrenia and their effect on outcome.

As such it has long been recognised that reactions to mental illness play a crucial role in subsequent disablement (Wing, Bennett & Denham, 1964). Wing and Morris (1981) argue that the reaction to the illness is at least as important as the symptoms themselves in determining outcome. Hence, reactions to illness may be viewed as a substantial problem for rehabilitation.

The World Health Organisation defines three levels of consequences of disease: impairment refers to the loss or abnormality of structure or function, disability refers to any restriction or lack of ability to perform activities resulting from the impairment and handicap is defined as the disadvantage for the individual that limits or prevents normal role functioning resulting from the impairment or disability (Wood, 1980). If
schizophrenia is to be considered as a disease, then its disabilities may be conceptualised as social disabilities and its handicaps as an interaction with the reactions of others (Shepherd, 1984). The purpose of this study is to explore the impact of schizophrenia on the identity of the individual, in terms of its impairments, disabilities and handicaps.

1.2. IDENTITY

The study of identity and self originated in existential and phenomenological philosophy. It has a long history in personality and social psychology, being a central tenet of many theories, since the writings of James (1890), Cooley (1902) and Mead (1934). It disappeared from view during the rise of behaviourism in psychology but re-emerged with force in the subsequent "cognitive revolution" (Gecas, 1982). In social psychology, the importance of self as a mediator between actions and the environment is increasingly recognised (Markus & Wurf, 1987).

Definition and terminology are problematic issues. The terms self or self-concept and identity appear in the literature in various guises. This makes comparison of theories difficult, as the terminology employed does not easily translate one to another. As Breakwell (1992a) asserts, placing a sharp distinction between the two constructs is difficult and they are used differently depending on the theoretical background of the author, whilst often attempting to understand the same underlying processes. Deaux (1992), in a review of this area, again notes the difficulty in distinguishing between the two constructs, but suggests that self has often referred to a more global, abstract concept, whereas identity has been more specifically related to aspects of self-definition. In Britain, social identity theory has provided an impetus for studying the nature of self within the context of social group membership (Tajfel, 1981; Turner, 1987). Formulations have often been around the membership of specific intergroup contexts or particular identities, such as occupation, gender and ethnicity.

Breakwell (1992a) describes two lines of theory of the relationship between identity and self in social psychology. In processual interactionism (Blumer, 1969) identity is seen as processual, that is emergent, reciprocal, negotiated and situated, changing in relation to time and context; it forms a part of the self-concept but its contents are
transient. In social interactionist theory (Stryker, 1979), identity is considered to be structural, as internalised roles, which are the actions and thoughts expected of someone in a particular social position. The self-concept is considered a product of the hierarchical organisation of role identities and is defined by levels of salience, commitment to and importance of these identities.

Breakwell (1986, 1992a,b,c) has formulated "identity process theory". It is presented not as a reconceptualisation of identity but rather as a means of facilitating "systematic examinations of threat and coping strategies" (p.11). In particular, identity process theory is concerned with the process of identity change in relation to the impact of events rather than just the contents, categories or particular role identities at any given time. The ideas about identity contained within the theory are not new but rather derived from past discussion of self and identity. The theory attempts to integrate these ideas into a framework.

Identity process theory has been chosen as the theoretical basis of this study because it draws together aspects of identity theory into a coherent framework. The theory emphasises identity processes in response to threat. This seems particularly relevant to the literature on schizophrenia, as will be discussed below. A brief outline of the main propositions of identity process theory will be given. Then the literature on schizophrenia pertinent to identity will be examined from the perspective of identity process theory, before its proposed effect on identity is summarised and methodological issues discussed.

1.3. IDENTITY PROCESS THEORY

The model presented is a social psychological one in which both intrapsychic and socio-political processes are deemed necessary to an understanding of identity processes. Identity is treated as a dynamic social product, which resides in psychological processes but can only be understood in relation to its social context and historical perspective. As such, identity is seen as a dynamic product of the interaction between the human cognitive capacities i.e. memory, consciousness and organised construal, and the influence of the processes which make up the social context.
1.3.1. The Structure of Identity

Within identity process theory (Breakwell, 1986), identity development is viewed as continuing throughout life, beginning with the interaction of the biological organism with the social context. The biological organism provides the core of identity and its parameters set the limits of identity development, its impact lessening with the accumulation of experience. The biological organism may be considered as one of the structural components of identity and is described as both a structure and a set of processes.

Identity is viewed as consisting of the content and value dimensions. Content refers to the characteristics that define the individual, which may be shared in some aspects with others but together make a unique configuration. A central distinction described by most theorists is that of the personal or private identity versus social identity, defined by social roles and relationships. Beginning in James' (1890) differentiation of the "I" and "me", or the knower and known, throughout identity theorising attempts to distinguish the self as subject versus object, the personal versus social and the actual versus ideal are evident. Importantly and in common with other theorists, Breakwell (1986) seeks a resolution of the perennial conflict in self and identity theorising between these dichotomies of identity content, through an understanding of the social processes which create the dynamic relationship between the contents of identity. The social-personal dichotomy had become central to identity theory, although most authors speak in terms of structure and do not attempt to describe the processes that link the two, missing out the psychological processes involved. The existence of this distinction has been questioned (Hollis, 1977), because of the development of personal identity through the individual's personal experience of social roles and relationships. Evidence suggests that individuals perceive a difference at a phenomenological level although individuals differ in their perceptions (Turner, 1976), that consciousness of the difference is greater when they come into conflict (Scheier & Carver, 1983) but that identity is essentially made up of both (Fenigstein, Scheier & Buss, 1975).
Breakwell argues that the individual is involved in the active and interdependent processes of accommodating to and assimilating self-conceptions derived from the social world, and that identity is the "relatively permanent residue" (p. 17) of this continuing process. A continuous, dialectic relationship between personal and social identity is proposed and the distinction of private versus personal identity is abandoned in identity process theory. It is argued that this cannot be criticised as implying crude determinism, however, because the process is one of active interpretation on the part of the individual. Breakwell argues that it would be an underestimation of the contradictory nature of the social pressures involved to assume that the individual could respond passively. Hence, identity is conceptualised as both a product of this process and an intrinsic part of the process itself.

Two dimensions of identity are specified in the theory, the content and value dimensions. In line with most theories of identity, the specific contents and organisation of identity are not viewed as fixed but are seen as changing in relation to each other depending on the social context experienced. Two approaches to describing the organisation of identity contents are apparent in the literature. There is evidence that the looseness or tightness of connections between contents may vary between individuals (e.g. Zavalloni, 1983) although the reasons for this are not fully understood. The relative salience or centrality of specific elements may also vary, and this seems to relate to characteristics of the situation making certain contents more relevant to the individual at a particular time.

The value dimension of identity refers to evaluation of the constituents of identity based in personal and social beliefs. This alludes to the process of self-evaluation also a central feature of identity theorising generally. It is proposed that each element in the content dimension will have a value attached to it. The values ascribed may not necessarily be constant, however, but responsive to the changing social context. Hence, the value dimension is seen as under perpetual revision in relation to the social context.
1.3.2. The Processes of Identity

Breakwell (1986) points out that most theories of identity concentrate on the structure without specifying the processes of identity, although they may be implied. Breakwell proposes two kinds of processes, accommodation/assimilation and evaluation. Assimilation refers to the process of absorbing new components into the identity structure and entails the reorganisation of salience of existing elements to achieve this. Accommodation refers to the process of adjustment in the existing structure in response to new elements, and involves activity in information-processing and memory systems. The two processes are interdependent and complimentary. The process of evaluation refers to the attachment of values to the elements of identity, via a process of personal and social comparison.

1.3.3. The Principles of Identity

Breakwell (1986) originally delineated three principles, described as fundamental codes which guide identity processes, that have been consistently demonstrated in a variety of studies from different theoretical traditions. The processes of assimilation and accommodation appear to function to create feelings of distinctiveness, continuity, and self-esteem for the individual. A fourth, self-efficacy, was added later (Breakwell, 1992b). There is general agreement about these, although others may exist. There may be times when these principles are in conflict with each other and which takes priority may depend on the social context. These changes in centrality of the principles is proposed as in part explaining situation-specific changes in behaviour. Cognitive processes are considered a necessary but distinct part of identity processes. Although the derivation can be traced in the literature on identity, there is no clear definition of each principle given in the theory. Similarly, the notion of a principle is not fully explained.
(i). Self-esteem

Self-esteem has been a central tenet of all identity theories in some form (Wells & Marwell, 1976). James (1890) highlighted its fundamental importance in the experience of self and defined it as the equation of success over pretensions. Breakwell (1986) does not give the definition of self-esteem that she is working from although numerous exist in the literature. The motivation to maintain and enhance a positive conception of oneself has achieved increasing importance in a number of theories as a motive for change (Gecas, 1982). This is conceptualised as occurring when a discrepancy occurs between the ideal self and the image of self perceived from actual behaviour. A central proposition of important theories is that information-processing and social behaviour are motivated towards the maintenance or enhancement of self-esteem and that the self-esteem is a fundamental human motive. The self-serving bias evident in attribution theory or defensive causal attributions supports strongly the notion of self-esteem maintenance or enhancement as a central motivation (Bradley, 1978). Rosenberg (1979) demonstrates that there is a tendency to distort reality in such a way as to protect self-esteem through selectivity strategies such as selective perception of which others are significant to the self, which social comparisons are made and which aspects of the self-concept are central. The reconstruction of personal histories (Greenwald, 1980) and ego-defence mechanisms (Hilgard, 1949) are also proposed as distorting reality in the service of self-esteem. Although high self-esteem is generally connected with positive outcomes, Mischel (1979) argues that self-enhancing information processing and biased self-encoding may be both the benefit and the cost, in terms of reduced accuracy in perceptions, of high self-esteem.

A distinction between global self-esteem and specific self-esteem has emerged in the literature. Global self-esteem, referring to the individual's positive or negative attitude to the self as a totality, has been the main focus of the body of research in self-esteem (Rosenberg et al, 1995). Recently, however, a number of writers have highlighted the relevance of studying the nature of specific self-esteem, that is relating to specific facets of the self (e.g. Harter, 1985; Marsh & Shavelson, 1985; Marsh, 1990). There is
evidence that although they may be dynamically interrelated, global and specific self-esteem are not interchangeable (Marsh, 1986), and that the degree of concordance between the two depends on the centrality of that facet to the person. Global and specific self-esteem have been found to relate differently to outcomes and consequences. Global self-esteem is a poor predictor of behaviour in comparison to specific self-esteem, which may bear much in common with self-efficacy; there is consistent evidence that global self-esteem is related to psychological well-being, in particular, the relationship between poor global self-esteem and depression (see Rosenberg et al, 1995).

(ii). Continuity

The notion of identity processes striving to maintain a sense of continuity is also a central tenet evident in many theories of identity (see Gordon & Gergen, 1968). It is generally seen as a weaker motivation than self-enhancement (Gecas, 1982). Continuity may be defined as a sense that the "me now" is the same as the "me then", with some sense of connectedness or unbrokenness between experiences of self (Allport, 1955; James, 1890). The concept is prominent in the writings of Erikson (1968) in his definition of ego identity as "accumulated confidence that one's ability to maintain inner sameness and continuity is matched by the sameness and continuity of one's meaning for others" (p.197): within this he also crosses the personal and social divide. The continuity principle is not intended to be incongruent with growth and change but relates to a subjective sense of consistency despite situation-specific differences in behaviour and changes in the individual over time (Gergen & Davis, 1985; Shotter, 1985). Essentially it is a perceived sense of consistency, actively created through the identity processes even when objective consistency does not exist. Again the processes of reconstrual of personal history and selectivity are evidence of its importance as a motivating factor in identity processes.
(iii). Distinctiveness

It is proposed that there is the motivation in identity processes to optimise a sense of uniqueness or distinctiveness from others. The derivation of the notion is least clearly specified in the literature although it may be extrapolated from James' (1890) sense of identity as derived from the experience of thoughts and ideas as belonging to the individual, distinct from those that do not, in Erikson's (1968) notion of a defined personality and Lynd's (1961) emphasis on individual uniqueness. It is embedded perhaps in the discussion of self-other differentiation in developmental psychology (e.g. Piaget).

It is notable that in social psychology, the concept of distinctiveness has largely been treated at the level of intergroup relations and is prominent in theories of intergroup behaviour. Tajfel (1981) argues that although much of behaviour may be understood at the level of interactions between individuals, we often behave as members of defined and distinct social categories. The seeking of positive distinctiveness through group differentiation and intergroup comparison is central to his theory of the formation of social identity. It is argued that group formation occurs through processes of self-categorisation which are functional in terms of providing a sense of coherence, by making self-other perceptions and expected behaviour predictable, and by allowing for the development of positive self-esteem through competitive intergroup distinctions (Turner, 1981, 1982).

The difficulty in extracting definitions of the concept of distinctiveness from the literature may be explained by the idea that a fundamental sense of "individuality" is central and unquestioned in Western thought, the notion of a unified, coherent and bounded self being intrinsic in Western psychology; Kitzinger (1992) discusses the arguments created by the social constructionist perspective that this is a culturally and historically specific notion of personhood and notes, in support of distinctiveness as a guiding principle, the value that is placed on individuality in Western society. Essentially, whether it is culturally specific or not, distinctiveness or individuality may certainly be viewed as a valued motivation in our society.
Identity process theory implies that positive ways of being distinct are sought although this is not explicitly stated and discussion of the impact of negative distinctiveness is lacking. The question of how much distinctiveness is optimal is not discussed in identity process theory. A number of social psychological theories posit a tension between opposing needs for assimilation or commonality with others and a need for uniqueness or individuation (e.g. Brewer, 1993; Codol, 1984; Snyder & Fromkin, 1980). It may be argued that a balance is sought between these opposing demands and that "optimal distinctiveness" is achieved only when both needs are satisfied (Brewer, 1993; Soloman, 1980). It is acknowledged that the need for distinctiveness may be culturally related and context specific. Breakwell (1992b) suggests that this principle may fluctuate most in its relative importance. It may be that fluctuations in the importance of the distinctiveness principle can be explained by the situational and cultural value attached to individuality in opposition to commonality at any given time. Identity process theory lacks discussion of the relationship between these two needs.

(iv). Efficacy

The efficacy principle relates to Bandura's concept of self-efficacy (Bandura, 1977a,b, 1989), described as a motivation to maintain an identity structure that is characterised by competence and control. An emphasis on the importance of a sense of personal control and capability as central to identity functioning predates Bandura however, and is evident in the writings of Cooley, Turner and Erikson (see Gordon & Gergen, 1968). Bandura developed the concept in the context of social learning theory (Bandura, 1977a) with the emphasis on cognition, in terms of expectation and beliefs, in the acquisition and retention of behaviour, in contrast to the behavioural tradition. Crucially, Bandura distinguishes outcome expectancy from efficacy expectancy. Outcome expectancy is defined as the expectation that a given behaviour will lead to certain outcomes, whereas efficacy expectancy is defined as the belief that one can successfully perform the required behaviour to produce the outcome. Hence, self-efficacy refers to a sense of personal mastery, rather than the expectation of outcomes. In
essence, "perceived self-efficacy is concerned with beliefs in one's capabilities to mobilise the motivation, cognitive resources, and the course of action needed to meet given situational demands" (Bandura, 1977b - p. 194). Self-efficacy must be differentiated from Rotter's (1966) conceptualisation of locus of control, although it is not uncommon for them to be confused in the literature. Locus of control is essentially concerned with beliefs about action-outcome contingencies, rather than beliefs in one's own ability to perform desired behaviours.

Bandura asserts that efficacy beliefs influence both the initiation and persistence of behaviour. Efficacy beliefs will also influence the choice of behavioural settings, in that the individual will avoid threatening situations with which they do not believe they have the skills to cope. Self-efficacy is proposed not as the only factor influencing behaviour, there must also be incentives and opportunities to produce that outcome, but of central importance in the initiation and persistence of coping efforts. There is evidence for the effects of direct, vicarious and symbolic information on expectations and beliefs about competence from social learning theory research. Positive physiological states may also enhance self-efficacy. Self-efficacy is seen as both cause and effect in relation to action. The individual's experience and history will influence their expectations of competence in a given area and influence their initiation of action and persistence with that action in that area. The experience of this in turn will influence self-efficacy.

Importantly, Bandura stresses the situation or task-specific nature of self-efficacy. An individual may perceive themselves as efficacious in one area but not in another: a general sense of self-efficacy pervading all activities is not proposed, although some authors argue the case for a global dimension of self-efficacy (Sherer et al, 1982; Breakwell, 1986, 1992b). Bandura (1977b) concludes that the social learning approach is a "microanalysis of perceived coping capabilities rather than on global personality traits or motives of effectance" (p. 203).
1.3.4. The Relationship Between the Principles

Self-esteem is posited as perhaps the superordinate principle in identity process theory (Breakwell, 1992b), with the other three acting as elements contributing to it. Hence it is accorded no less importance than in other identity propositions and psychology at large. This position does not go uncriticised, however: it has been suggested that the importance of self-esteem has been overrated in identity theory (Abrams & Hogg, 1988; Deaux, 1992; Gordon, 1968). Deaux (1992) suggests that needs for self-knowledge, meaning and guides for action may have as much importance in motivating identity processes and may precede concerns about self evaluation in the formation of identity.

Breakwell (1992b) suggests that distinctiveness may generally be subordinate to self-esteem. This may explain its fluctuating nature. The personal and social value attached to individuality in a particular setting or context may dictate the impact of the individual's experience of distinctiveness on their level of self-esteem.

Continuity is also suggested as subordinate to self-esteem (Breakwell, 1992b). Other theories imply a more central role for the continuity or internal consistency motive, however, rather than it influencing identity via an impact on self-esteem. For example, self-verification theory asserts that "negative self-conceptions may help people maintain a viable self-system and predictable orderly social relations" (Swann, Stein-Seroussi & Giesler, 1992 -p.289), stressing the importance of continuity in terms of its predictive value whether it is positively evaluated or not. Further study is required to elucidate the relationship between the two.

Further, the relationship between self-esteem and self-efficacy may be viewed as overlapping. Related to the distinction between specific and global self-esteem, self-esteem based on a sense of power or competence has been distinguished from self-esteem based on a sense of virtue or moral worth (Gecas, 1982), derived from norms and values relating to personal and interpersonal conduct. It is also noted, however, that these two aspects may blur at the experiential level (Covington & Beery, 1976). Hence, the efficacy principle is viewed as to some extent subordinate to the self-esteem principle.
1.3.5. The Social Context of Identity

Identity is considered a social product: the person gains their sense of self by understanding how others see them, but this is a dynamic process as the individual interprets and affects the social context. Two dimensions of the social structure are considered important. First is the structure of the social context, comprising interpersonal networks, group memberships and intergroup relationships, within which the individual moves. In relation to identity, these generate role-prescriptions and belief systems. Social change is viewed as the norm. Second is the process of social influence in which belief systems and their contradictions are propagated. The individual is presumed to move within the matrix of the social context, motivated by the search for self-esteem and positive social identity. Breakwell asserts that if achievement of a positive social identity is not possible then the individual may seek social change.

1.3.6. The Nature of Threats to Identity

Breakwell (1986) asserts that identity is threatened when experiences obstruct the processes of identity from complying with the principles of distinctiveness, self-esteem, continuity and self-efficacy. They are varied in form and are defined in relation to their implications for identity within individual consciousness. An internally generated threat may occur when an individual changes his/her social position in some way which has implications for compliance with one of the other principles of identity. In contrast, changes in the social context may pose externally derived threats to identity by negating one of the principles. Threats may relate to individual characteristics but also on a broader level to the individual's self-categorisation.

1.3.7. Strategies for Coping with Threats to Identity

Attempts to cope with threats to identity vary. Breakwell (1986) defines a coping strategy as an action or thought, the goal of which is to modify or remove a threat to
identity. The aim may be the removal of aspects of the social context which generate threat, movement into a less threatening social position, or revision of the individual's identity structures. Coping strategies can function at an intrapsychic, interpersonal or intergroup level. A number of strategies have been identified in each of these sections and are described below:

(i). Intrapsychic Strategies

1. Deflection

i). Denial may entail denial of the fact of occupying the threatened position at all, that being in that position is threatening, of the need to alter identity despite the threat or of the emotional implications of changing identity in response to the threat. These strategies may be a preliminary to others, as a way of "buying time". If it continues, denial may damage the individual's ability to remain in contact with reality.

ii). Depersonalisation also may be transient way of coping initially. In psychosis it may be chronic.

iii). Real and Unreal Selves: Aspects at variance with the self-concept may be evaluated as unreal and therefore not influencing identity.

iv). Fantasy constitutes a temporary consciously controlled escape from the threat.

v). Reconstrual or Reattribution may entail redefining the properties/meaning of the position the individual finds him/herself in or redefining the reason for being in that position, such as shifting to an external locus of control.

2. Acceptance

This always involves some alteration of identity, but aiming to minimise damage to the principles.

i). Anticipatory Restructuring involves gradually altering identity if a known threat approaches. It may avoid sudden changes in continuity and distinctiveness but could still challenge self-esteem.

ii). Compartmentalisation is encapsulating the unwanted part of the identity structure as separate from the rest. It usually involves holding conflicting views of the self which may be difficult to maintain.
iii). Compromise Changes: An alternative, modified identity is adopted - the sick role if the individual becomes unemployed for example.

iv). Fundamental Change involves surrender to the threat and changes in self-definition.

v). Salience of Principles: The priorities amongst the three principles may be changed in emphasis but this can only occur if one remains less threatened.

3. Evaluation refers to the process by which the individual evaluates aspects of identity in relation to social belief systems.

i). Revaluation of the Existing Content Dimension of Identity can involve revaluing the element of identity which is under threat, inflating some other element, or engaging in activities to increase self efficacy.

ii). Revaluation of the Prospective Content of Identity involves a refusal to accept the social value attached to the position or identity, or challenging others' right to make judgements relating to it. Group methods may be sought to back this up and help counteract external challenges.

(ii). Interpersonal Strategies refer to strategies in which relationships are altered.

i). Isolation functions to avoid stigma, pity, aggression or rejection and may go in conjunction with denial.

ii). Negativism entails getting into conflict with anyone who challenges the individual's identity structure, rejecting their expectations and refusing to change.

iii) Passing refers to removing oneself from the position of threat either psychologically through denial or socially by deceitfully portraying oneself differently.

iv). Compliance tends to occur when other strategies have failed and entails accepting the role of the threatened position. This may be associated with learned helplessness.

(iii). Intergroup Strategies

These may involve belonging to other social groups to offset the stigmatised one, seeking group support or group action in terms of pressure groups and social movements.
It is hypothesised by Breakwell that strategies are chosen depending on the nature of the threat and the individual's resources. If attempts to cope fail, which they may, then identity changes or withdrawal occurs. These changes may challenge the basic principles of identity but within the context of ongoing identity development.

1.4. IDENTITY AND SCHIZOPHRENIA

In this study, it is proposed that identity process theory can provide an integrative framework for understanding the literature and clinical observations pertaining to identity in schizophrenia. This offers the possibility of assessing the impact of schizophrenia on the identity of the individual and provides predictions about the array of strategies for coping that may be employed. It is proposed that the framework of identity theory can provide information about the factors relating to successful adjustment to schizophrenia and clarifies a number of conflicts regarding successful adjustment within the schizophrenia literature.

The relevance of attempting to understand schizophrenia within an identity theory framework is reinforced by clear evidence in the literature that schizophrenia can affect the individual's sense of self in a number of ways. The approaches to studying the effects of schizophrenia on sense of self can largely be criticised for being atheoretical, there are few attempts to assess schizophrenia from any particular social psychological theoretical perspective. A notable exception is the work of Rosenberg, Gara and colleagues (Gara, Rosenberg & Cohen, 1987; Rosenberg & Gara, 1985). Their theory is aimed at assessing the contents and structural organisation of those contents of identity, in particular the degree of elaboration of identity. Their approach is not concerned with the processes of identity change with which this study is concerned. Their theory proposes that schizophrenia is intrinsically a disorder of self, and therefore, focuses mainly at the level of impairment rather than the various levels of impact described below.

There is evidence in the literature on schizophrenia, however, that it may affect identity at the three levels of impairment, disability and handicap, thus suggesting that Rosenberg's approach may be important but too narrow to fully explain the effects of
schizophrenia. At the level of impairment, the phenomenological experience of the individual, in terms of the symptoms of psychosis itself, may influence identity. At the level of disability, the effect of schizophrenia on role performance via both personal experience and societal views in the form of stigma affect identity. At the level of handicap, the negative views of and beliefs about mental illness and schizophrenia in particular are proposed as affecting identity. Hence an impact both in terms of personal experience and its interaction with the social context is evident.

A number of theories of styles of adjustment to or coping with schizophrenia have been posited and are central to the literature on schizophrenia. These are generally known as theories of recovery styles. All are derived from clinical observation rather than being grounded in identity theory. Generally there is a paucity of research on schizophrenia that can claim to be well-grounded in social psychological theory. Identity process theory may provide an integrative framework by which to understand these clinical observations; the fit between the two supports the efficacy of approaching schizophrenia from this theoretical perspective.

1.4.1. Identity and Positive Symptoms

Many authors argue that the experience of psychosis itself challenges the individual's sense of self and competence. The research to date in this field is largely anecdotal, perhaps necessarily due to the subject matter, and has not been met with rigorous methodology. Therefore the field remains highly theoretical.

This perspective encompasses the view that the experience of positive symptoms (hallucinations, delusions, thought disorder etc.) constitutes a threat to the continuity of the identity of the individual; by definition a psychotic break constitutes a major alteration in the perceptual experience of the individual which throws them into conflict with both their own previous experiences and the experiences of others.

Two authors in particular have conceptualised schizophrenia in this way. Estroff (1989) describes schizophrenia is an "I am" illness that takes over the identity of the person, because it creates such profound emotional and cognitive upheaval, transforming the self as it is known both inwardly and outwardly by others. It is suggested that certain
aspects of cognition crucial to self-construction are particularly vulnerable in schizophrenia, including disturbances in the way the individual remembers, learns, attaches meanings to experiences, and knows what is real and unreal. Fabrega (1989) also argues that schizophrenia alters the sense of self, the boundaries between self and other and the ability of the self to relate meaningfully to the cultural world. In particular, Fabrega argues that continuity of experience may be disturbed by the changing nature of perceptions in a psychotic break.

The importance of identity in schizophrenia is reflected in the psychoanalytic conceptualisation of schizophrenia as a disorder of the self. Psychoanalytic theorists (Kohut & Wolf, 1978; Wolf, 1982) propose that the loss or absence of the self constitutes the illness, and that a lack of coherent self is the hallmark of psychosis. This is the view proposed by Rosenberg and colleagues. A central feature of psychosis is impaired functioning of the self, including self-definition, self-awareness and regulation (Hemsley, 1977; Frith, 1979; Andreason et al, 1982; Saccuzzo, 1986).

There are few studies assessing the impact of positive symptoms on identity directly, although two interview studies are illustrative. Estroff (1981) concludes from interview material that "the most potent factors were clients' subjective experiences with and responses to symptoms, the meanings attached to these experiences by clients and others, and the degree to which the client was restrained in meeting cultural expectations for health by the symptoms and his or her responses to them" (p.233). Similarly, Lally (1989) found that engulfment of identity in a patient role was related to length of time in hospital and the presence of hallucinations in particular, supporting the notion that a psychotic break in itself may disturb identity. Causality is unclear however: a psychotic break may be evidence of greater pathology leading to longer hospitalisation and a greater propensity to develop a patient identity. It is proposed however that hallucinations may be viewed as a transitional experience: if they are recognised as hallucinations, then an identity crisis ensues. This supports the proposition that the mental phenomena characteristic of schizophrenia may constitute a threat to identity.
1.4.2. Identity and Positive Roles

The debilitating effect of schizophrenia is partly due to its impact on role performance. The evidence of schizophrenia's negative effects on the capacity to work, make social relationships etc. is expansive. The adoption of a sick role or patient identity may depend on the number and quality of alternative roles available to the individual (Gove & Hughes, 1979; Thoits, 1986). Herzlich and Pierret (1987) assert that the presence of illness may often force inactivity leading to a loss of role and therefore identity. Understood in relation to identity process theory, it may be assumed that a lack of alternative positive roles limits opportunities for revaluation of the content of identity and the seeking of a positive identity through inflation of other parts of the self.

Three authors in particular have presented an alternative explanation of chronicity in schizophrenia, relevant to the notion of alternative competent roles. Ciompi (1980b) in a controversial article, asks if chronic schizophrenia is really an artefact, a situational consequence of acute illness. Referring to the associated syndrome of negative symptomatology, Ciompi cites evidence concerning the impact of institutionalisation, understimulation, social expectation and family factors on outcome. Similarly, Bleuler (1978) argues that the "impoverished personality" seen in chronic schizophrenia can be compared to that produced by long-standing frustration "after an uneventful unsatisfactory life during which the person's talents and abilities had no occasion to develop" (pp.633-634).

The most potent and challenging argument is provided by Warner (1985), in a impassioned analysis of schizophrenia in the wider political and economic context. He argues that the fate of people with schizophrenia is largely determined by the forces of production and the material conditions that surround them, and that historically the outcome in schizophrenia depends on shifts in their perceived usefulness in the labour market. Evidence of improved outcome in situations of low unemployment is cited and Warner claims that the features of chronic schizophrenia resemble the effects of long-term unemployment. As such, much of what has been considered intrinsic to the chronic
effects of the "illness" may be blamed on the marginalisation and alienation of people with schizophrenia from the industrial workforce.

The idea is raised that the effect of mental illness on identity is not wholly direct but via the effect on role performance. This may be understood as reducing opportunities to develop a positive identity by limiting the possible personally and socially valued identity contents available to the individual.

1.4.3. Identity and Stigma

In defining stigma, Goffman (1963) is concerned with the situation of the individual who is the possessor of a "deeply discrediting" attribute, who is disqualified from receiving full social acceptance due to the possession of some attribute which discredits them. Stigma comprises the two aspects of how the person feels and how others react to them. These two aspects, shame and rejection, are indivisible and that it is their interaction which constitutes stigma (Cumming & Cumming, 1965).

There is evidence that members of the public express rejecting views of mental illness particularly when they hold beliefs that mentally ill people are dangerous (Link et al, 1987). This may be particularly pertinent currently because of the extensive media coverage linking people with schizophrenia to acts of violence. Similarly, Skinner et al (1995) found deeply held stigmatising views about people with mental illness when compared with two other deviant social roles (ex-drug addict and ex-convict), although the ex-convict role was seen more negatively.

1.4.4. The Effects of Labelling on Identity

Labelling theory forms part of the social interactionist view of identity and has become highly influential in mental health, stimulating much research. Being labelled mentally ill is considered as constituting a threat to identity because of the way that society devalues people with mental illness. This proposition created a debate which continued in the schizophrenia literature throughout the 1970's.
Labelling theorists argue that the label of "mentally ill" pressurises the individual into adopting a view of themselves embodying the stereotypes and popular images of insanity and that deviance is created and maintained by social roles imposed on and internalised by the individual (Lemert, 1951; Scheff 1966, 1975; Schur, 1971,1972, 1980). Hence, it is the experience of being labelled which leads to adoption of a sick role, characterised by dependence, submissiveness, passivity and helplessness (Parsons, 1951). The process begins when the person breaks social norms and is labelled as mentally ill, limiting their capacity for self-control, reinforcing symptomatic behaviour and leading to a "career" of chronic mental disability (Scheff, 1975).

Some studies provide evidence for the labelling hypothesis in terms of a relationship between acceptance of a medical model of illness and dependence, a psychosocial model of illness and independence (Morrison et al, 1977; Augostinos, 1986), whereas others have not (Wehler, 1979). In most of these studies the measures used have demonstrated poor reliability however. Those who promote the use of educational approaches as a means of increasing understanding and acceptance of illness have found evidence that a sick role that is detrimental to the patient is not inevitable (Birchwood, Smith & Cochrane, 1992). Link (1987) found evidence that pre-existing negative beliefs about psychiatric patients become self-applicable when someone is labelled as such, leading to devaluation of the self and fear of rejection. In Lally's study (1989) interview material provides evidence that there is a relationship between engulfment by the patient role and length of time in hospital along with the presence of hallucinations.

The labelling hypothesis implies that the individual is the passive recipient of a culturally devalued role; the possibility of active interpretation or rejection of that role is not acknowledged within the theory. Weinstein (1983) in an important review of studies of patients' perceptions of stigma criticises the labelling debate for failing to consider patients' own perceptions of stigma as a central issue of concern. Labelling theory implies that the person diagnosed should experience stigma resulting in feelings of rejection and expectations of discrimination. He points to the irony that Scheff, one of the main proponents of labelling theory, did not explore the perceptions of patients.
themselves. Weinstein's analysis of 35 studies of patients' views indicates that patients have a more favourable attitude to their experiences than labelling theory would predict and that some of the main propositions of labelling theory are not supported. Ex-patients were found to have unfavourable attitudes in only half the studies analysed. The propositions that patients learn the negative societal view of mental illness and that ex-patients feel stigmatised and find re-entry into social roles problematic were upheld. This indicates that patients understand societal reactions to disturbed behaviour and hospitalisation but do not necessarily internalise them, and that labelling theory underestimates the degree to which patients may reject deviant labels on their own behalf.

Engulfment in a patient role is not inevitable and alternative coping strategies exist. Combining labelling theory with cognitive dissonance theory, Warner (1985) argues that if a person possesses an internal sense of self-worth, then being labelled as mentally ill will lead to cognitive dissonance due to the stigma attached to mental illness. In order to resolve the dissonance, the person may either reject the diagnosis altogether which constitutes the use of denial or reattribution as coping strategies, or accept their diagnosis and conform to the stereotype of poor self-control and competence, which constitutes fundamental change and compliance as coping strategies, or reject the negative public image of mental illness which implies revaluation of the prospective content of identity and potentially the use of intergroup coping strategies and the propagation of social change. Although labelling theory has provided a useful impetus for research and information concerning the effects of labelling on the individual, the theory is too narrow to explain the array of identity processes that may occur in the individual experiencing schizophrenia. The integrative framework of identity process theory explains these findings more accurately.

1.4.5. Identity and the Process of Adjustment to Schizophrenia

If schizophrenia has an impact on identity then it would be expected that identity processes would be enacted in response in order to cope with that threat. The processes of identity change and revaluation have occasioned some study within the literature and
there is evidence for ensuing processes within the self, which may be interpreted as identity processes, aiming to cope with threat to the identity principles. The literature supports the notion of processes of evaluation, accommodation and assimilation initiated in response to the experience of schizophrenia, consistent with identity process theory. A number of studies provide evidence of processes in recovery that indicate construction/reconstruction of an enduring sense of self as active and responsible (Davidson & Strauss, 1992; Lally, 1989; Pollack, 1989). The strategies of deflection of the threat through real/unreal selves, acceptance through compartmentalisation and revaluation of the content dimension are evident. In particular, the work of Lally (1984) may be interpreted as demonstrating the process of change in individuals who become engulfed within the patient identity and role. From self-report measures, they appear to move through different strategies of identity change, from initial deflection, either through denial or reconstrual of the meaning of the social position, and finally to some degree of acceptance but with the interpersonal strategy of isolation to mitigate the full effects of stigma, to full acceptance and fundamental change in identity and compliance with the patient role. Loss of self-esteem ensues and mourning for a lost self. Change in identity is proposed as a process with transitional experiences and events.

1.4.6. Identity and Coping Strategies and Styles in Schizophrenia

The ways in which people with schizophrenia attempt to cope or recover has been an issue of concern within the literature. It is notable that all the theories produced resemble elements of identity process theory although, again, authors in this area of research can be criticised for ignoring the social psychological theories of identity.

As early as the 1920's, there was interest in this issue and attempts to form typologies of reactions to schizophrenia. Mayer-Gross (1920) was the first to define styles of recovery in schizophrenia, from psychoanalytic theory, in terms of fixed attitudes that determined subsequent course, including denial of the future or despair, delusional creation of a new life, denial of the psychotic experience itself and the "melting" of the illness into a continuous set of life values. Although the terminology is
vague and difficult to interpret, an array of coping styles is described, offering a broader view than that of labelling theory and consistent with identity process theory. Elements of both deflection of the threat in order to protect identity and acceptance are implied, either leading to hopelessness with the depletion of self-esteem or "melting" which may be reinterpreted as successful assimilation.

McGlashan and his colleagues propose that individual reactions to schizophrenia cluster around two distinct types, which they term "integrative" and "sealing-over" (McGlashan et al, 1975; McGlashan, Docherty & Samuel, 1976). An integrative response is characterised by recognition of continuity between mental activity and personality before, during and after a psychotic episode, seeking information about psychotic experiences and taking responsibility, with a flexible attitude being demonstrated. This may be reinterpreted as assimilation and acceptance of the threat to identity posed by schizophrenia along with the maintenance of identity. In contrast, sealing-over occurs when the psychotic experience is isolated and encapsulated, seen as alien to the person and the rest of their problems, being suppressed rather than explored. This description closely resembles a deflective coping strategy, including denial, unreal selves or compartmentalisation. The authors hypothesised that an integrative reaction would be associated with better outcome but found that there was no relationship with outcome in schizophrenia (McGlashan, 1987), although evidence for the categorisation was found. This research was carried out by the rather unorthodox method of telephone interviews, however, and a definition of what is meant by good outcome is not given. Otherwise, there is a dearth of studies attempting to assess the validity of this formulation.

Shepherd (1984) described a dichotomy of reactions to schizophrenia typically observed in clinical practice. "Denial" applies to those who deny the existence of their psychiatric problems and related difficulties. "Exaggeration" applies to those who may overstate their difficulties, adopt a sick-role and become dependent. Both ways of coping are seen to create problems: those adopting denial may hold onto unrealistic goals for themselves and reject offers of help and treatment thereby exacerbating their difficulties, whereas those who adopt exaggeration may lack confidence and avoid challenge for fear of exacerbating their difficulties but not use the skills they do have, leading to further
disability. Shepherd's proposal stems from observation in clinical practice; few studies have tested his proposal, although some evidence is provided by Taylor and Perkins (1991). The relationship between Shepherd's description of denial and identity process theory is evident, whereas exaggeration is less easily mapped onto the theory; it may be understood in terms of acceptance and total compliance with a patient role to the exclusion of other roles. Shepherd's theory relies on a simple dichotomy however, failing to acknowledge the more complex array of coping strategies which identity process theory would predict.

Taylor and Perkins (1991) attempted to operationalise and measure Shepherd's (1984) categories of denial and exaggeration. Their approach to studying identity, however, is to look solely at the categories of patient versus non-patient identities within the content dimension, as if they are mutually exclusive; their measures of denial/exaggeration are also fundamentally flawed by relying on a comparison of patient versus staff views which is open to interpretations other than the demonstration of insight. It was hypothesised that coping style would be linked with identity, in that deniers would identify themselves as community members, whereas exaggerators would see themselves as psychiatric patients. The relationship between identity and demographic and service usage variables was explored. A dichotomy was identified between denial and exaggeration, supporting Shepherd's theory. Unexpectedly, however, it was found that identity and coping style did not covary in the way expected: it was possible for those who identified themselves as patients to deny their problems and for those who identified themselves as community members to exaggerate their problems etc. Consequently, the authors suggest that these two variables represent separate constructs. Due to the difficulty in measuring insight however, it is impossible to say whether this dichotomy is valid. Counter-intuitively, community identity was associated with having more friends in the hospital than outside and is suggested as reflecting the fact that relationships within the hospital would not challenge the patient's view of themselves. Exaggeration was associated with lower self-esteem. Patient identity was more common in younger patients with shorter hospital careers and the authors suggest that this reflects a need to overstate disabilities in order to secure help in this era of reduced hospitalisation. The authors
make use of identity process theory to explain the initially confusing results. It is proposed that in an attempt to maintain identity against the threat posed by mental illness and hospitalisation, the individual may either encapsulate these parts of experience in an "unreal self" or use a compartmentalising strategy to separate them. The issue of how some people come to identify themselves as patients and yet say that they do not have psychiatric problems requires closer scrutiny; it is suggested that patient identity may function to protect this group from recognising their real difficulties in functioning in the outside world.

These theories provide a useful starting point based on clinical observation but fail to take account of identity theory. A dichotomy between deflection of the threat of the experience of mental illness and its accommodation to the detriment of identity is noted. As such the more complex aspects of adaptation are generally ignored.

Common to all of these approaches is the observation of deflection of the threat to identity by denial of mental illness. This raises the issue of insight which is central to the literature on schizophrenia and will be discussed generally and in relation to identity process theory in some detail below.

1.4.7. Identity and Insight/Denial in Schizophrenia

Insight may be viewed as the opposite of denial, one of the intrapsychic strategies for coping with threat to identity in Breakwell’s theory. The literature on "insight" in schizophrenia is explored here in an attempt to assess whether denial of difficulties (lack of insight) can be considered as a strategy for coping with the threat to identity that schizophrenia may pose. The centrality of insight in understanding schizophrenia and alternative theories of its derivation are discussed.

The accepted view within current psychiatric opinion is that schizophrenia is an illness influencing mental functioning that sometimes requires hospitalisation or medication. It is a frequent observation that the patient may disagree with this; the failure to acknowledge the presence of mental disorder and the need for treatment is generally termed lack of insight (McEvoy et al, 1989a). Numerous definitions of insight have
appeared in the literature focusing on recognition of psychological, emotional or intellectual impairment and the attribution of hospitalisation or treatment to this (Eskey, 1958; Whitman & Duffey, 1961; Carpenter et al, 1973).

A number of studies have demonstrated that lack of insight is a common feature in schizophrenic patients. Appelbaum et al (1981) found that even 50% of voluntary hospitalised schizophrenics denied the need to be in hospital. The W.H.O. International Pilot Study of Schizophrenia (Carpenter et al, 1973), assessing recent onset patients across different cultures, demonstrated that insight was in fact so rare (only some 3% demonstrating a significant degree of insight) that the authors suggest lack of insight as a discriminating variable for schizophrenia. These authors have been criticised however, for using a bland measure of insight (Amador & Strauss, 1993) and requiring total agreement with the medical model for insight to be deemed present.

In accordance with this view, most psychiatric textbooks argue that assessing insight is informative in relation to mental state (e.g. Gelder et al, 1983; Freedman et al, 1975). An insight question is included in most mental state examinations but the term is usually not operationalised or instructions on its measurement given (Markova & Berrios, 1992). Despite the fact that it is afforded significance in modern psychiatry, the concept remains ill-understood and confusing, to the extent that many authors ignore it (David, 1990). One of the difficulties in drawing conclusions from the literature is that various studies use different approaches to assessing insight and the subjects may be at different stages of recovery (David, 1990). Greenfield et al (1989) point out that there have been few studies in which patients' own experiences of psychosis have been analysed.

Controversy remains regarding the relationship between insight, acute symptomatology and prognosis. McEvoy et al (1989a) found that insight did not increase universally as psychopathology improved in a group of hospitalised patients. No reduction in insight was found as mental state improved that would support a "sealing over" hypothesis and levels of insight remained the same in 40% of their group suggesting that insight may be resistant to treatment. Most studies demonstrate an increased risk of relapse (Heinrichs et al, 1985; McEvoy et al, 1989b) and poorer psychosocial functioning (McGlashan & Carpenter, 1981; Soskis & Bowers, 1969) in
relation to lack of insight. This indicates that insight may have prognostic value in the assessment of schizophrenia (Amador & Strauss, 1993). Insight is related to compliance but imperfectly; patients can lack insight but still accept medication and vice versa (Van Putten et al, 1976; Lin et al, 1979; McEvoy et al, 1981; Bartko et al, 1988). David (1990) argues that the relationship is circular if, as in many studies, recognition of need for treatment is taken as evidence of insight.

Three main theories of the lack of insight observed in schizophrenia are proposed in the literature; neurological deficits, cognitive biases and motivational/emotional defences are cited to explain this phenomenon (Birchwood et al, 1994; Markova & Berrios, 1992). Hence lack of insight is generally viewed as either stemming from a biological basis or as a defence against unwanted realisations that would damage self-esteem or identity.

Evidence for a neurological explanation for lack of insight remains equivocal (Cuesta & Peralta, 1994; Lysaker & Bell, 1994; Young et al, 1993; McEvoy et al, 1993): only some of the manifestations of lack of insight can be accounted for by neurological deficits. Exploration of the possible influence of neurological factors in lack of insight in schizophrenia is not the main purpose of this study and its full consideration is beyond the scope of this research. The impact of neurological deficits will be discussed in relation to the results.

The second type of theory advanced to explain lack of awareness in schizophrenia is that denial of symptoms is protective of identity and self-esteem, and can therefore be considered to be a strategy for coping with threatened identity. One aspect of this has been the proliferation of theories concerning attributional and attentional processes. Recently, cognitive theories of delusions and hallucinations have been developed, suggesting that they constitute extreme forms of normal cognitive processes, such as external attribution, drawing conclusions from limited evidence etc. In the case of hallucinations, this is seen as a perceptual distortion. Conceptual difficulties arise if the traditional view of delusions in particular is adhered to: absolute belief has been proposed as the defining characteristic of at least "primary" delusions (Jaspers, 1913; Bleuler, 1913), hence precluding the possibility of insight altogether. There is a growing body of evidence, however, regarding the dimensional nature of delusions and most modern
authors contest the notion of absolute conviction and the conceptualisation of delusions as categorically different to normal beliefs (Kendler et al, 1983; Garety, 1985; Brett-Jones et al, 1987). Delusions are now often conceptualised as beliefs that function to protect identity and self-esteem (see Bentall, 1990 - for a review). Further, Claridge (1990) provides evidence for a dimensional rather than a categorical model of mental disorder, with schizotypal traits found to varying degrees in the general population. This is supported by evidence that delusions can be amenable to cognitive therapy and the efficacy of educational approaches to increase insight (see Birchwood & Shepherd, 1992 for a review). Amador et al (1991) have suggested that poor insight in schizophrenia may be conceptualised as an overuse of normally adaptive cognitive distortions or biases, in order to protect self-esteem and identity. It is suggested that insight may be too threatening to the integrity of the self, which introduces the idea of self-deception or psychological defence at either a conscious or unconscious level, and how much insight is useful for the well-being of the individual is questioned (Markova & Berrios, 1992).

A great deal of work has focused on the concept of self-deception and the apparent paradoxical idea that different parts of the self may have access to different knowledge about the self (Martin, 1985). The Freudian model (A. Freud, 1941) states that the ego struggles against unwanted beliefs about the self by not allowing them into consciousness. Based on Sartre's theories (1957), Fingarette (1969) argues that the process is not unconscious but rather that the person remains vague in engaging in the realities that are unwanted, refusing to "spell them out" into consciousness. The motivation is to protect identity. The cognitive theories alluded to above suggest an exaggeration of normal self-serving cognitive biases including attributional, memory etc.

Despite attempts to distinguish between these different theoretical perspectives, they may not necessarily be incompatible (Birchwood et al 1994). Amador and Strauss (1993) argue that poor insight may be attributable to a mixture of neuropsychological deficits and psychological defences.
1.4.8. Methodological Issues in the Measurement of Insight/Denial

The measurement of insight is a vexed issue. There have been a number of attempts to define dimensions within the construct and develop measures. These have usually comprised a combination of three dimensions, acknowledgement of the presence of symptoms, attribution of symptoms to illness and the recognition of need for treatment (e.g. Greenfield et al, 1989; David, 1990). Markova and Berrios (1992) argue that there is really no empirical evidence for these three aspects of insight. In particular recognition of need for treatment is somewhat medically value-laden, as it is usually referring to a belief in the efficacy of medication, hospital etc., all of which can and have been called into question by patients and others alike. There is a need to agree the common denominators of insight in order to create valid and clinically useful measures which has not been achieved yet (Birchwood et al, 1994).

A variety of measures have been designed, with their construction and emphasis reflecting the author's conceptualisation of insight (McEvoy et al, 1989a; David, 1990, 1992; Markova & Berrios, 1992; Amador & Strauss, 1993; Birchwood et al, 1994). All attempts to measure insight in the literature may be criticised, however, for relying on a comparison between a professional's view of the individual's difficulties (derived from case notes, interview or checklist), which are not generally defined or anchored to observable behaviours, and the individual's presented view of their difficulties. This difference is assumed to be a measure of insight. This approach may be flawed in two ways. First, the view of the professional is a subjective interpretation of the presence of internal events which can only be known to the individual. Second, there may be biases in reporting by the patient i.e. the patient's wish not to acknowledge difficulties to the investigator despite having insight or approval seeking effects leading to agreement. This difficulty has plagued both research and clinical assessment of insight in schizophrenia.

For the purposes of this study, more objective information regarding the observable manifestations of illness in terms of behaviour is collected from both patient and professional to provide a more solid basis for comparison. Further information regarding the unobservable aspects of mental events will be collected, permitting an exploration of
the relationship between the two. This will also permit a more detailed assessment of the occurrence of exaggeration of difficulties.

1.4.9. Identity and Perceived Control over Illness

As described above, there is controversy in the schizophrenia literature as to whether insight and acceptance of illness is in fact helpful to the adjustment of the patient. As noted earlier good insight has been associated with good outcome in some instances but not others. It is proposed that using identity process theory as a framework for reassessing this literature may clarify this issue in the light of the work on perceived control over illness.

This area of conflict may be clarified by adding that the individual requires more than just insight to improve outcome. Sense of control over the course of the illness and perceived ability to use treatment effectively may also be necessary to make insight useful. Similarly, Strauss and Carpenter (1981) suggest that attempts to develop insight should also include developing an appreciation of the sequential relationships between symptoms and environment to learn a sense of mastery over symptom development. There is evidence that many individuals employ self-devised techniques to control their symptoms (Brier & Strauss, 1983), and that techniques can be learnt (Arieti, 1974). This forms the basis of recent developments in cognitive approaches to treating the symptoms of psychosis (Birchwood & Shepherd, 1992). Warner et al (1989) propose a psychotherapeutic model which combines the acceptance of illness along with an internal locus of control. This approach bears some similarity to McGlashan et al's concept of an integrative recovery process as noted previously. In terms of identity process theory, this implies that the threat presented by illness may in part be due to the uncontrollability of the experiences associated with it, threatening the self-efficacy principle.

In a thorough study, Warner et al (1989) assessed the degree of stigma attached to mental illness, self-esteem, locus of control and psychopathology/functioning in a sample of 54 psychotic patients. A self-labelling schedule developed for the study, requiring the subject to classify themselves as having one of the diagnoses or suffering emotional
problems or being emotionally healthy was used to assess acceptance of an illness label; this simple approach is valuable but ignores retrospective insight and recognition of specific symptoms. A semantic differential measure was used to assess stigma, the subjects attributing adjectives from pairs to the concepts of self, most people in the general public and the average mentally ill person; only the results of the latter were used in the analysis, so it is not clear to what extent subjects identified themselves as similar to their conception of the average mental patient. This is important in the light of Weinstein's (1983) findings that patients may demonstrate more unfavourable opinions when rating mental patients generally than when specifically relating mental illness to themselves.

The results showed that acceptance of the illness label *per se* was not associated with poorer functioning and therefore did not support the central hypothesis of labelling theory. People who accepted the illness label, however, tended to have poorer self-esteem if they perceived high levels of stigma attached to mental illness, lending support to that aspect of labelling theory and the conceptualisation of stigma as a threat to identity. The study does not show how those individuals who accepted an illness label but not the stigma attached were able to do so. Rejection of the illness label and better functioning were associated with an internal locus of control. As this was a correlational study, then causality could be in either direction: it is possible that patients with poorer functioning lose a sense of control and adopt the illness label. The authors suggest that the psychotherapeutic model is supported, in that both acceptance of illness and internal locus of control are necessary for good functioning and that sense of control should be a therapeutic aim along with insight. They suggest that locus of control may account for the relationship found between poor outcome and high expressed emotion in families (Vaughn & Leff, 1976), in that high expressed emotion may foster an external locus of control.

Further evidence of the importance of sense of control is provided by Birchwood et al (1993) in one of the few studies of psychological factors associated with depression in people with psychosis. Depression is considered of clinical concern because high rates have been found (between 20 & 45%, see Siris, 1991 for review), it is linked to suicide
(around 10%, Drake & Cotton, 1986) and increased risk of relapse (Johnson, 1988). Birchwood et al argue that depression can be conceptualised as a psychological response to chronic illness and that the illness and associated disabilities can be construed as an uncontrollable life event. Depression is placed on a continuum with demoralisation. Their study aimed to test the hypothesis that depression occurs when the individual absorbs the negative images of mental illness. The final group studied included 84 patients, who may be a relatively high functioning group because of their ability to live outside hospital; information on pathology/functioning was not collected, so there is no indication of whether the findings can be extrapolated to other patient populations. Depression, health locus of control and self-esteem were measured using recognised scales. A "Beliefs about Illness" scale was designed for the study, based on some of the research concerning self-image and stigma described earlier; the five subscales aim to measure belief in "self as illness", control over illness, stigma, including the need for separation from society and the feeling of being punished, and perceived effects of illness on independence. The questionnaire is conceptually and structurally muddled, however, with some questions containing two statements that could be answered separately and questions that require all-or-none answers, precluding an accurate assessment of the individual's attitude. The assessment of stigma is based on assumptions about the kind of stigma experienced which do not take account of the expectation of rejection by others and again ask about general attitudes rather than internalised experiences of stigma. The measure of illness acceptance included just two questions, again requiring absolute answers and the precise nature of the individual's view may be missed.

Importantly, the results of this study showed that health locus of control was most closely associated with depression. Acceptance of the illness label was associated with lower perceived control and external locus of control. The authors interpret these results as indicating that the roots of depression in psychosis lie in hopelessness regarding the illness, associated disabilities and the risk of relapse. They add hopelessness regarding continuing unemployment to this list although it was not directly studied. Causality cannot be assumed from a correlational study, however, but the sense of control factor is so strong that depressive thinking could not account for it.
The evidence provided by these two studies is somewhat flawed by the methodology employed. Perceived control over specific symptoms is implied but not directly studied. The self-efficacy theory predicts that efficacy relating to symptoms would influence initiation and persistence in coping responses and influence specific self-esteem.

1.5. THE EFFECTS OF SCHIZOPHRENIA ON THE INDIVIDUAL IDENTITY PRINCIPLES

1.5.1. Threats to Self-esteem

There has been little study of self-esteem in schizophrenia, although it is a common adjunctive observation that self-esteem may be negatively affected by schizophrenia. Self-esteem has been linked to suicide in schizophrenia; Cotton et al (1985) summarise the position in noting the dual effects of premorbid aspirations becoming unrealistic at the onset of schizophrenia and the gradual erosion of self-esteem by the limits it places on gratifying experiences.

The effect of schizophrenia on self-esteem may primarily be through three pathways, the effect on competence, which will be discussed in relation to self-efficacy, the effect on performance of personally and socially valued roles and the effect of labelling and stigma on the individual.

(i). Self-esteem and Positive Symptoms

The evidence that schizophrenia affects self-esteem detrimentally is mixed, however, with some studies indicating that people diagnosed with schizophrenia do not necessarily demonstrate lower self-esteem than normals (Rogers, 1958; Kaplan, 1975; Wylie, 1979). There is a growing body of evidence that the content of delusions and the attributions made for voices can also protect self-esteem (Lyons et al, 1994; Kinderman, 1994; Bentall & Kaney, 1996). Alternatively, symptoms may be experienced as uncontrollable and aversive, demoralising the individual (Warner, 1989; Birchwood et al, 1993). Hence, the relationship between positive symptoms and self-esteem is emerging as a complex one.
(ii). Self-esteem and Positive Roles

As discussed above, schizophrenia has a severe effect on the ability to perform socially valued roles, particularly the work role. This precludes the individual from developing their self-esteem through role performance and diminishes the ability to protect self-esteem by revaluating the contents of identity or seeking efficacy experiences: there are likely to be few other aspects to inflate or develop in order to detract from the mental illness aspect of identity.

(iii). Self-esteem and Stigma

The third level at which schizophrenia may impact on self-esteem refers to labelling and stigma. Analysed within the identity process theory framework, labelling theory asserts that being designated by society as belonging to the category of the mentally ill may be construed as a threat to the principle of self-esteem in terms of the devalued role prescribed and the stigma experienced by those in that role. The proposition of labelling theory is that this threat is coped with by acceptance and fundamental change in identity to take on the patient role. There is some evidence that acceptance of the illness label is associated with lower self-esteem and depression (Van Putten, Crompton & Yale, 1976; Birchwood et al, 1993). As described above, however, acceptance of diagnosis or the patient role and internalisation of the stigma associated may not be inevitable (Weinstein, 1983; Warner, 1985). The alternative strategies of rejecting the stigma associated with schizophrenia etc. may be seen as attempts to protect self-esteem from the negative impact of stigma.

1.5.2. Threats to Continuity

The effect of schizophrenia on continuity may also function at all three levels.

(i). Continuity and Positive Symptoms

First is the discontinuity in the experience of self created by a psychotic breakdown. By definition, the presence of positive symptoms of psychosis constitutes a disruption of the normal cognitive processes which are fundamental to identity processes (as described above), including perceptual experience, memory and construal. It is proposed that this
experience disrupts the sense of internal consistency, of the "me now" being the same as the "me then". This may be particularly true if psychotic symptoms are recognised as such by the individual, which necessitates a recognition of the changes within the self and prevents external explanations.

(ii). Continuity and Positive Roles

Continuity may also be disrupted, however, by the effect of schizophrenia on role performance. Diagnosis and prognosis may change the person's views of their capabilities and make previously held aspirations for the future unrealistic, by disrupting their ability to function in socially valued roles. Again, the magnitude of disruption to the continuity principle is likely to depend on the degree to which these difficulties are acknowledged.

(iii). Continuity and Stigma

The third level would be that of the experience of labelling and stigma. Analysed within the identity process theory framework, labelling theory asserts that being designated by society as belonging to the category of the mentally ill may be construed as a threat to the principle of continuity because of the major change in status. Hence the view held of the individual by others and potentially the view he or she holds of him or herself would be altered by entry into the socially devalued category of the mentally ill. Labelling theory implies that the individual tends to cope with this threat to identity intrapsychically by acceptance and interpersonally by compliance. As described above, the degree to which the diagnostic label is accepted by the individual and the level of acknowledgement of the presence of symptoms will dictate the degree to which continuity is affected. Essentially, lack of insight and rejection of the mental illness label may also be viewed as attempts to protect the sense of continuity.

1.5.3. Threats to Distinctiveness

(i). Distinctiveness and Positive Symptoms

Distinctiveness may also be assumed to be affected at three levels but to a lesser extent at the level of the experience of symptoms: psychosis may affect the boundaries
between self and other through a sense of thoughts being heard, removed, replaced etc. by others, which may sometimes be a feature.

(ii). Distinctiveness and Positive Roles

At the level of disability, the reduction in role performance will also affect opportunities to develop and express distinctiveness and individuality.

(iii). Distinctiveness and Stigma

More importantly, perhaps, is the effect of belonging to a well-defined category on the sense of distinctiveness: in labelling theory, the role of mental patient is proposed as a superordinate role to others. Analysed within the identity process theory framework, labelling theory asserts that being designated by society as belonging to the category of the mentally ill may be construed as a threat to the principle of distinctiveness because of entry into a category with set of societally defined roles and expectations, diminishing the ability to express individual uniqueness. If the label of mental illness and the associated stigma is accepted, then the individual tends to cope with this threat to identity intrapsychically by acceptance of and interpersonally by compliance with the cultural view of mental patient to the detriment of their individuality. The degree to which distinctiveness is affected, however, is likely to depend on the degree to which the label and stigma are accepted and internalised by the individual. Lack of insight and rejection of the label may also be seen as strategies for protecting distinctiveness.

1.5.4. Threats to Self-efficacy

The impact of schizophrenia on the efficacy principle also appears to function at the three levels described above.

(i) Self-efficacy and Positive Symptoms

The experience of symptoms may be conceptualised as potentially uncontrollable mental events and the occurrence of illness/hospitalisation etc. may be conceptualised as a potentially uncontrollable life event. The effect on identity is proposed as depending on the degree to which the individual can develop a sense of efficacy in relation to these events. Efficacy relating to symptoms may protect the efficacy principle and its related
impact on self-esteem. As yet, the focus of schizophrenia research has been on locus of control, rather than self-efficacy for specific behaviours, although self-efficacy would provide a more accurate explanatory model.

(ii) Self-efficacy and Positive Roles

At the level of disability, the effect of schizophrenia on role performance is likely to deplete the individual's sense of competence in relation to the demands and tasks of social and work roles.

(i) Self-efficacy and Stigma

At the level of stigma, the societal view of mental illness is one characterised by incompetence and unpredictability. Not only may the individual feel that they are unable to perform successfully the behaviours required to avoid others judging them on the basis of stereotypic beliefs about the mentally ill, but they may also internalise this stereotype, hence affecting their own self-efficacy. It is proposed that the self-efficacy principle may be affected through a reduction of sense of control over mental events, the internalisation of a view of the mentally ill as lacking in competence and the perceived difficulty in controlling the nature of others reactions.

The effects of schizophrenia on the efficacy principle may again be mitigated by the degree to which the individual acknowledges symptoms and accepts the illness label and associated stigma. Denial of the illness label and of the presence of symptoms may be a strategy for protecting the efficacy principle and obviating the need to revise identity.

1.5.5. Schizophrenia and Coping with Threats to Identity

Breakwell's theory predicts that the effects of schizophrenia on the identity principles will be mediated by coping strategies employed by the individual. The literature on schizophrenia reviewed above provides evidence of processes of adjustment and reconstruction of identity. As stated above, coping strategies may be at the intrapsychic, interpersonal or intergroup levels.

The literature suggests that the impact of schizophrenia on identity may be mitigated by the degree to which the individual acknowledges their symptoms and difficulties. Denial (lack of insight) may be one strategy for protecting positive identity
from the threat of schizophrenia. This functions at the intrapsychic level and may be in conjunction with isolation, at the interpersonal level. Denial can be contrasted with insight or acknowledgement of symptoms and disabilities, but also with exaggeration. This may also be viewed as a strategy for coping with the threat to identity from schizophrenia, involving acceptance and fundamental change to identity at the intrapsychic level and possibly compliance at the interpersonal level. Where denial or exaggeration are not employed, the literature suggests that developing efficacy relating to positive symptoms may mitigate the negative impact of schizophrenia on identity.

1.6. METHODOLOGICAL ISSUES IN THE ASSESSMENT OF IDENTITY IN SCHIZOPHRENIA

The research on identity in schizophrenia to date has tended to use a categorical approach and to focus on the contents of identity rather than the processes of change. An approach fast becoming the standard method is to assess the extent to which the individual identifies him or herself with either a typical mentally ill person or a typical non-mentally ill person, using a semantic differential (Bender & Pilling, 1985; Thompson, 1988; Taylor & Perkins, 1991). As the theory and research described above indicate, the ideal for well-being and realism is more likely to be the existence of both as identity contents. This dichotomy seems to be an oversimplification of the position in which a person with a mental illness finds him or herself.

The key issue may in fact be changes in identity relating to the experience of mental illness, rather than "snapshots" of identity contents at any given time. As Breakwell (1992a) comments, longitudinal studies assessing the processes of identity change over time are the best way to elucidate this issue. Further, self-report measures may not tap the aspects of identity which are unconscious or not readily available to description by the individual. It is recommended that self-report data be used in conjunction with less direct methods of observation (Breakwell, 1992a). Unfortunately, a longitudinal study is beyond the scope of this research.

In this study, an attempt will be made to measure the self-reported experiences of change in each of the identity principles in relation to the experience of being mentally ill.
In order to make the assessments palatable and relevant to those who do not consider themselves as mentally ill, the wording is cautious, giving experience of mental health services as an alternative. The self-esteem principle will be measured at the level of global self-esteem, rather than specific areas of self-esteem, to assess the impact of schizophrenia on the global sense of self-worth and psychological well-being. This is in conjunction with measures of self-efficacy for the specific areas of demand in the experience of schizophrenia.

Although self-efficacy is understood to be one of the four identity principles in Breakwell’s theory, in this study it was treated separately. Within Breakwell’s theory, self-efficacy is considered as subordinate to the self-esteem principle. As the literature on schizophrenia implies, self-efficacy specific to the experiences of schizophrenia may have a significant impact on other aspects of identity, particularly self-esteem. Whereas previous studies have assessed the more global constructs of locus of control, it seemed more useful in this study to explore the impact of efficacy relating to specific symptoms and disabilities relating to schizophrenia on the other identity principles. Hence, self-efficacy is treated as a strategy for coping with threatened identity, rather than an identity principle, in this study.

Regarding the measurement of self-efficacy, Bandura (1977a,b) states specifically that an analysis of self-efficacy must be specific to a task or demand situation and that all three aspects of magnitude, strength and generalisability should be measured. Most studies seem to employ measures of magnitude and strength which have been shown to adequately predict performance if used to form a composite measure (Lee & Bobko, 1994).

In this study, self-efficacy for the specific features of the experience of schizophrenia which may threaten identity are measured, including the experience of symptoms and the effect on role performance. Because of the specificity of these measures, specific self-esteem, which is a highly related concept, is not measured.
1.7. THE AIMS AND HYPOTHESES OF THIS STUDY

This study aims to examine identity process theory in relation to the particular case of schizophrenia. It is proposed that the experience of psychotic symptoms (impairment), of social disability and of stigma (handicap) may threaten identity. The aim is to explore the effects of schizophrenia on the identity principles of continuity, distinctiveness and self-esteem at these three levels.

A number of possible strategies for coping with the threat to identity posed by schizophrenia will also be explored. Insight or denial of difficulties and exaggeration of difficulties will be assessed. Self-efficacy relating to difficulties will be treated as a possible strategy for coping with threatened identity, because of its particular relevance in psychosis as indicated by the literature. With regard to insight, a further aim of this study is to explore whether there is a relationship between the accuracy of reporting behavioural manifestations of illness and the unobservable mental events by the patient, allowing exploration of approaches to measuring insight/denial.

Overall, it is hoped that the study will provide useful information for clinicians involved in providing therapy for people diagnosed with schizophrenia and will explore the relevance of an identity theory approach in this field. The specific hypotheses are as follows:

Threat-related hypotheses:

1. It was predicted that positive identity would be associated with less severe positive symptoms. Therefore higher scores on the identity measures would be associated with lower scores on positive symptoms.

2. It was predicted that positive identity would be associated with the presence of alternative positive roles. Therefore higher scores on the identity measures would be associated with higher scores on the number of alternative positive roles.
3. It was predicted that positive identity would be associated with less perceived stigma. Therefore, higher scores on the identity measures would be associated with lower scores on stigma.

Coping-related hypotheses:

4. It was predicted that positive identity would be associated with denial of difficulties (lack of insight) and, tentatively, denial of any change to identity due to mental illness. Therefore, high scores on the identity measures would be related to low scores on insight and low scores on the acknowledgement of change.

5. It was predicted that acknowledgement of change in identity due to mental illness would be associated with the presence of insight generally. Therefore, higher scores on insight would be related to higher scores on acknowledgement of change.

6. It was predicted that positive identity would not be associated with exaggeration of difficulties. Therefore, it was expected that low scores on the identity measures would be associated with exaggeration on the insight measures and with acknowledgement of change in identity. It was also predicted that this would be associated with low scores on self-efficacy.

7. It was predicted that positive identity would be associated with the presence of greater self-efficacy. Therefore high scores on the identity measures would be associated with high scores on self-efficacy.
2. METHOD

2.1. PARTICIPANTS

The participants were fifty men with a diagnosis of schizophrenia. All of them were living in the community in a variety of settings but all had been hospitalised previously. As broad a sample as possible was sought in terms of current and past symptoms, level of functioning and service usage. Participants were recruited from three different health districts. Altogether 125 possible participants were identified in two of the areas. In the third district, only clients who had agreed to be interviewed were introduced to the investigator by clinical staff. Due to differences in the requirements of the Ethics Committee in this area, no information was available regarding the numbers of clients who may have been appropriate but declined to participate.

Diagnosis was confirmed using the DSM-IV criteria (American Psychiatric Association, 1994 – see Appendix I), from information in the case notes. Clients with dual diagnoses were excluded, along with those with a diagnosis of simple schizophrenia because florid symptoms have never been present and of schizoaffective disorder because of the differences in presentation, life history etc. Where controversy concerning diagnosis was evident in the notes, the client was not included in the study.

Of the 125 clients in the first two districts, the client’s General Practitioner refused to give permission for them to be approached in 6 cases, 9 General Practitioners did not reply, 10 clients were deemed to be unfit to participate by other staff involved in their care, 40 clients did not reply to letters inviting them to take part and 9 clients replied but refused. In three cases, interviews were started but abandoned due to the client declining to continue. Fifty interviews were completed including two clients from the third health district.
2.2. MEASURES

2.2.1. Measurement of the Identity Principles

(i). Self-esteem

Current global self-esteem was measured using questions taken from the Crown Self-esteem Scale (Crown et al, 1977). This was chosen because of the standardisation data available and its previous use with a schizophrenic population (Roy et al, 1983). The scale is taken originally from Rosenberg (1965) with slight alterations. For the purposes of this study it is proposed that four items will be taken from this measure as follows:

1). On the whole, I am satisfied with myself.
2). At times I think I am no good at all.
3). I feel I am a person of worth, at least on an equal plane with others.
4). I feel I do not have much to be proud of.

These statements were rated by the individual on a five point scale of "very much (0) to "not at all" (4). Scores on statements 2 and 4 are reversed. Lower scores indicate higher self-esteem.

N.B. The measures of continuity and distinctiveness described below were designed specifically for this study. A series of statements were devised, based on the conceptualisation of the identity principles in the literature. A small-scale pilot study was carried out in order to assess these statements as measures of continuity and distinctiveness, as no other measures with which to compare were found.

The original statements were shown to ten Mental Health professionals (Occupational Therapists, Psychiatrists, Nurses and Clinical Psychologists) and to ten Mental Health clients. Their assessment of the statements in terms of clarity, ease of understanding and their perception of the meanings of the statements were used to refine them. Finally, the four statements which best seemed to capture the concepts under study were chosen.
(ii). Continuity

Sense of continuity was measured with four statements as follows:

1). Although I have felt quite different at various times in my life, I know I am the same person deep down.
2). Because my behaviour changes so much in different situations, I find it difficult to feel that I am really the same person inside.
3). I may show different sides of my personality depending on whom I am with but I still think of myself as basically the same person.
4). The changes I have been through make me feel that I am really not the same person as I used to be.

These statements were rated by the individual on a five-point scale of "very much (0) to "not at all" (4). Scores on statements 2 and 4 are reversed. Lower scores indicate a greater sense of continuity.

(iii). Distinctiveness

Distinctiveness was measured with four statements as follows:

1). I feel that I have a distinct character of my own.
2). I do not have a good sense of my individuality.
3). Although there are ways in which I am like other people, I feel that really I am a unique person.
4). I find it hard to feel that I am different to others in a positive way.

These statements were rated by the individual on a five-point scale of "very much (0) to "not at all" (4). Scores on statements 2 and 4 are reversed. Lower scores indicate a greater sense of distinctiveness.

(iv). Acknowledgement of Change to the Identity Principles

To assess whether the participant felt that self-esteem had changed in the past in response to mental illness, the following question was added to the self-esteem questions: "My experiences of being a mental patient and of mental hospitals affected my sense of feeling good about myself".
To assess whether sense of continuity had changed in the past in response to mental illness, the following statement was added to the continuity questions:

“My experiences of being a mental patient and of mental hospitals altered my sense of continuity as a person”.

To assess whether sense of distinctiveness had changed in the past in response to mental illness, the following statement was added to the distinctiveness questions:

“My experiences of being a mental patient and of mental hospitals have altered my sense of being a distinctive person (in a good way)?”

### 2.2.2. Measures Relating to Threats to Identity

**(i). Symptoms and Disabilities**

Symptoms and behaviour problems were measured using the first twenty items of the Social Behaviour Schedule (SBS) (Wykes & Sturt, 1986), except item 12 (“Posturing and Mannerisms”) because of the difficulty with presenting this question during the interview. Information on the variance accounted for by this item within the overall score is unavailable; as the items relate to discrete areas of behaviour, it was decided that the omission of one item would not invalidate the final scores.

The SBS items are twenty specific behavioural items (Appendix II), in which symptoms are rated only if they result in some form of observable and defined behavioural disturbance. Most of the SBS items are rated on a scale of 1 to 4, with 0 indicating no behavioural difficulty and 4 indicating severe or frequent behavioural difficulty. Three items are rated on a similar scale of 0 to 3 and two on a scale of 0 to 2. The scale was administered to the individual’s keyworker (the person most closely involved in that individual's care) and specific examples were requested. In order to verify the reliability of staff ratings on this measure, a second rating by a different member of staff was obtained, for the same period of time for 15 participants (29% of the total sample). Two items concerning hallucinations and delusions from the SUMD (described below under “Acknowledgement of Illness or Exaggeration/Denial of Illness”) were also administered.
The behavioural areas covered in the SBS have been shown in previous research to describe the kind of difficulties exhibited by people with long-term impairments which may result in admission or dependence on psychiatric services, and there is some overlap with the symptoms a psychiatrist would expect to treat. The scale has been shown to demonstrate adequate inter-rater reliability (between 84% and 100% agreement, with a mean of 94%), inter-informant reliability (between 70% and 99% agreement with a mean of 86%), and test-retest reliability (between 72% and 96% agreement, with a mean of 83%). The validity of the scale is also proposed as adequate due to the association between the behavioural scores and level of supervision (Wykes & Sturt, 1986).

In order to assess functioning and disability, the Social Role Performance Schedule (SRP) (Hurry & Sturt, 1981) was administered to both the individual’s keyworker. The SRP schedule measures social functions or roles that most adults in our society would be expected to perform (Appendix III). Eight areas are covered: household management (HM), employment (EM), management of money (MM), child care (CC), intimate relationships (IR), other social relationships (OR), social presentation of self (SP) and coping with emergencies (CE). Higher scores indicate poorer levels of functioning in each area. Hurry and Sturt (1981) report a highly significant correlation between the scores on the SRP and scores on the Present State Examination (PSE) (Wing et al, 1977), indicating its validity as a measure of social disablement in relation to mental disorder.

In order to verify the reliability of staff ratings on this measure, a second rating by a different member of staff was obtained, for the same period of time for 15 participants (29% percentage of the total sample).

(ii). The Presence of Positive Roles

The presence of alternative positive roles was taken from the number of roles available to the individual as evidenced on the SRP. Employee, parent, spouse and friend are covered by the SRP. In line with Thoits' (1986) study of role identities, relative and group membership was also added to the list. As in Thoits study, the number of role identities was summed to give a score for each person.
(iii). Stigma

The approach taken to measure perception of stigma is derived from Link et al (1987) and includes questions concerning the expectation of devaluation and discrimination by society (Appendix IV). These aspects were measured using a set of twelve questions rated on six-point Likert scales from strongly agree (one point) to strongly disagree (six points). A higher score indicates a greater expectation of stigma. The author reports adequate internal consistency (alpha = 0.82) and reliability (alpha = 0.78) for the scale (Link 1987; Link et al, 1989).

2.2.3. Measures Relating to Coping Strategies

(i). Acknowledgement of Illness or Exaggeration/Denial of Illness

Two aspects were measured. The first concerned observable behavioural difficulties, which are the manifestations of schizophrenia. The second is the unobservable symptoms experienced internally by the individual, which can only be measured by self-report. The relationship between acknowledgement of these two aspects was investigated, to ascertain whether lack of acknowledgement of internal symptoms varied in relation to lack of acknowledgement of behavioural difficulties.

Awareness of symptoms and behaviour problems was measured using the SBS (described above) (Wykes & Sturt, 1986). The scale was administered to the individual's keyworker and to the individual. To obtain a score for acknowledgement of behavioural difficulties associated with schizophrenia, the difference between the individual's rating and the keyworker's rating was calculated. This allowed for both the calculation of lack of acknowledgement and exaggeration of behavioural difficulties.

Awareness of symptoms that are not observable as well as a general measure of acceptance of the illness label, recognition of the consequences of mental illness and belief in the efficacy of medication was obtained using items from the Scale to Assess Unawareness of Illness (SUMD) (Amador & Strauss, 1993). This assesses both awareness of and attribution for different symptoms associated with long-term mental illness, experienced currently and in the past. This is a standardised scale with ratings
being made from a direct interview with the individual. The presence of particular symptoms is first checked in the case notes and from staff report. Only the three general items and the two items concerning hallucinations and delusions were administered in this study (Appendix V). The SUMD is designed so that any scale or individual item can be used independently of the others depending on the goal of the investigation.

The psychometric properties of the SUMD are reported by Amador et al (1993). For items on the current awareness subscale, interrater intraclass correlation coefficients (ICC) ranged from 0.56 to 0.97 (median=0.88), with three items having correlations below 0.7. The ICC for the subscale total score was 0.9. For items on the retrospective awareness subscale, interrater correlations ranged from 0.56 to 0.98 (median=0.80), with two items having correlations below 0.70. The ICC for the subscale total score was 0.86. The validity of the scale has been demonstrated in that it has moderate to high correlations with other recognised measures of insight. Amador and colleagues conclude that this is a valid approach to measuring insight and that it can be performed reliably.

(ii). Awareness of Difficulties in Functioning/Disability

In order to assess insight into functioning and disability, the Social Role Performance Schedule (SRP) (Hurry & Sturt, 1981) was administered to both the individual and their keyworker. The scores given by the individual were compared with those given by the member of staff. A measure of acknowledgement of difficulties in functioning versus exaggeration of difficulties in functioning was calculated from this comparison.

(iii). Self-efficacy in Relation to Symptoms and Disabilities

Self-efficacy was measured in the specific areas relating to schizophrenia to provide a score of self-efficacy combining efficacy relating to symptoms and role performance. During the administration of the SBS, the SUMD items and the SRP, questions regarding efficacy were asked following each item. The approach to measuring self-efficacy is derived from Lee and Bobko (1994). The magnitude of self-efficacy was measured using the following statements, in response to which a "yes" or "no" answer was requested.
"I have the ability to do something to control whether this happens or not most of the time" (for the SBS and SUMD items)

and

"I have the ability to perform well in this role most of the time" (for the SRP items)

The strength of self-efficacy was measured for each item with the following question, rated on a ten point scale from "no confidence" (0) to "total confidence" (10):

"How confident are you in your ability to do this".

A composite measure combining both magnitude and strength of self-efficacy was calculated by summing the strength raw scores for items in which a yes answer was given to the magnitude question. Lee and Bobko (1994) found this method of operationalising the self-efficacy concept to be the one with the highest convergent and predictive validities when compared with other methods.

2.2.4. Demographic Details

Information on age, age at diagnosis of illness (or first hospitalisation if unavailable), number and length of hospitalisations and time since last hospitalisation was collected from the case notes. Information regarding the participant's living circumstances, daily activities, knowledge of their diagnosis and attribution for the reasons for becoming ill or having contact with Mental Health Services was obtained during the interview with the participant.

2.3. PROCEDURE

Ethical approval for the study was obtained in three Health Districts. In the first two, men diagnosed with schizophrenia were identified from the medical records. Diagnosis and exclusion criteria were checked in the medical notes. The investigator sought permission from their Consultant Psychiatrist (where relevant) and then wrote to the General Practitioner of each possible participant to seek approval for their patient to be approached. A letter was then sent to prospective participants asking whether they
were interested in taking part in the study, followed by a meeting to explain what the study would entail before informed consent was obtained.

In the third district, the keyworker approached the client first and gained permission from them to pass their details to the investigator before the Consultant Psychiatrist, General Practitioner or client were approached directly.

The measures were then administered by the investigator in the form of a structured interview with the individual and with their keyworker separately, within a four week period. In the interview with the patient, although the format was standardised (i.e. wording of the questions), the ordering of questions within measures remained flexible, in order to follow the client’s train of thought and to help the interview flow better. The questions relating to distinctiveness, continuity and self-esteem were spaced out and given during the administration of the other measures. Further information was gained from the case notes where appropriate. Debriefing was offered when necessary.
3. RESULTS

3.1. DEMOGRAPHIC DATA

Information concerning background factors of interest were collected. Frequencies are shown below.

Table 1: Demographic Data:

<table>
<thead>
<tr>
<th></th>
<th>mean</th>
<th>Standard deviation</th>
<th>median</th>
<th>minimum</th>
<th>maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>41.26</td>
<td>11.577</td>
<td>42.5</td>
<td>23</td>
<td>67</td>
</tr>
<tr>
<td>Age at diagnosis</td>
<td>22.36</td>
<td>3.843</td>
<td>22</td>
<td>15</td>
<td>32</td>
</tr>
<tr>
<td>Number of admissions</td>
<td>4.78</td>
<td>3.627</td>
<td>4</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Total length of time spent in hospital (years)</td>
<td>3.448 years</td>
<td>5.94 years</td>
<td>0.932 years</td>
<td>2 weeks</td>
<td>24 years</td>
</tr>
<tr>
<td>Time since last discharged from hospital</td>
<td>5.235 years</td>
<td>5.682 years</td>
<td>3.8 years</td>
<td>1 month</td>
<td>24 years</td>
</tr>
</tbody>
</table>

Table 2: Living Circumstances

<table>
<thead>
<tr>
<th>Fully independent</th>
<th>Family care</th>
<th>Living with partner</th>
<th>Group home</th>
<th>24-hour staffed care</th>
</tr>
</thead>
<tbody>
<tr>
<td>28%</td>
<td>28%</td>
<td>2%</td>
<td>14%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Table 3: Day Care

<table>
<thead>
<tr>
<th>None</th>
<th>Hospital day care</th>
<th>Non-hospital day care</th>
<th>Sheltered employment</th>
<th>Voluntary work</th>
<th>Normal employment</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>54%</td>
<td>10%</td>
<td>6%</td>
<td>18%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Table 4: Hobbies

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Partly Absorbing Hobby</th>
<th>Wholly Absorbing Hobby</th>
</tr>
</thead>
<tbody>
<tr>
<td>60%</td>
<td>38%</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>

Table 5: Social Networks

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Isolated bar</th>
<th>Family</th>
<th>Hospital Friends</th>
<th>Non-hospital Friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>28%</td>
<td>26%</td>
<td>14%</td>
<td></td>
<td>32%</td>
<td></td>
</tr>
</tbody>
</table>

Table 6: Knowledge of Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis known</th>
<th>Diagnosis not known</th>
</tr>
</thead>
<tbody>
<tr>
<td>84%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Table 7: Attribution of Difficulties or Hospitalisation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Illness</td>
<td>22%</td>
</tr>
<tr>
<td>Stress and Mental Illness</td>
<td>22%</td>
</tr>
<tr>
<td>Drugs and Mental Illness</td>
<td>14%</td>
</tr>
<tr>
<td>Stress</td>
<td>10%</td>
</tr>
<tr>
<td>Other People</td>
<td>8%</td>
</tr>
<tr>
<td>Drugs</td>
<td>4%</td>
</tr>
<tr>
<td>Other People and Mental Illness</td>
<td>4%</td>
</tr>
<tr>
<td>Physical Illness</td>
<td>4%</td>
</tr>
<tr>
<td>Medication</td>
<td>4%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>2%</td>
</tr>
<tr>
<td>Upbringing</td>
<td>2%</td>
</tr>
<tr>
<td>Spirits and Powers</td>
<td>2%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>2%</td>
</tr>
</tbody>
</table>

3.2. DESCRIPTIVE AND COMPARISON DATA

Data from this study has been compared to data from relevant papers, providing normative data for the measures used.
3.2.1. Identity Principles

As the measures of continuity and distinctiveness have not been used previously, there is no data with which to compare.

Table 8: Frequencies of Identity Principle Measures

<table>
<thead>
<tr>
<th></th>
<th>mean</th>
<th>standard deviation</th>
<th>minimum</th>
<th>maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuity</td>
<td>9.840</td>
<td>3.872</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Distinctiveness</td>
<td>6.680</td>
<td>2.759</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>7.740</td>
<td>3.155</td>
<td>3</td>
<td>15</td>
</tr>
</tbody>
</table>

3.2.2. Acknowledgement of Change to Identity Principles

Table 9: Frequencies of Acknowledgement of Sense of Change to Identity Principles

<table>
<thead>
<tr>
<th></th>
<th>No Sense of Change</th>
<th>Negative Sense of Change</th>
<th>Positive Sense of Change</th>
<th>Positive and Negative Sense of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuity</td>
<td>46%</td>
<td>32%</td>
<td>6%</td>
<td>16%</td>
</tr>
<tr>
<td>Distinctiveness</td>
<td>52%</td>
<td>36%</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>32%</td>
<td>50%</td>
<td>4%</td>
<td>14%</td>
</tr>
</tbody>
</table>

It is noted that there is a fairly even distribution between no sense of change and some sense of change for both continuity and distinctiveness. Regarding self-esteem, however, there is a much higher proportion of participants acknowledging sense of change, particularly negative sense of change.

Table 10: Sense of Change to Principles Overall is Shown Below:

<table>
<thead>
<tr>
<th>No Sense of Change</th>
<th>Some Sense of Change</th>
<th>Sense of Change on All Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>18%</td>
<td>60%</td>
<td>22%</td>
</tr>
</tbody>
</table>
3.2.3. Social Behaviour Schedule

Table 11: Social Behaviour Schedule (Staff 1 Ratings)

<table>
<thead>
<tr>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>72.060</td>
<td>14.380</td>
<td>43-114</td>
</tr>
</tbody>
</table>

Table 12: Percentage of Patients Scoring 2 or more on SBS items (Staff 1 Ratings)

<table>
<thead>
<tr>
<th>SBS Item</th>
<th>Data from this Study Percentage</th>
<th>Data from Sturt &amp; Wykes (1987)</th>
<th>Data from Wykes, Sturt &amp; Creer (1982) People attending day units</th>
<th>Data from Wykes, Sturt &amp; Creer (1982) People in residential units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8</td>
<td>25.7</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>2</td>
<td>26</td>
<td>13.9</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>3</td>
<td>18</td>
<td>25.8</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td>37.9</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>21.3</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>6</td>
<td>14</td>
<td>27.2</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>7</td>
<td>14</td>
<td>9.1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>26</td>
<td>30.3</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>9</td>
<td>26</td>
<td>13.6</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>10</td>
<td>14</td>
<td>22.7</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>11</td>
<td>8</td>
<td>6.1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>14</td>
<td>15.1</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>13</td>
<td>6</td>
<td>6.1</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>14</td>
<td>34</td>
<td>12.1</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>15</td>
<td>6</td>
<td>1.5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>16</td>
<td>34</td>
<td>39.4</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>17</td>
<td>8</td>
<td>23.1</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>18</td>
<td>36</td>
<td>16.7</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>19</td>
<td>10</td>
<td>16.9</td>
<td>10</td>
<td>14</td>
</tr>
</tbody>
</table>

Although the pattern of scores on individual items varies from the others' samples, the average number of problems shown (with a score of 2 or more) is not dissimilar. In this study, the average number of problems in the last month was 3.47 (prorated to 21 items for comparison), whereas the average number of problems quoted by Wykes &
Sturt (1986) and Sturt & Wykes (1987) was 4.3. In line with previous studies, no item was shown by more than by 40% of the participants.

3.2.4. Social Role Performance Schedule

Table 13: Social Role Performance Schedule Frequencies (Staff 1 Ratings)

<table>
<thead>
<tr>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.620</td>
<td>4.703</td>
<td>7-25</td>
</tr>
</tbody>
</table>

Table 14: Percentage Scores on SRP items (staff 1 ratings) (scores of 1 or more = “a serious problem at least on occasion”)

<table>
<thead>
<tr>
<th>SRP Item</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Household Management</td>
<td>76</td>
</tr>
<tr>
<td>2 Managing a Budget</td>
<td>92</td>
</tr>
<tr>
<td>3 Employment</td>
<td>46</td>
</tr>
<tr>
<td>*4 Childcare</td>
<td>100</td>
</tr>
<tr>
<td>5 Intimate Relationships</td>
<td>84</td>
</tr>
<tr>
<td>6 Family Relationships</td>
<td>62</td>
</tr>
<tr>
<td>7 Social Activity</td>
<td>80</td>
</tr>
<tr>
<td>8 Handling Emergencies</td>
<td>70</td>
</tr>
</tbody>
</table>

* Childcare: only 6 of the participants had this role available to them, 100% of whom were disabled in this role

The participants in this study had a greater number of roles available to them than the participants in Sturt & Wykes’ (1987) study. The average number of roles available to these participants was 7 (i.e. only childcare was considered as unavailable to any of them), as opposed to 6.5 roles being available to subjects in Sturt & Wykes study. The sample in this study also demonstrates generally slightly better role functioning than in Sturt & Wykes (1987) study of 66 patients (shown below). A proportion of the participants in their study were current in-patients. This may account for these
differences, as all the participants in this study were in the community, where more roles would be available to them.

**Table 15: Comparison of Percentage Scores with Data from Wykes & Sturt (1987)**

<table>
<thead>
<tr>
<th></th>
<th>This Study n=50</th>
<th>Sturt &amp; Wykes(1987) n=66</th>
</tr>
</thead>
<tbody>
<tr>
<td>least number disabled in any role</td>
<td>46%</td>
<td>50%</td>
</tr>
<tr>
<td>number disabled in employment role</td>
<td>92%</td>
<td>100%</td>
</tr>
<tr>
<td>number disabled in at least one role</td>
<td>74%</td>
<td>89%</td>
</tr>
<tr>
<td>number disabled in all roles</td>
<td>0%</td>
<td>17%</td>
</tr>
</tbody>
</table>

3.2.5. Positive Social Roles

**Table 16: Frequencies for Social Roles**

<table>
<thead>
<tr>
<th>Number of Roles</th>
<th>mean</th>
<th>standard deviation</th>
<th>minimum</th>
<th>maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.58</td>
<td>1.295</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

3.2.6. Devaluation-Discrimination Scale

**Table 17: Frequencies for the Devaluation-Discrimination Scale (Stigma):**

<table>
<thead>
<tr>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.350</td>
<td>10.026</td>
<td>22 –70 (poss. total = 84)</td>
</tr>
</tbody>
</table>
Table 18: Devaluation-Discrimination Measure Compared with Link et al (1989) “Repeat Treatment Contact Patients”

<table>
<thead>
<tr>
<th>Item</th>
<th>Data From This Study (n=50) mean (s.d.)</th>
<th>Data Presented By Link et al (1989) (n=115) mean (s.d.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4.020 (1.450)</td>
<td>3.94 (1.64)</td>
</tr>
<tr>
<td>2</td>
<td>3.542 (1.650)</td>
<td>3.66 (1.62)</td>
</tr>
<tr>
<td>3</td>
<td>4.102 (1.661)</td>
<td>4.09 (1.44)</td>
</tr>
<tr>
<td>4</td>
<td>4.520 (1.529)</td>
<td>4.40 (1.63)</td>
</tr>
<tr>
<td>5</td>
<td>4.204 (1.581)</td>
<td>4.14 (1.45)</td>
</tr>
<tr>
<td>6</td>
<td>4.800 (1.229)</td>
<td>4.47 (1.52)</td>
</tr>
<tr>
<td>7</td>
<td>4.510 (1.401)</td>
<td>4.48 (1.32)</td>
</tr>
<tr>
<td>8</td>
<td>3.760 (1.636)</td>
<td>3.57 (1.61)</td>
</tr>
<tr>
<td>9</td>
<td>5.080 (0.966)</td>
<td>4.71 (1.30)</td>
</tr>
<tr>
<td>10</td>
<td>3.640 (1.588)</td>
<td>3.65 (1.68)</td>
</tr>
<tr>
<td>11</td>
<td>4.357 (1.514)</td>
<td>4.41 (1.55)</td>
</tr>
<tr>
<td>12</td>
<td>4.300 (1.446)</td>
<td>4.23 (1.45)</td>
</tr>
<tr>
<td>Total</td>
<td>4.238 (0.826)</td>
<td>4.14 (0.89)</td>
</tr>
</tbody>
</table>

Scores in this study are compared with the “repeat treatment contact” group, who are the most similar clinically, in Link et al’s (1989) study. The scores show very similar patterns.

3.2.7. Scale to Assess Unawareness of Mental Disorder

Table 19: SUMP Frequency Scores

<table>
<thead>
<tr>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>36.380</td>
<td>10.810</td>
<td>12-53</td>
</tr>
</tbody>
</table>
Table 20: Comparison with Data from Amador et al (1993)

<table>
<thead>
<tr>
<th>SUMD Item</th>
<th>Data from this Study mean (s.d.)</th>
<th>Data from Amador et al (1993) (n=43)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1c</td>
<td>2.380 (1.524)</td>
<td>3.14 (1.6)</td>
</tr>
<tr>
<td>1p</td>
<td>2.260 (1.440)</td>
<td>2.46 (1.6)</td>
</tr>
<tr>
<td>2c</td>
<td>2.180 (1.446)</td>
<td>2.48 (1.4)</td>
</tr>
<tr>
<td>2p</td>
<td>2.160 (1.462)</td>
<td>2.11 (1.2)</td>
</tr>
<tr>
<td>3c</td>
<td>2.140 (1.512)</td>
<td>3.08 (1.8)</td>
</tr>
<tr>
<td>3p</td>
<td>2.140 (1.512)</td>
<td>2.93 (1.7)</td>
</tr>
<tr>
<td>4c</td>
<td>2.200 (1.654)</td>
<td>2.10 to 4.03 (s.d. 1.7 to 0.9)</td>
</tr>
<tr>
<td>4p</td>
<td>2.800 (1.654)</td>
<td>1.7 to 3.67 (s.d. 1.3 to 1.6)</td>
</tr>
<tr>
<td>5c</td>
<td>2.480 (1.854)</td>
<td>2.10 to 4.03 (s.d. 1.7 to 0.9)</td>
</tr>
<tr>
<td>5p</td>
<td>2.880 (1.573)</td>
<td>1.7 to 3.67 (s.d. 1.3 to 1.6)</td>
</tr>
</tbody>
</table>

The participants in this study have slightly lower scores indicating slightly greater insight than in Amador et al’s (1993) study.

3.2.8. Self-efficacy

Table 21: Frequencies for Self-efficacy

<table>
<thead>
<tr>
<th>mean</th>
<th>standard deviation</th>
<th>minimum</th>
<th>maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>81.88</td>
<td>40.238</td>
<td>29</td>
<td>193</td>
</tr>
</tbody>
</table>
### 3.3. RELIABILITY OF MEASURES

Table 22: Reliability checks were carried out on all measures; results are reported below.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Details</th>
<th>Alpha</th>
<th>Standardised Item Alpha</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>*SBS (patient)</td>
<td>37/38 items SBS14=0 variance 49/50 cases</td>
<td>0.6971</td>
<td>0.6826</td>
<td>65.160</td>
<td>9.830</td>
</tr>
<tr>
<td>*SBS (staff 1)</td>
<td>38/38 items 49/50 cases</td>
<td>0.8119</td>
<td>0.8100</td>
<td>72.060</td>
<td>14.380</td>
</tr>
<tr>
<td>*SBS (staff 2)</td>
<td>38/38 items 49/50 cases</td>
<td>0.7655</td>
<td>0.7748</td>
<td>74.667</td>
<td>13.173</td>
</tr>
<tr>
<td>**SRP (patient)</td>
<td>7/7 items 48/50 cases</td>
<td>0.6319</td>
<td>0.6401</td>
<td>13.560</td>
<td>3.970</td>
</tr>
<tr>
<td>**SRP (staff 1)</td>
<td>7/7 items 48/50 cases</td>
<td>0.7217</td>
<td>0.7217</td>
<td>17.620</td>
<td>4.703</td>
</tr>
<tr>
<td>**SRP (staff 2)</td>
<td>7/7 items 15/15 cases</td>
<td>0.8441</td>
<td>0.8492</td>
<td>19.867</td>
<td>5.805</td>
</tr>
<tr>
<td>*SUMD (patient)</td>
<td>10/10 items 50/50 cases</td>
<td>0.8675</td>
<td>0.8751</td>
<td>33.620</td>
<td>10.810</td>
</tr>
<tr>
<td>*SUMD (staff 1)</td>
<td>9/10 items SUMD5p=0 variance 50/50 cases</td>
<td>0.7926</td>
<td>0.7192</td>
<td>25.980</td>
<td>6.333</td>
</tr>
<tr>
<td>*SUMD (staff 2)</td>
<td>10/10 items 15/15 cases</td>
<td>0.9089</td>
<td>0.9219</td>
<td>37.067</td>
<td>13.703</td>
</tr>
<tr>
<td>Efficacy re: SBS</td>
<td>19/19 items 49/50 cases</td>
<td>0.7914</td>
<td>0.7930</td>
<td>29.000</td>
<td>25.702</td>
</tr>
<tr>
<td>**Efficacy re: SRP</td>
<td>7/7 items 50/50 cases</td>
<td>0.8034</td>
<td>0.7985</td>
<td>15.860</td>
<td>16.116</td>
</tr>
<tr>
<td>Efficacy re: SUMD</td>
<td>3/3 items 50/50 cases</td>
<td>0.8194</td>
<td>0.8195</td>
<td>11.100</td>
<td>10.397</td>
</tr>
<tr>
<td>**Total Efficacy</td>
<td>29/29 items 49/50 cases</td>
<td>0.8492</td>
<td>0.8503</td>
<td>81.880</td>
<td>40.238</td>
</tr>
<tr>
<td>Continuity</td>
<td>4/4 items 50/50 cases</td>
<td>0.7341</td>
<td>0.7599</td>
<td>9.84</td>
<td>3.872</td>
</tr>
<tr>
<td>Distinctiveness</td>
<td>3/3 items 50/50 cases</td>
<td>0.6654</td>
<td>0.6672</td>
<td>9.560</td>
<td>3.406</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>3/3 items 50/50 cases</td>
<td>0.6593</td>
<td>0.6629</td>
<td>10.340</td>
<td>3.729</td>
</tr>
<tr>
<td>Stigma</td>
<td>12/12 items 46/50 cases</td>
<td>0.8128</td>
<td>0.8189</td>
<td>4.237</td>
<td>0.825</td>
</tr>
</tbody>
</table>

* * “warning, determinant of matrix is zero” **SRP4 (childcare) removed
Cronbach's alpha is above 0.7 for all measures, except the SBS and SRP patient ratings, the Distinctiveness and Self-esteem measures. As these were approaching the critical level of 0.7, it was decided to treat them as reliable.

Reliability checks were carried out on the two measures designed specifically for this study, concerned with continuity and distinctiveness. These indicate that the measures of continuity and distinctiveness may be viewed as forming discrete measures which provide reliable scores.

3.4. THE MEASUREMENT OF ACKNOWLEDGEMENT OF ASPECTS OF MENTAL ILLNESS

In order to assess the measurement of the patient's degree of acknowledgement of their symptoms, behaviours and disabilities, staff and patient ratings were taken on the same measures to look for differences. In order to check the reliability of the staff view, two staff rated the same patient for the same time period in 15 cases. Correlation coefficients between their ratings are shown below:

Table 23: Pearson Product Moment Correlation Coefficients of staff one versus staff two measures.

<table>
<thead>
<tr>
<th>SCALE</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBS SUM</td>
<td>0.8438</td>
<td>.000</td>
</tr>
<tr>
<td>SBS SUM current items only</td>
<td>0.8426</td>
<td>.000</td>
</tr>
<tr>
<td>SBS SUM past items only</td>
<td>0.6769</td>
<td>.006</td>
</tr>
<tr>
<td>SRP SUM</td>
<td>0.6883</td>
<td>.005</td>
</tr>
</tbody>
</table>

Correlation coefficients between staff one and staff two on the SBS and the SRP are around the critical level of 0.7. Ratings made by staff one were therefore considered reliable and were used for comparison with the patients' ratings in subsequent analyses.
Subsequently, an index of whether the person rated themselves as having fewer or greater problems or disabilities than the staff rated them as having was taken by subtracting the staff’s total (staff 1) from the participant’s total on the SBS and SRP. These have been named “under-rating” (participant rates self as having fewer problems than staff rate them as having) and “over-rating” (participant rates self as having greater problems than staff rate them as having).

Table 24: Frequencies for Over- and Under-rating:

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over-rating on SBS</td>
<td>7.211</td>
<td>5.483</td>
<td>1-18</td>
<td>19 (38%)</td>
</tr>
<tr>
<td>Under-rating on SBS</td>
<td>17.214</td>
<td>10.257</td>
<td>1-38</td>
<td>28 (56%)</td>
</tr>
<tr>
<td>Accurate raters on SBS</td>
<td></td>
<td></td>
<td></td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Over-rating on SRP</td>
<td>2.75</td>
<td>2.006</td>
<td>1-6</td>
<td>12 (24%)</td>
</tr>
<tr>
<td>Under-rating on SRP</td>
<td>6.556</td>
<td>4.813</td>
<td>1-17</td>
<td>36 (72%)</td>
</tr>
<tr>
<td>Accurate raters on SRP</td>
<td></td>
<td></td>
<td></td>
<td>2 (4%)</td>
</tr>
</tbody>
</table>

As can be seen from the table above, under-rating was far more common on both measures than over-rating. Also, the proportion of participants who rated themselves as the same as staff rated them is very small on each. The results indicate that generally participants considered themselves to have less serious problems and disabilities than staff considered them to have. To a lesser extent, a group of participants did consider themselves to have more serious difficulties than staff considered them to have. Further, participants who under-rated on one measure did not always under-rate on the other and so on.
Table 25: Numbers of Participants Falling into Each Cell (and percentage of overall sample):

<table>
<thead>
<tr>
<th></th>
<th>Over-rating on SBS</th>
<th>Under-rating on SBS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over-rating on SRP</td>
<td>7 (14%)</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>Under-rating on SRP</td>
<td>12 (24%)</td>
<td>22 (44%)</td>
</tr>
</tbody>
</table>

Within the assessment of insight, a matter of interest was to investigate the validity of the general measure of insight (SUMD) by comparing it with behaviourally anchored measures. One of the issues to be assessed was whether a measure of the person’s overall view of whether they suffer from mental illness, require treatment etc. (SUMD) would be correlated with behaviourally anchored measures of functioning and disability (SBS and SRP). Correlation coefficients were calculated between SUMD scores and degree of under- and over-rating on the SBS and SRP.

Table 26: Pearson Product Moment Correlation Coefficients, Numbers of Cases and Probabilities.

<table>
<thead>
<tr>
<th></th>
<th>SUMD (higher scores mean greater insight)</th>
<th>Under-rating on SBS</th>
<th>Over-rating on SBS</th>
<th>Under-rating on SRP</th>
<th>Over-rating on SRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUMD (higher scores mean greater insight)</td>
<td>1.0000 (n=50)</td>
<td>p=.</td>
<td>-.4106 (n=28)</td>
<td>p=.03*</td>
<td>.0646 (n=19)</td>
</tr>
<tr>
<td>Under-rating on SBS</td>
<td>1.0000 (n=28)</td>
<td>p=.</td>
<td>.5398 (n=22)</td>
<td>p=.01*</td>
<td>.6714 (n=4)</td>
</tr>
<tr>
<td>Over-rating on SBS</td>
<td>1.0000 (n=50)</td>
<td>p=.</td>
<td>-.3429 (n=12)</td>
<td>p=.275</td>
<td>-.3048 (n=7)</td>
</tr>
<tr>
<td>Under-rating on SRP</td>
<td>1.0000 (n=50)</td>
<td>p=.</td>
<td>1.0000 (n=50)</td>
<td>p=.</td>
<td>1.0000 (n=50)</td>
</tr>
</tbody>
</table>

*indicates a significant correlation
--- indicates where the groups are mutually exclusive and therefore cannot be correlated.
As can be seen from the table above, under-rating on SBS correlates significantly with under-rating on SRP. This means that those who rate themselves as having less severe difficulties with behaviour and symptoms than staff rate them as having, tend to rate themselves as having less severe difficulties with role performance as well. SUMD scores correlate negatively with under-rating on SBS, indicating that less insight as measured by SUMD is associated with viewing symptoms and behavioural problems as less severe than the staff’s view. This adds validity to the use of the SUMD as a measure of insight. Interestingly, SUMD scores are also correlated with over-rating on SRP; this indicates that greater insight as measured by SUMD is associated with rating one’s disabilities as more severe than the staff’s rating. Over-rating on the SRP is associated with greater insight on the SUMD; the number of participants included in this analysis are small however (n=12), so this result must be treated with caution.

3.5. RELATIONSHIPS BETWEEN ACKNOWLEDGEMENT OF ASPECTS OF MENTAL ILLNESS AND OTHER FACTORS

Greater insight (as measured by the SUMD) was found to correlate significantly with less difficulty with symptoms and behaviour problems (SBS) (Pearson’s r = .4011, p=.004, n=50) and with role performance (SRP) (Pearson’s r =-.3347, p=.018, n=50). Greater insight was also associated with less total time spent in hospital (Pearson’s r =.3404, p=.016, n=50) and with more time since last being in hospital (Pearson’s r =.2915, p=.040, n=50). Further, less insight, as measured by greater under-rating on the SBS, was associated with greater difficulties with role performance (SRP, staff one rating) (Pearson’s r = .4111, p = .030, n = 28) and with less time since last time in hospital (Pearson’s r = -.5466, p = .003, n = 28). Less insight, as measured by greater under-rating on the SRP, was associated with more time in hospital (Pearson’s r = .4380, p = .008, n = 36), more admissions (Pearson’s r = .5594, p = .000, n = 36) and greater difficulty with symptoms and behaviour problems (Pearson’s r = .4637, p = .004, n = 36).

Greater insight was also associated with broader and more community social networks (Spearman’s rho = .4586, p = .001, n = 50). An analysis of variance was carried
out to assess the differences between the means of the four categories of social networks on insight (SUMD), stigma and the identity principles.

Table 27: Multiple Analysis of Variance. Identity, Stigma and Insight by Social Networks

<table>
<thead>
<tr>
<th>Variable</th>
<th>Hypoth. SS</th>
<th>Error SS</th>
<th>Hypoth. MS</th>
<th>Error MS</th>
<th>F</th>
<th>Sig. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>12.188</td>
<td>475.432</td>
<td>4.063</td>
<td>10.335</td>
<td>.393</td>
<td>.759</td>
</tr>
<tr>
<td>Continuity</td>
<td>54.837</td>
<td>679.883</td>
<td>18.279</td>
<td>14.780</td>
<td>1.237</td>
<td>.307</td>
</tr>
<tr>
<td>Distinctiveness</td>
<td>4.278</td>
<td>368.602</td>
<td>1.426</td>
<td>8.013</td>
<td>.178</td>
<td>.911</td>
</tr>
<tr>
<td>Stigma</td>
<td>362.3178</td>
<td>4562.807</td>
<td>120.7726</td>
<td>99.19146</td>
<td>1.21757</td>
<td>.314</td>
</tr>
<tr>
<td>Insight (SUMD)</td>
<td>1212.914</td>
<td>4512.866</td>
<td>404.3046</td>
<td>98.10578</td>
<td>4.12111</td>
<td>.011*</td>
</tr>
</tbody>
</table>

The results indicate that there is a significant difference between the four categories of social networks in terms of insight but not in terms of identity principles or stigma. The results of a Scheffe's post hoc analysis indicates that the difference lies between the completely isolated group and the group with non-hospital friends (means shown below).

Table 28 shows the means for SUMD by Social Network Categories:

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entire population</td>
<td>36.3800</td>
<td>10.8098</td>
<td>50</td>
</tr>
<tr>
<td>Completely isolated</td>
<td>29.9286</td>
<td>7.7506</td>
<td>14</td>
</tr>
<tr>
<td>Isolated bar family</td>
<td>35.0000</td>
<td>10.9011</td>
<td>13</td>
</tr>
<tr>
<td>Hospital friends only</td>
<td>38.0000</td>
<td>9.6090</td>
<td>7</td>
</tr>
<tr>
<td>Hospital and non-hospital friends</td>
<td>42.4375</td>
<td>10.8072</td>
<td>16</td>
</tr>
</tbody>
</table>

From consideration of the data, it became evident that, although there were some interesting relationships between variables emerging, there was no linear model linking
the central variables as had been expected. Consequently, multiple regression analyses were not carried out as had been originally envisaged. The specific relationships which emerged between variables are discussed instead.

In order to assess the relationships between key variables within the data, a number of analyses were carried out. Although scores on the identity principles were not found to be associated strongly with the insight variables, a number of relationships with other key variables were found.

Lower scores on continuity were associated with younger age (Pearson’s r = .3216, p=.023, n=50) and lower scores on distinctiveness were associated with greater length of time since last in hospital (Pearson’s r = -.3013, p=.033, n=50). Lower scores on self-esteem were associated with less time spent in hospital (Pearson’s r = .3185, p=.024, n=5) and a tendency, although not significant, to be associated with less under-rating of symptoms and behavioural problems (on the SBS) (Pearson’s r = .3633, p=.057, n=28). Scores on distinctiveness and continuity were also correlated (Pearson’s r = .2970, p=.036, n=50). Lower scores on self-esteem were also associated with broader and more community based social networks (Spearman’s rho = -.4679, p = .001, n = 50).

The influence of social networks was also investigated. Broader and more community based social networks were associated with less total time spent in hospital (Spearman’s rho = -.3335, p = .018, n =50) and fewer admissions (Spearman’s rho = -.2874, p = .043, n = 50). The presence of more positive social roles was also associated with broader and more community networks (Spearman’s rho = .4988, p = .000, n = 50).

3.6. ASSOCIATIONS BETWEEN THE MAIN VARIABLES

Hypothesis one predicted that positive identity would be associated with less severe positive symptoms. The positive symptom items on the SBS and the SUMD were summed to give scores of past and present positive symptoms.

Specifically, there was an association between participants rating themselves as having greater difficulties with symptoms and behavioural problems (SBS) and lower
scores on distinctiveness (Pearson’s r = -.2796, p = .049, n = 50). Thus participants who felt that they had significant difficulties in any of the areas measured tended to report a less positive sense of distinctiveness. It is not clear, however, whether this means that they felt too or not distinctive enough; this issue is explored in detail in the Discussion Section (see p.257).

Hypothesis two predicted that positive identity would be associated with the presence of positive roles. The presence of positive social roles was not significantly correlated with the identity principles (self-esteem: Pearson’s r = .0776, p = .592, continuity: Pearson’s r = .1328 p = .358, distinctiveness: Pearson’s r = -.0213, p = .884, n = 50). This does not support the hypothesis that the number of alternative positive roles protects a positive sense of identity. Specifically, there was an association between participants rating themselves as having greater difficulties with role performance (SRP) and lower scores on distinctiveness (Pearson’s r = -.3353, p = .017, n = 50). Thus participants who felt that they had significant difficulties in any of the areas measured tended to report a less positive sense of distinctiveness, either too or not distinctive enough (see p.262). Greater self-rated difficulties with role performance were associated with longer time since last in hospital (r = .2836, p = .046). Performance of more positive social roles, however, was associated with less over-rating of symptoms and behaviour problems (SBS) (Pearson’s r = -.5162, p = .024, n=19).

In order to assess whether the impact of the presence of alternative positive roles on identity, analyses of variance were carried out.

Table 29: Analysis of Variance in Identity Principles Grouped by Positive Social Roles:

<table>
<thead>
<tr>
<th>Variable</th>
<th>Hypoth. SS</th>
<th>Error SS</th>
<th>Hypoth. MS</th>
<th>Error MS</th>
<th>F</th>
<th>Sig. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>44.278</td>
<td>443.342</td>
<td>8.856</td>
<td>10.076</td>
<td>.879</td>
<td>.503</td>
</tr>
<tr>
<td>Continuity</td>
<td>48.672</td>
<td>686.048</td>
<td>9.734</td>
<td>15.592</td>
<td>.624</td>
<td>.682</td>
</tr>
<tr>
<td>Distinctiveness</td>
<td>49.576</td>
<td>323.304</td>
<td>9.915</td>
<td>7.348</td>
<td>1.349</td>
<td>.262</td>
</tr>
</tbody>
</table>

As shown above, there were no differences between the groups.
Hypothesis three:

Stigma was not correlated with the identity principles (self-esteem: Pearson’s r = .2488, p = .081, continuity: Pearson’s r = .0688, p = .635, distinctiveness: Pearson’s r = -.1243, p = .390, n=50) as had been expected. As can be seen from Table 18, however, scores on stigma tended to be high throughout. A greater sense of perceived stigma was associated with less difficulty with current symptoms and behaviour problems (SBS, staff one rating) (Pearson’s r = -.2986, p = .035, n = 50).

Hypotheses four and five predicted that lack of insight into mental illness would be associated with the maintenance of positive identity and denial of sense of change to identity. In order to assess hypotheses four and five, it was necessary to investigate the relationship between acknowledgement of sense of change to identity principles and insight. Taking the group who reported no sense of change on any principle (n=9) and comparing it with the group who reported sense of change on all three principles (n=11), Mann-Whitney tests were carried out to assess whether these two groups differed in terms scores on the identity principles or insight.

Table 30: Results of Mann-Whitney Tests of Acknowledgement of Sense of Change with Insight and the Identity Principles:

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>U</th>
<th>W</th>
<th>Corrected for Ties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>z</td>
</tr>
<tr>
<td>SUMD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No change</td>
<td>30.7778</td>
<td></td>
<td></td>
<td>-1.5610</td>
</tr>
<tr>
<td>All change</td>
<td>39.2727</td>
<td>29</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>CONTINUITY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No change</td>
<td>7.6667</td>
<td></td>
<td></td>
<td>-2.2200</td>
</tr>
<tr>
<td>All change</td>
<td>11.8182</td>
<td>20.05</td>
<td>65.5</td>
<td></td>
</tr>
<tr>
<td>DISTINCTIVENESS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No change</td>
<td>6.5556</td>
<td></td>
<td></td>
<td>-.7747</td>
</tr>
<tr>
<td>All change</td>
<td>7.4545</td>
<td>39.5</td>
<td>84.5</td>
<td></td>
</tr>
<tr>
<td>SELF-ESTEEM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No change</td>
<td>5.5556</td>
<td></td>
<td></td>
<td>-2.3767</td>
</tr>
<tr>
<td>All change</td>
<td>9.0000</td>
<td>18.5</td>
<td>63.5</td>
<td></td>
</tr>
</tbody>
</table>
Those who acknowledged sense of change did not differ significantly from those who did not in terms of insight or distinctiveness. Those who acknowledged sense of change showed significantly lower scores on continuity and self-esteem.

Correlation coefficients were also calculated to assess whether acknowledgement of sense of change to principles was associated with degree of under- or over-rating on SBS or SRP, which constitute the other measures of insight employed within the study. As is shown in the table below, acknowledgement of symptoms was not significantly correlated with any of these measures of insight.

Table 31: Spearman's rho Correlation Coefficients:

<table>
<thead>
<tr>
<th>Acknowledgement of sense of change to identity principles</th>
<th>Over-rating on SBS</th>
<th>Under-rating on SBS</th>
<th>Over-rating on SRP</th>
<th>Under-rating on SRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>- .2655</td>
<td>-.2205</td>
<td>.5231</td>
<td>-.1956</td>
<td></td>
</tr>
<tr>
<td>(n=19)</td>
<td>(n=28)</td>
<td>(n=12)</td>
<td>(n=36)</td>
<td></td>
</tr>
<tr>
<td>p=.272</td>
<td>p=.260</td>
<td>p=.81</td>
<td>p=.253</td>
<td></td>
</tr>
</tbody>
</table>

These results indicate that where sense of change to the identity principles is experienced it is likely to be associated with less positive identity generally but is not associated with greater insight, as had been predicted.

Further, scores on the identity principles were not found to be correlated with under-rating on SRP (self-esteem: Pearson's r = -.2096, p = .220, continuity: Pearson's r = -.2307, p = .176, distinctiveness: Pearson's r = -.2902, p = .086, n=36) or with any of the other measures of insight. There was a non-significant tendency for lower scores on continuity to be associated with less under-rating on the SBS (Pearson's r = 1.4518, p=.052, n=19). Scores on the other identity principles were not found to be associated with any of the insight variables.

There is no evidence of an association between the acknowledgement of sense of change to identity principles and any of the insight or under-/over-rating measures. Hence, the hypothesis that acknowledgement of sense of change is associated with greater insight can be rejected.
Hypothesis six:

Over-rating of symptoms, behaviour problems and disabilities was not found to be associated with the acknowledgement of sense of change to the identity principles (see Table 31). There was a tendency for over-rating of symptoms and behaviour problems (SBS) to be associated with greater scores on continuity but this was not significant (Pearson’s r = .4518, p = .052, n = 19). Over-rating on neither measure was related to any of the other identity principles. Over-rating was not found to be associated with self-efficacy. Over-rating of symptoms and behaviour problems (SBS) was associated with more admissions (Pearson’s r = .5342, p = .018, n = 19) and with fewer positive social roles (Pearson’s r = -.5162, p = .024, n=19). Over-rating of disabilities was associated with greater insight (SUMD) (Pearson’s r = .5925, p = .042, n=12). Due to the small number of subjects involved in this correlation, however, this result must be treated cautiously.

Hypothesis seven:

Self-efficacy was not correlated with the identity principles (self-esteem: Pearson’s r = -.1705, p = .236, continuity: Pearson’s r = .1660, p = .249, distinctiveness: Pearson’s r = -.0461, p = .750, n=50). Greater self-efficacy was associated with fewer hospital admissions (Pearson’s r = -.3376, p = .016, n = 50), although not specifically the total length of time spent in hospital. Positive symptom scores were not found to be correlated with the number of admissions (Pearson’s r = .0130, p = .928 (current) and r = .0028, p = .985 (past)), nor with overall self-efficacy (Pearson’s r = .1743, p = .226 (current) and r = .1299, p = .374 (past). Increased efficacy relating to positive symptoms was found to be associated with higher scores on self-esteem (Pearson’s r = .2944, p = .038).
4. DISCUSSION

4.1. INTRODUCTION

The demographic data collected indicate that this sample shows fairly typical patterns for schizophrenic men (American Psychiatric Association, 1994). The age of first diagnosis or hospitalisation was generally in the early 20’s. The sample showed varied patterns of service usage, including number of admissions, length of time spent in hospital and time since discharged from hospital. This indicates that a broad range of participants was accessed, representing the different experiences of schizophrenic men now living in the community. Nearly a third of the participants were living independently, nearly a third living with families and nearly a third in 24-hour staffed homes. Again, this indicates that a range of patients was accessed, as the latter group is likely to have greater disabilities than the first, indicated by their need for full time care. Interestingly, more than half were not attending any kind of day care, although a significant minority was attending sheltered work placements. Also, most had no significant hobby in their lives. Only a third had friends or contacts that they had not met through the hospital, and nearly a third reported no social contacts whatsoever.

The vast majority of the participants knew their diagnosis was schizophrenia. More than half attributed their difficulties or hospitalisation to mental illness, although a number of those felt this was combined with another reason, such as drugs or stress. This may be due to some bias in the sample studied; although care was taken in the way subjects were approached, it is possible that those with greater insight were more likely to volunteer to participate.

4.2. SENSE OF CHANGE TO IDENTITY

In identity process theory, identity is seen as a dynamic social product of the interaction between the internal and the social. This study attempted to assess both aspects, that is the internal effects of the experience of the illness and ensuing self-
images, plus issues relating to the position in society in which schizophrenia and its consequences place people.

More participants in this study reported that their sense of identity had changed than not. This varied between sense of change to one, several or all principles. The study provides evidence that those who acknowledge a sense of change to the identity principles experience a significantly less positive sense of continuity and self-esteem but not distinctiveness. This implies that sense of change to identity was common and that, when it occurs, the sense of change to identity experienced was generally negative, especially in relation to self-esteem. The lack of correlation between acknowledgement of sense of change to identity and distinctiveness is something of an anomaly and will be dealt with later in the section on distinctiveness. Only a small minority reported that no sense of change to the identity principles had occurred. It had been expected that this would be associated with less insight; the finding that participants rarely experienced no sense of change to identity may explain why no such association was found.

Thus, this study provides support for the hypothesis that schizophrenia constitutes a threat to identity and may initiate sense of change to identity; high levels of sense of change to identity were indicated by the participants and particularly change to the detriment of a positive sense of identity. It was also hypothesised that the threat posed by schizophrenia may occur at the three levels of impairment, disability and handicap; these will be dealt with in turn.

4.3. THREATS TO IDENTITY IN SCHIZOPHRENIA

4.3.1. Identity and Positive Symptoms (Impairment)

The experience of positive symptoms was an area that participants were not always willing to discuss openly. Some would answer direct questions evasively but then give more details in the course of conversation later, suggesting that it was an uncomfortable subject. Others seemed keen to discuss their experiences and did so vividly, perhaps indicating the great impact that such experiences can have on the individual.
Statistically, no direct relationship was found between severity of difficulties with symptoms and behaviour problems, or the presence of positive symptoms, and identity. Insight into symptoms and less positive identity were related but not strongly: there was a tendency (not statistically significant) for greater under-rating of behaviours and symptoms generally to be associated with more positive continuity and self-esteem. This could imply that denying problems protects a positive sense of continuity and self-esteem, which would support the hypothesis that lack of insight is a coping strategy for protecting identity. Alternatively, it may mean that those with a greater sense of continuity and self-esteem are more likely to overestimate their functioning. Insight into positive symptoms was not specifically related to identity. It is possible that this relationship is not strong because of the different levels at which participants reported experiencing identity change, that is at the impairment, disability and handicap levels. Consequently, this would dilute any relationships found.

In response to the identity questions, many participants cited their experience of positive symptoms (impairment) as influential in changing their identity. Some reported experiencing some intrinsic change to self, relating to the onset of illness. A few described this as the death of self, others as a feeling of deadness, sometimes relating to the medication. Another expressed this as, "before I had my breakdown I knew myself but now I am not sure how to be". This provides evidence that psychotic illness may threaten continuity, concurring with previous research. For some, however, the sense of loss of continuity seemed to be mainly at the time of the illness and several of the participants described regaining a sense of continuity after the florid period was over. Hence, it seems that a psychotic breakdown can either affect continuity temporarily or more permanently; the circumstances under which continuity can be regained would be a useful area for further study.

Previously, the loss of a coherent sense of self has been suggested to be the hallmark of schizophrenia. In this study, many of the participants reported losing their sense of a coherent self, such as "I don't feel that I am an 'I' really" or "I do have a character of my own but it is made up of parts of other people's characters". Many gave examples of finding it difficult to differentiate symptoms from reality or self from
symptoms - most vividly, “the doctors look for you to have insight into how you are not well but you can’t separate yourself from this”. Further, for many, the experience of self was intrinsically combined with delusional beliefs. One stated that he had recently regained a sense of self because God and his voices had told him so. Another gave a vivid example of how his beliefs about himself, albeit delusional beliefs, affected his sense of distinctiveness, “I feel too powerful, not too different but too powerful. Being the sun, people get upset with what I am. They stare at me when it is raining”. This provides evidence that positive symptoms could pose a greater threat to distinctiveness than was envisaged. This is discussed further in the section on distinctiveness.

Florid symptoms were described as aversive, terrifying and horrifying. Voices could be experienced as a constant disruption to thoughts, as insulting or threatening. Some participants described a sense of shame about these experiences, such as, “I wish I could wear a tie and not say things to myself that are silly” or “the most important thing to resolve in my life is that I do strange things in front of people, to be more consistent”.

Equally, positive symptoms could be seen as good. Hallucinations were often attributed to having some kind of special knowledge, intelligence or sensitivity that is denied to others and could be seen as paranormal or spiritual experiences. They could also be attributed to outside forces, benign or malignant. Hallucinations were sometimes attributed to internal sources such as one’s own thoughts or the voices of one’s conscience, or to illness or distortions of perception. Voices could be generated to help with decisions, could be comforting, reassuring or provide company. Some participants described very powerful experiences when in a psychotic breakdown, as beautiful and wonderful; one coined this as “brain expanded, hyperturbo, schizi-mode”.

Very commonly, participants exhibited a mixture of beliefs about their symptoms, often holding complex and conflicting ideas at the same time. For example, this could entail both considering them as a symptom of schizophrenia at the same time as believing that one had special powers. Different explanations were sometimes given at different stages of the interview. For example, one man first described his belief that he was Jesus as a delusional idea, then that he was Jesus, and finally summarising his attitude as “I think I am Jesus but I shelve it”. }

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Breakwell's theory proposes that identity consists of the content and value dimensions (Literature Review – section 2.1.1. "The Structure of Identity"). In this study, the relative value of the different contents of identity, as ascribed by the individual, were not explored formally. As the qualitative data demonstrates, symptoms such as hallucinations may be evaluated positively or negatively by the individual. Hence, they may be a source of positive identity as much as posing a threat to it. This distinction was not assessed within this study.

4.3.2. Identity and Role Performance (Disability)

A relationship between the experience of disabilities related to schizophrenia and identity was found. Higher self-rated difficulties with role-performance, i.e. the perception of self as more disabled in day to day activities, was associated with a less positive sense of distinctiveness. This supports the hypothesis that disabilities due to schizophrenia threaten identity and that the effects of schizophrenia on identity are in part via its effects on role performance. Whether the threat to distinctiveness constitutes feeling too distinct from others or not distinct enough is unclear, however.

The effect of difficulties with everyday roles on identity was clearly reflected in participants' comments. Many mentioned the issue of being unable to do a "normal job" and not being "on the same path as others" in terms of having a house and job; one complained that the illness "robs you of your freedom to have a career and work". This was especially evident in relation to self-esteem: many attributed a lack of self-esteem to lack of opportunity for work and achievement. For several, this was evidently the most important factor in their sense of identity, particularly where they had worked in the past but subsequent to the onset of illness been unable to. Work was sometimes closely identified with adulthood and a mature sense of self; for example, in answer to the questions about continuity, one participant stated, "I do not know who I was before, I was not an adult before. I had a breakdown before I had a job and became established".

Although the value attached to different social roles was not formally assessed in this study, the qualitative data indicated that the work role was deemed important by many of the participants. Their difficulties in achieving success in a work role, however,
were attributed to lack of ability due to illness by some, and to stigma and an unfair societal attitude by others, or a combination of the two. Hence, this straddles the disability and handicap levels. This is illustrated by the comment, “I’m treated as someone with a problem, not someone who gets involved with everyday things”.

The presence of more positive social roles was not directly associated with a less positive sense of identity. It was associated with less over-rating of symptoms and behaviour problems. Having more positive social roles to perform may have helped participants to see their difficulties in a more positive light or seeing their problems more positively may have helped them to enter into more positive roles. There was little variation, however, in the number of positive roles that people felt were available to them. It is possible that views about ability to function in the roles available may be the more important factor, rather than the number of roles available.

Having more positive social roles was also related to having broader and more non-hospital social networks. It is easy to see how the two may go together, each providing an opportunity for the other. More community and broader social networks were associated with less time spent in hospital. It is likely that more time in hospital disrupts social networks to a greater degree. Further, greater self-rated difficulties with role performance were associated with greater time spent in hospital. This suggests that either longer spells in hospital have greater detrimental effects on the ability to perform everyday roles, as they are known to do, or that those with poorer role-performance tend to need to stay longer in hospital. There may be an interaction between the two.

4.3.3. Identity and Stigma (Handicap)

Within identity process theory, identity is considered to be affected by both the social structure and processes of social influence (described in the Literature Review – section 2.1.4. “The Social Context of Identity”). The processes of social influence constitute the belief systems prominent in the individual’s cultural context. In this light, the influence of perceived stigma, referring to the individual’s perception of the dominant belief systems regarding mentally ill people, would be expected to have an important impact on identity.
Unexpectedly, positive identity was not directly associated with stigma in this study. The experience of being labelled as mentally ill, however, was often mentioned in relation to sense of change in identity. Participants noted the effects of other people’s reactions and the issue of not being sure what to say about oneself to new people. Stigma was sometimes related to the distinctiveness questions; for example, one stated that they did not feel distinctive because mentally ill people are “categorised in a certain category”. Further, negative societal views of the mentally ill were mentioned by many participants as a causal factor in their experience of self-esteem change.

Current thinking on the experience of stigma and labelling suggests that although mental health patients may be considered a highly stigmatised group, they are not just passive recipients of societal views and do not automatically internalise them. It is now recognised that mental health patients may react in different ways, possibly rejecting negative views. This concurs with identity process theory, in that a number of ways of coping with threats to identity are recognised. This is also reflected in the results of this study. There is evidence within the qualitative data of the impact of perceived stigma on the individual. Most of the participants recognised that they were labelled as schizophrenic, although not all of them agreed with this. There was also evidence of different ways of coping, such that an overall detrimental effect on identity was not inevitable.

Participants generally perceived mentally ill people to be highly stigmatised and strong views were often expressed when the devaluation-discrimination questions were asked. Participants described their experiences as being “treated as second class citizens”, “condemned to the back of the class”, “branded”. They reported feeling that society is prejudiced, especially towards those without visible disabilities, and that people are “not conditioned” to accept mental illness. Many referred to the media reports of violence by schizophrenic patients as exacerbating this situation. The comments made during the interviews often implied that participants disagreed with these views and thought them unfair. This indicates that negative societal views were not always internalised.
Interestingly, some felt that the stigma was justified to some degree or in some instances. One commented, for example, that other patients do not always "see things clearly and may be a bit tiresome—they are more likely than the norm to talk a bit of nonsense". It was not uncommon for participants to feel that prejudice against "mental patients" was justified in relation to contact with children: many felt that someone with a mental illness could behave unpredictably or could be harmful to children.

Greater stigma was associated with greater difficulties with symptoms and behaviour problems (staff rating). It is possible that this is because people with more severe symptoms and behaviour problems behave strangely, therefore attracting more attention. This could cause them to be or to feel more stigmatised.

In this study, the experience of rejection was measured but the degree to which this was internalised by the individual was not measured directly. It was evident from the qualitative data collected during the interviews that participants did not always agree with the negative stereotypes of mental illness or apply the stigma ascribed to mentally ill people to themselves. For example, one participant summarised it as, "I never felt any stigma. You go to a doctor if you get ill, you go to a psychiatrist if you get mentally ill. There are writers and people who have had mental illness". Thus, the data suggests that various coping strategies may have been employed by the participants, mediating the negative effects of stigma. These may vary between acceptance and compliance with the stereotyped role of the mentally ill person, or rejection of these stereotypes. If the latter is the case, this may be employed in conjunction with intergroup strategies. Further study of the coping strategies, which help mitigate the impact of stigma on identity, would be a useful area for future study. Within identity process theory, it is expected that coping strategies will mitigate the impact of threats to identity posed by schizophrenia. Evidence for this is discussed below.
4.4. IDENTITY AND COPING WITH THREAT

4.4.1. Processes of Adjustment

Some evidence for processes of adjustment to schizophrenia was found in this study. A less positive sense of continuity was associated with younger age. This may indicate that a sense of continuity can be re-established over time and suggests a process of adjustment to the threat. This could either be through the processes of accommodation or assimilation. Some of the participants expressed, during the interviews, a feeling of having lost but then regained a sense of continuity. It could also be that identity is more fluid in young adulthood anyway. For some participants, it seemed that illness had begun at a young age before an adult identity was really established anyway. Although sense of continuity was not statistically related to age at diagnosis, there was little variety in age at diagnosis as most had been diagnosed between 18 and 26. On average, the interviews were being carried out about 20 years after diagnosis, so many processes of adjustment are likely to have occurred in between. Younger participants were nearer the time of diagnosis and may have been more aware of the effects on identity that diagnosis or first hospitalisation wrought. Development of continuity in adults in the normal population has not been studied, however. This would help elucidate the issues discussed above.

Some participants also felt that changes to self-esteem had occurred but that self-esteem had been regained. Several felt that their identity had only been affected whilst in hospital or whilst ill and that they had regained a sense of positive identity as soon as they were well again.

Many examples of active coping were described during the interviews. These could be practical e.g. relaxation, walking, reading, being alone, not watching TV etc., or internal, e.g. “channelling self”, “framing the voices”, “understand the voices, get the knack of them”.

A positive sense of identity change was experienced in some cases, although this was always in conjunction with some negative sense of change. Some described being “a mental patient” as a useful experience, in that it made them emotionally stronger, made
them face up to problems or helped them mature. Others reported that it helped them develop greater sensitivity to the suffering of others or a broader experience of other peoples' lives. One described a greater sense of freedom, in that it no longer mattered what other people thought of him. Sometimes, during the interviews, it felt as if some mitigating factor or "saving grace" was sought to help make the experience more palatable. Considering the coping strategies observed within the framework of identity process theory, this could be interpreted as coping with the threat by revaluation and focusing on some other aspect of identity. In other cases, participants compared their own with other possible life histories, for example, "It was a useful experience being a mental patient. I've learnt some things.... If it had not been one path it could have been another, I could have been in a wheelchair". Again, this seems to be revaluation of the content dimension by comparing with others.

Various types of coping mechanisms seem to be employed. Compartmentalisation, that is holding the unwanted part of the identity structure as outside the rest, may be used to accept the illness definition alongside conflicting definitions. The value and meaning of hallucinations, for example, were often interpreted positively, whilst still acknowledging the diagnosis of schizophrenia.

Within a general exploration of adjustment processes, a number of specific coping strategies were assessed in depth, which have particular significance in the schizophrenia literature. These include insight, denial, exaggeration and self-efficacy.

4.4.2. Insight and Denial

The levels of insight demonstrated in this study seemed generally high. This is illustrated by the fact that 62% attributed their difficulties at least in part to mental illness (see Table 7 – Results Section) as well as achieving slightly higher scores than in the original study with the insight measure. This may reflect bias in selection for the study, in that participants with greater insight may have been more willing to discuss their difficulties and therefore more likely to volunteer for interview. Very poor insight is expected close to the onset of schizophrenia, whereas the participants in this study had at
least all been discharged following their first breakdown and were mostly several years on.

The study included several measures of insight used in parallel, in order to check the validity of the self-report measure and to assess insight for different aspects of the effects of schizophrenia. This has not eased interpretation but has lead to a complex and interesting array of results.

More participants thought they had less severe symptoms and behavioural problems and less difficulty with performing everyday roles than staff thought them to have. What remains for interpretation is whether staff over-estimate patients’ difficulties or whether patients are underestimating their difficulties.

There is a body of research comparing staff perceptions with patient perceptions of various aspects of illness and treatment. This has largely been carried out with general rather than psychiatric patients, although there have been a few studies specifically in psychiatry. Generally, most research studies have shown poor levels of agreement between patients and nurses regarding perceptions of illness, levels of stress and worry experienced by patients, involvement in medical decisions and helpful aspects of treatment (Johnston, 1976, 1982; Davies & Peters, 1983; Connelly, 1992; Farrell, 1991). In most cases, although not invariably, staff seemed to over-estimate the stress levels or worries experienced by patients in medical settings. Further, the few studies concerned with psychiatric settings demonstrated similar levels of disagreement (Nolan, 1989; Farrell, 1991; Carson & Sharma, 1994; Herbert & Salmon, 1994). Most of these studies have been exploratory, were not based on any theory and few suggestions about the factors influencing staff’s perceptions have resulted. Most of the studies were not specifically concerned with psychiatric symptoms, however, and there is a dearth of research in this area. If staff tend to overestimate the worries and stresses of their patients, compared to the patients’ own perceptions, then it is possible that this also occurs with psychiatric symptoms. Hence, assuming that the discrepancy between staff and patient perceptions of symptoms and disabilities is due to denial on the patient’s part must be treated cautiously.
Those who rated themselves as having less severe difficulties with symptoms and behavioural problems tended to rate themselves as having less severe difficulties with role performance as well. Greater insight was associated with less under-rating (that is, greater accuracy or a view nearer to the staff's) of symptoms and behaviour problems.

Greater insight (on array of measures) tended to be associated with less total time spent in hospital, more time since the last admission and less difficulty with both symptoms and behaviour problems, and role performance. This could be interpreted to mean that when patients are well, i.e. needing less time in hospital and experiencing less difficulty with functioning, that they have more insight. This would imply insight as part of the illness, fluctuating with mental state. As such, it could be considered a symptom or cognitive deficit. Alternatively, this could indicate that experiencing greater difficulty with functioning and being in hospital pose a threat to the individual's identity; denial maybe used as a defence against this threat. Assessing the interrelationships between these factors at different stages of the process of adjustment for the individual may help to clarify this.

Greater general insight about illness was associated with having more community-based social networks and broader social networks, as opposed to isolation or family-contact only. There are two possible explanations. Making and maintaining relationships may be easier for patients with greater insight: they may be more socially acceptable. Alternatively, having more varied contact might help the person to develop greater insight, possibly by providing social comparisons. Consistent with the coping strategies delineated in identity process theory, denial and isolation may be used together, as isolation protects the person's denying stance from challenge. One issue of concern, however, is the inclusion of people with paranoid symptoms; their particular symptoms may preclude them from making relationships and, typically, they would be more likely to attribute their difficulties to external causes.

Acknowledgement of sense of change to the identity principles was not associated with greater insight as had been predicted. It had been proposed that acknowledgement of having schizophrenia would be the most influential factor in changing identity. What may not have been taken into account are the different levels at which this might have
impact on identity. As such, then a straightforward relationship between insight and sense of change to identity would not be expected. During the interviews, participants cited a number of reasons for the impact of their experiences “as a mental patient” (the question was purposefully left broad to allow for different aspects of the impact of the illness to be brought in) in changing their sense of self-esteem, continuity or distinctiveness. These included the following: the experience of the illness itself and positive symptoms, the negative effects of medication and ECT, “being in the system”, institutionalisation and becoming afraid of the outside world, stigma, being stereotyped and fearing other people’s reactions, as well as “not having a job or a normal life”. These are consistent with the three levels of impairment, disability and handicap as described. As insight was generally found to be high in this study, and the extent of sense of change to identity was also found to be high, a number of different pathways between the two may exist, perhaps depending on what is uppermost or important in that person’s mind and in their experience.

4.4.3. Exaggeration of Difficulties

A smaller number of the participants considered themselves to have worse problems than the staff considered them to have. This seems to fit with Shepherd’s description of a continuum between exaggeration and denial of problems.

Greater insight was associated with greater over-rating of disabilities (that is, greater exaggeration of disabilities or a view further from staff’s). The general insight measure (SUMD) is a linear measure and gives scores for insight rather than scores for under- or over-rating, so there is no possibility of a score for exaggeration. Exaggeration of disabilities would be expected to be associated with viewing oneself as ill and needing treatment etc., indicated by scoring highly on insight. This suggests either that staff under-estimate the disabilities of a small group of patients for some reason, or that a small group of patients do exaggerate their difficulties. This is consistent with the conceptualisation of “exaggerators” given by Shepherd. Less over-rating of symptoms and behaviour problems was associated with more positive social roles. This suggests that either performing more positive social roles increases confidence about abilities, or
that more confidence about abilities enables more opportunities for positive social roles to be sought or taken up. Otherwise, these two groups, those who over-rate and those who under-rate their difficulties, did not differ significantly on any of the main variables. Hence, exaggeration of disabilities was not associated with a less positive sense of identity, less self-efficacy or greater perceived stigma etc. In Taylor and Perkins' (1991) study, they suggest that exaggeration of difficulties was associated with lower self-esteem; the results of this study do not support this. Similarly, Taylor and Perkins speculate that the reason younger patients in their study were more likely to ascribe a patient identity to themselves was in order to compete for services. In this study, exaggeration of difficulties was not found to be related to age.

It is possible that finding no relationships between under- and over-rating and the main variables indicates that people are at different stages of an adjustment process. This would be consistent with identity process theory, in that some may have compensated for the negative impact of exaggerated difficulties. Hence, exaggeration must not be viewed as a simple construct with only one outcome. The nature of this in relation to the rest of identity and coping must be explored for each individual.

The finding that exaggeration of symptoms and behaviour problems was not associated with higher scores on insight (the belief that one is mentally ill) suggests that this may be different to exaggeration of difficulties with role performance (which is associated with viewing oneself as mentally ill). Instead, it appears that some patients were more open about their symptoms than they would normally be. The confidential nature of the interview may have helped to reassure people that no further action would be taken on the basis of what they said (e.g. hospitalisation, increased medication etc.). The questions were perhaps more exhaustive than many routine visits by clinical staff. It also seems that the patients did not necessarily view these symptoms as evidence that they were mentally ill, in that they were not associated with the general insight score. Hence, patients may have clear awareness of their problems and symptoms but not necessarily attribute them to mental illness.
4.4.4. Self-efficacy in Relation to Illness

In this study, self-efficacy was measured for all aspects of the illness. Identity was not directly associated with overall self-efficacy. Efficacy relating to positive symptoms in particular was associated with self-esteem. This indicates that a greater sense of control over hallucinations, delusions, bizarre behaviour, thought disorder etc. was associated with higher self-esteem.

This was reflected in the qualitative data collected during the interviews: lacking a sense of control over symptoms often seemed to be linked to a sense of failure or inadequacy. One participant described this as, “I thought there should be something strong enough in me to battle away the voices”. Equally, gaining a sense of control over symptoms seemed to be related to adjustment. One described his progress in adjusting to the illness as, “I decided to take charge of my thoughts. I can control things, use my will on it. I reorganised my mind, did a spring clean on it”. Others described specifically needing to gain control over hallucinations in order to cope as “understanding the voices, get the knack of them, never let them be in control” and “framing voices to cope with them”.

A greater sense of self-efficacy was generally associated with fewer hospital admissions but not with the total length of time spent in hospital. As the presence of positive symptoms is potentially related to admission, this aspect was also investigated. Overall self-efficacy was not related to the presence of more positive symptoms (past or present). Thus, it seems unlikely that the effects of experiencing positive symptoms on efficacy could explain the relationship with admissions. This, however, is a difficult area to study: whether the symptom had ever been present or not was rated, rather than the severity, frequency etc. Hence, the extent of positive symptoms could not be taken into account. Another possible explanation is that the process or fact of being admitted and then re-admitted has a detrimental effect on self-efficacy. Alternatively, those with less self-efficacy may be more likely to turn to or accept hospital admission as a solution to their difficulties. It is possible that compulsory rather than voluntary admission has a detrimental effect on self-efficacy. The type of admissions was not explored in this study; longitudinal research would be useful in this area.
To summarise, this study provides evidence for a continuum between denial and exaggeration of difficulties, although the relationship between this and identity is not straightforward. Despite high levels of recognition of "mental illness", it was still more common for participants to rate themselves as having less severe difficulties than staff did. Further, the variety of levels at which the experience of "mental illness" seemed to affect identity meant that a direct relationship between acknowledging sense of change to identity and insight was not found. The relationship between self-efficacy and the number of admissions merits further investigation. Most importantly, self-efficacy relating to positive symptoms was clearly related to self-esteem; findings on the relationship between schizophrenia and each identity principle will be discussed below.

4.5. THE EFFECTS OF SCHIZOPHRENIA ON THE IDENTITY PRINCIPLES

4.5.1. Schizophrenia and Self-esteem

Sense of change to identity consequent on schizophrenia was commonly reported by the participants of this study, especially detrimental effects to self-esteem. At the level of impairment, lack of control over positive symptoms seemed to lead to a sense of failure, this is reflected both statistically and qualitatively. Alternatively, some aspects of positive symptoms could increase self-esteem, such as grandiose delusions, or interpretations of the meaning of hallucinations. Here, the extensive work on cognitive theories of positive symptoms is relevant. A number of studies are converging to indicate that delusions may in themselves be strategies for protecting self-esteem, or protecting the individual from conscious awareness of underlying negative self-evaluations (Lyons et al, 1994; Kinderman, 1994; Bentall & Kaney, 1996). Consequently, the relationship between positive symptoms and self-esteem may be complicated, delusions being a coping strategy in themselves rather than presenting as a threat to identity.

There was a tendency for less under-rating of (that is, greater insight into) symptoms and behaviour problems to be associated with less self-esteem. This adds some, albeit weak, support to the hypothesis that lack of insight protects self-esteem.
Greater self-esteem was associated with having spent more time in hospital. This could imply that time in hospital provides an opportunity for self-esteem to be increased. This also suggests that exposure to the community may have a detrimental effect on self-esteem, either through exposure to one’s own disabilities or to social comparisons.

Similarly, less self-esteem was associated with broader and more community social networks, as opposed to remaining isolated or having family contact only. No significant difference in self-esteem was found between the group who had hospital friends only and those who had community friends or contacts. This suggests that isolation protects self-esteem, by reducing exposure to experiences that might challenge one’s view of oneself. Another side to this, however, is the issue of paranoia; patients with paranoid delusions or feelings may be more likely to stay isolated but may also be more likely to blame their difficulties on external causes, thus protecting self-esteem. The kinds of delusions exhibited by patients were not directly investigated in this study; the presence of either grandiose or paranoid delusions (and even types of paranoid delusions) may have implications for identity.

4.5.2. Schizophrenia and Continuity

The concept of continuity is itself complex and therefore difficult to measure. It entails both a sense of changing and maturing alongside a sense of being the same person deep down. This may sound conflicting at times, for instance, we might say the “me as a child” is extremely different to the “me as an adult”, and yet the sense of continuity is preserved. One difficulty with this study was designing questions that would be consistently understood. Some understanding of the complexity of the concept was often reflected in participants’ answers, however. For example, one shows a clear understanding, “every experience makes me see things differently but I am still the same me”, whilst another demonstrates uncertainty about what has affected them, “I’m not sure if it’s the illness that makes you different or just growing up”. Further investigation is needed, to clarify these processes in a normal population.

Qualitatively, this study indicates that sense of continuity was often affected by schizophrenia. This seemed to occur at the level of impairment, with fundamental
changes in the experience of self, as well as at the levels of disability and handicap. Some felt they had regained their sense of continuity though. A less positive sense of continuity was correlated with younger age; whether this implies that sense of continuity can be regained with time or whether continuity is naturally more fluid at younger ages is not clear.

4.5.3. Schizophrenia and Distinctiveness

The concept of distinctiveness is partly derived from group theories, within which there is both the idea of belonging to that group as well as that group being distinct from others. From this arises the issue of balancing distinctiveness and commonality and the question of how much distinctiveness is optimal. Essentially, distinctiveness, unlike the other identity principles, does not appear to be a linear concept; it does not seem to be the case that the more distinctiveness one has the better. Instead, there may be optimal levels of distinctiveness for an individual, a population or a situation.

The balancing of distinctiveness versus commonality is reflected in the comments made by participants throughout the interviews; experiences of feeling both too distinct and not distinctive enough are expressed. Some expressed seeking a greater sense of individuality and feeling that the illness/hospitalisation robbed them of that. Some felt categorised by others and related lack of distinctiveness to lack of work achievement etc. Others seemed to wish to be less distinctive, “I don’t want to be a distinctive person, I’d like to be the same as everyone else”. The nature of the symptoms of schizophrenia can cause someone to lose a sense of common reality with others. One stated, “I think being too distinctive caused my downfall, now I see more points of view”, perhaps reflecting how cut off from other people’s thought processes and views of reality he felt when ill; this was echoed by another, who stated that “mental illness made me too distinctive”. A sense of being too distinctive can also be associated with delusional ideas, especially relating to special powers (grandiose) or particular threat to the individual (paranoid). One participant’s comment, “I feel too powerful, not too different but too powerful” demonstrates this. It also depends how important distinctiveness is to the individual: another participant stated “it is not important to have a character but it is important to
think responsibly". This perhaps reflects the priorities enforced by the illness, in that achieving control over one's own mind may be more important than distinguishing oneself from others.

Hence, it is not clear how sense of distinctiveness functions in a population defined by abnormal experiences, especially one in which extreme experiences of losing commonality with others can occur and where a cohesive sense of self can be lost. Consequently, sense of distinctiveness is difficult both to measure and to conceptualise. As one participant succinctly put it, distinctiveness is "both a good and a bad thing".

Consequently, interpretation of the findings of this study in relation to sense of distinctiveness is not straightforward. Lower scores on distinctiveness were associated with greater length of time since last hospitalisation. Although this may mean that individuals experienced a less positive sense of distinctiveness or commonality, it is not clear in which direction this tends to be. For some, it may be that they feel less distinctive, perhaps due to lack achievement or recognition of their own difficulties through social comparisons. Alternatively, they may feel too distinctive, odd or unusual, again through social comparisons and exposure to the community. A less positive sense of distinctiveness was also associated with greater perceived difficulties with symptoms/behaviour problems and role performance (patients’ own ratings). This seems to indicate that recognition of the patient’s own difficulties in functioning makes it harder to feel distinctive in a positive way. Alternatively, it may be that those who do not feel distinctive in a positive way are more likely to see themselves as having greater difficulties. Sense of distinctiveness was not related to over- or under-rating in these areas, however, which suggests that the former interpretation is more likely. What remains difficult to interpret is whether this caused them to feel too distinctive or not distinctive enough. It may also be that this depends on the individual, their previous experience, their values etc.

The loss of a coherent sense of self was often manifested in the comments given in answer to the distinctiveness questions. One stated, "I don’t feel that I am an ‘I’ really", whereas another said, "I do have a character of my own but it is made up of parts of other peoples’ characters". The difficulty in separating self from illness was clearly expressed
by, "the doctors look for you to have insight into how you are not well but you can't separate yourself from this". Sense of self may be a more useful concept with this population.

4.6. CONCLUSIONS AND IMPLICATIONS

The findings of this study suggest the need to recognise in clinical practice that schizophrenia presents a threat to identity and that the sense of change to identity it engenders is generally negative. It seems that the threat can be at any or all of the levels of impairment, disability and handicap. Processes of adjustment to the threat may ensue and a positive sense of continuity or self-esteem may be regained. Sense of distinctiveness may also be affected but whether this leads to feeling too distinctive or not distinctive enough remains unclear. Most importantly, the processes for each individual need to be carefully assessed.

People with schizophrenia may hold a mixture of beliefs regarding the meanings of their symptoms and experiences; they may agree with their diagnosis but not attribute particular experiences or symptoms to schizophrenia. Apparently conflicting views may be held at the same time. Hence, the assessment of insight and attribution needs to be thorough if the perspective of the individual is to be understood. Total insight may, in fact, not be necessary for good functioning.

Disabilities, that is difficulties with performing everyday roles, seem to have a particular effect on identity. This does not just relate to the number of roles available but, more importantly, to the person's perceptions of their abilities. This reinforces the importance of rehabilitation, or providing support that enables people to maintain their social role functioning. More time in hospital is associated with fewer positive social roles, more restricted social networks and perceiving one's disabilities as greater, which again reinforces the need for rehabilitation or the provision of prosthetic social environments to enable people to function successfully outside hospital.

Lack of insight or denial of difficulties was associated with greater time in hospital, less time since last admission and more severe symptoms, behaviour problems and
disabilities. This could be interpreted as both supporting either a cognitive deficit or emotional defence model of insight. Longitudinal research may help to clarify this.

Threat to self-esteem seems to be greater with more time out of hospital. This may indicate that exposure to the community and to one's deficits in role functioning may challenge self-esteem. Spending longer in the community also seems to leave people with schizophrenia with a less positive sense of distinctiveness but it is not clear which direction this is in. This should be taken into account when patients are encouraged to integrate into the community.

Stigma was generally perceived to be high. Being labelled schizophrenic, however, did not necessarily lead to a less positive sense of identity. The findings imply that the threat to identity may be resolved through a variety of coping mechanisms and coping should be encouraged. Exposure to the community may increase the level of stigma experienced and maintaining relationships with contacts from the hospital may protect the person from experiencing negative societal views. Isolating oneself may be understood as a means of protecting one's sense of identity. Again, this should be taken account of when encouraging people to integrate into the community.

Self-report measures, such as the SUMD, do seem to provide a measure of insight as adequate as any other available. The measurement of insight remains complex, however, because intrinsically a comparison between the views of the individual and professionals is made. The processes influencing how professionals rate patients are poorly understood.

Most patients were found to consider themselves as having less serious problems, symptoms or disabilities than the staff considered them to have. A smaller group seemed to exaggerate their difficulties, and the findings of this study support Shepherd's description of a continuum between denial and exaggeration. Those who over-rated their disabilities also tended to view themselves as mentally ill and in need of treatment, fitting with the view of exaggeration proposed. Those who tended to over-rate their symptoms and behaviour problems were not more likely to see themselves as mentally ill but seemed to be more honest about their difficulties. This implies that exaggeration applies
to over-rating disabilities rather than symptoms. In this study, exaggeration was not necessarily associated with lower self-esteem, as had been found in a previous study.

Greater self-efficacy relating to positive symptoms was associated with greater self-esteem. This supports the hypothesis that positive symptoms may constitute uncontrollable events, which violate the identity principles, and reinforces the importance of therapeutic approaches that develop a sense of control over symptoms (e.g. cognitive-behavioural therapy). Warner's therapeutic model, which proposes the importance of sense of control alongside insight, is also supported. In fact, the findings of this study would suggest that self-efficacy relating to positive symptoms is a more important factor in relation to identity than insight or denial.

Being admitted to hospital on more occasions was associated with lower self-efficacy. This requires further research into whether more frequent episodes of positive symptoms or compulsory as opposed to voluntary admissions lower self-efficacy, or whether those with less self-efficacy tend to be more willing to accept hospital as a solution. This may have serious implications for our understanding of the effects of relapse and hospitalisation.

This study indicates that identity process theory may provide a useful approach to assessing the effects of schizophrenia on identity. A difficulty with this study, however, is that it takes a "snap-shot", rather than assessing processes and the dynamic interplay of factors over time. The impact of any one factor is mitigated by the coping strategies being employed, such that threats to identity lead to adjustment processes and so on. This study also entered into "uncharted territory" by attempting to measure the identity principles directly. Whilst self-esteem and self-efficacy have been well researched, continuity and distinctiveness have not: both are conceptually complex, and therefore difficult to measure accurately, and there is a lack of information about their nature in ordinary populations with which to compare. The measures used in this study were new and untested with other populations. Distinctiveness may be especially complex in a population defined by abnormal experiences. Due to the nature of the relationships found, it was not possible to study the interactions between factors to assess the relative
importance of each in relation to protecting positive identity. Longitudinal research and further development of the identity measures would be most useful.

The value dimension of identity was not assessed in this study. The value attached to the experience of particular symptoms, to particular roles etc. was not explored. This may be an important area for future studies, as the degree to which particular identity contents are valued would have an impact on the identity principles. Similarly, when assessing self-esteem, the difference between the individual’s aspirations or ideal self and their perceived self was not explored, which could give a deeper understanding of the impact of schizophrenia for that individual. Another area of interest would be the impact of intergroup strategies in mitigating the negative impacts of schizophrenia on identity, such as the ‘user movement’ on the impact of stigma. This would constitute a broader study of coping strategies than was possible in this study.

This study illustrates the relevance of an identity approach to clinical work with people diagnosed with schizophrenia. The approach complements the recent development of psychological models of the processes underlying individual symptoms and of the impact of particular features of the experience of diagnosis, treatment etc. This study supports the proposal that the experience of symptoms and the consequences of diagnosis with schizophrenia can affect the individual at a number of levels, both personal and social. It has also been demonstrated that the importance of each will vary depending on the particular values and meanings for that individual, which may themselves be complex, with layers of explanation and attribution. Adopting an approach derived from the identity literature comprises assessment of both the individual meanings and evaluation of experiences, and the processes of adjustment and change that ensue in order to maintain or protect identity. In contrast to a more symptom-based approach, the strength of an identity model is that it encompasses the perspective of the whole person and their real difficulties in living.
5. REFERENCES


Appendix I: DSM-IV Criteria for Schizophrenia

A. Characteristic Symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

1. delusions
2. hallucinations
3. disorganised speech (e.g. frequent derailment or incoherence)
4. grossly disorganised or catatonic behaviour
5. negative symptoms, i.e. affective flattening, alogia, or avolition

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

B. Social/Occupational Dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least six months. This six-month period must include at least one month of symptoms (or less if successfully treated) that meet Criterion A (i.e. active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g. odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder Exclusion: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major
Depressive, Manic, or Mixed Episodes have occurred concurrently with the active phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Appendix II: The Social Behaviour Schedule (Items 1 to 20 only)

(1). COMMUNICATION: TAKING THE INITIATIVE
Does s initiate conversations? Will he or she approach a member of staff either to ask a question or to start a conversation?
If S approaches will he or she carry on the conversation after the initial comments?
0. Good range of spontaneous contacts. Can initiate a conversation and keep it going by spontaneous contributions. If someone else initiates a conversation, S responds appropriately and quite often keeps the conversation going (i.e. active as well as passive response).
1. Can sometimes initiate or maintain a conversation but this is infrequent or the range of topics is very limited. If another person initiates contact S usually responds appropriately, but only for a short time and then ceases to respond.
2. Occasionally speaks spontaneously, but this is unusual, and limited to greetings, brief factual exchanges etc. Quite often ignores another person's attempt at contact, or turns away.
3. Usually responds negatively to attempts to initiate conversation (e.g. turns away, walks out of room). Only spontaneous contact initiated by S himself is non-verbal (e.g. smiling, taking hand, or aggressive contact).
4. S says virtually nothing. He does not respond when greeted or spoken to. He initiates extremely few verbal or non-verbal contacts.

(2). CONVERSATION: INCOHERENCE
How far is S handicapped in engaging conversation with others through incoherence of speech? (N.B. this rating is not concerned with how articulate he is or how intelligently he can express himself. The incoherence of speech rated here is that associated with psychotic illness – e.g. flight of ideas, knight's move etc.).
0. No incoherence of speech.
1. Some occasional incoherence of speech (e.g. once or twice a month).
2. Incoherence of speech occurs more frequently (e.g. once a week). Most speech is
3. Frequent incoherence of speech (e.g. more than once a week).
4. S’s conversation is always or almost always characterised by incoherence of speech.
   Very difficult to understand anything he says.

(3). CONVERSATION: ODDITY/INAPPROPRIATENESS
How far does S’s conversation show a preoccupation with bizarre or eccentric topics, which most people (not only specialists) would regard as extremely odd. Give examples.
0. Above behaviour does not occur.
1. Above behaviour occasionally present (e.g. once or twice a month).
2. Above behaviour occurs more frequently (e.g. once a week) but most speech contains no such examples.
3. Above behaviour occurs very frequently (e.g. daily).
4. Virtually all S’s conversation is as described above.

SOCIAL MIXING: NOTE
The following three ratings are concerned with three different aspects of S’s ability to mix with others. These ratings give some picture of the extent to which people have to make allowances for S’s handicaps or social difficulties in order to interact with S. Thus S’s ratings on these three questions indicate how far he is restricted by his handicaps to relating only to immediate family or to professional carers.

(4). SOCIAL MIXING: ABILITY TO MAKE SOCIAL CONTACTS IN AN APPROPRIATE WAY
If S was standing at a bus stop and someone asked him or her when the next bus was expected would S be able to respond appropriately? Would he or she appear odd in manner?
0. S behaves appropriately in the way he makes social contact with others. Or S is not interested in making social contacts with others.
1. S makes social contacts with others to a degree, but is rather handicapped by lack
of grasp of what is and what is not socially acceptable (e.g. definitely behaved appropriately on one or two occasions in the last month).

2. S can approach others in a socially acceptable manner some of the time but quite often lapses into inappropriate behaviour (e.g. once a week).

3. Most of S’s attempts to make contact with others are inappropriate in nature (e.g. more than once a week but behaviour is not as extreme as in (4)).

4. S is quite unable to behave appropriately and creates frequent embarrassment because of the inappropriateness of his attempts to approach others. He never or virtually never approaches others in an appropriate fashion.

(5). SOCIAL MIXING: PROPORTION OF SOCIAL CONTACTS WHICH ARE HOSTILE IN NATURE
This rating is concerned with the sorts of contacts S makes with other people. The emphasis in this rating is on verbal or physical hostility. Only rate hostility if it is inappropriate or more extreme than the situation demands. Verbal hostility includes swearing etc. but does not include apathy or failures to respond to a social approach. Only rate physical hostility if S has had physical contact with another person which was of a hostile nature.

0. Contacts are nearly all appropriately friendly.

1. Mostly friendly contacts. Occasionally contacts are inappropriately hostile (e.g. one or two incidents in past month or more than this but of a relatively minor nature).

2. More frequent incidents of inappropriately hostile contact or a serious incident involving threatening behaviour in past month, but most contacts have been friendly.

3. Most contacts are verbally hostile (e.g. swears, accuses etc. more than once a week).

(6). SOCIAL MIXING: ATTENTION-SEEKING BEHAVIOUR
Does S try to monopolise people’s attention? Is he resentful if staff members, relatives etc. give attention to others?
0. S does not seek attention inappropriately.

1. S sometimes seeks to monopolise attention but does not get upset if attention is paid to others (e.g. an incident when S sought to monopolise attention occurred once in past month).

2. S sometimes seeks to monopolise attention of others, and also tends to get angry and resentful if attention is given to others.

3. S constantly makes demands on others attention (e.g. more than once a week).

4. S is constantly making demands on attention of others (either specific others such as a particular relative, or staff in Day Care or Hostel setting, or other people in general). S also frequently gets angry or resentful if any attention is given to others.

(7). SUICIDAL AND SELF HARMING IDEAS AND BEHAVIOUR
Ratings on this item should be made conservatively. A rating of 3 or more should only be made if the informant was sure that injuries which were sustained were intended by S to be of a suicidal nature.

0. S has not spoken of suicide or made any attempt.

1. S has alluded to suicide indirectly in past month.

2. S has spoken of suicide directly in past month.

3. S has made some kind of suicidal gesture in past month (e.g. scratching wrists). Or S has spoken of suicide several times in past month.

4. S has made a serious attempt at suicide or injured himself seriously in past month.

(8). PANIC ATTACKS AND PHOBIAS
This rating is concerned with how far S is troubled by anxiety, either attached to particular situations (e.g. being with people, travelling, leaving the house) or generalised feelings of anxiety and tension. Preoccupation with health worries is included if there are no objective grounds.

1. S is free enough from anxiety to be able to undertake any social or other activity he might choose.

2. S is troubled by occasional anxiety. Or S's anxiety is not excessively disabling.
because confined to small areas. Or level of anxiety is low enough that S can contain and live with it.

2. S is tense and anxious much of the time, and prevents him from functioning in key areas of life. Nevertheless S can cope with his anxiety in general.

3. S suffers anxiety most of the time. Or S has very frequent (e.g. twice weekly) anxiety attacks. There are few areas where S can function without being handicapped by anxiety.

4. S is extremely tense and anxious virtually all the time. His anxiety prevents him from doing almost anything at all and it troubles him constantly.

(9) OVERACTIVITY AND RESTLESSNESS
Overactivity should be rated if one or more of the following are present: Purposeless pacing up and down or rushing from room to room, frequent unnecessary movements, general restlessness, fidgeting. If either purposeless frequent pacing is present or more than one of the other behaviours is present then rate as marked overactivity.

0. No marked overactivity or restlessness.
1. Occasional periods of restlessness or overactivity (e.g. once or twice in past month).
2. Overactivity occurs quite often (e.g. weekly).
3. S shows marked overactivity frequently (e.g. daily or nightly).
4. S shows marked overactivity for long periods on a regular basis (e.g. spends most nights pacing up and down).

(10) LAUGHING AND TALKING TO SELF
Only rate here if it is obvious to the informant that S is not laughing socially i.e. evidence of laughing when alone or muttering so no-one else can catch what is said is enough evidence to consider making a rating.

0. No laughing or talking to self.
1. Occasional periods of laughing or talking to self (e.g. once or twice in past month).
   Can control behaviour if reminded.
2. More frequent episodes of laughing or muttering to self (e.g. three times in past
S has some difficulty in controlling behaviour if reminded.

3. Laughing or talking to self occurs often (e.g. weekly).
4. Very frequent laughing or talking to self (e.g. daily). Or less than daily but episodes last a long time.

(11). ACTING OUT OR BIZARRE IDEAS
This rating is concerned with whether S decides on some action because of his or her delusions. For example: (a) going to the scene of some major catastrophe because S feels his or her help is needed. (b) S assumes that he or she has millions of pounds and so either spends it or tries to spend it on expensive items.

0. No such behaviour.
1. Such behaviour has occurred once in past month.
2. Such behaviour has occurred more than once in past month.

(12). POSTURING AND MANNERISMS
This rating is concerned with odd, stylised movements or uncomfortable or inappropriate postures.

0. No posturing or mannerisms.
1. Some odd or uncomfortable postures or mannerisms occasionally (e.g. once or twice in past month).
2. Behaviour apparent more frequently (e.g. once a week).
3. Behaviour apparent very often (e.g. more than once a week).
4. Behaviour apparent frequently (e.g. S adopts odd postures or mannerisms much of the time and every day).

(13). SOCIALLY UNACCEPTABLE HABITS OR MANNERS
This rating concerns unacceptable habits e.g. scratching genitals, passing loud flatus, picking nose etc. Ask particularly about problems at meal times such as poor table manners.

0. Has good manners and behaviour is socially acceptable.
1. Behaviour is markedly unacceptable but S has positive qualities in manner.
2. Occasional unacceptable behaviour (e.g. markedly unattractive habit, surliness, uncouthness). However much of the time S is passively acceptable.
3. Frequent episodes of unacceptable behaviour as in (2) (e.g. once a week).
4. Behaviour is markedly unacceptable most of the time.

(14). DESTRUCTIVE BEHAVIOUR
Under this item only rate behaviour which results in destruction of property only. If an incident included some threatening behaviour to others as well as destruction of property then rate under item 5 only.
0. S has reasonable tolerance for provocation, is in control of angry feelings and acts in a socially appropriate manner.
1. Threatens to destroy property occasionally but has not actually done so.
2. Frequently threatens to destroy property.
3. Has damaged property in anger during past month e.g. broken windows, torn clothes.

(15). DEPRESSION
This rating concerns periods spent in S sitting with his head in his hands looking miserable, remarks such as “I wish I had never been born” or “life is pointless” etc. Do not assume suicidal behaviour is an indication of depression other signs need to be present to make a rating here.
0. No such behaviour.
1. Such behaviour occurs occasionally (e.g. one or two brief incidents in past month).
2. Such behaviour occurs fairly often or for fairly long periods (e.g. once a week).
3. Such behaviour occurs frequently (e.g. daily).

(16). INAPPROPRIATE SEXUAL BEHAVIOUR
This rating concerns sexual activity which is directed towards another person. Do not include self-stimulation. Where S is unaware of social constraints e.g. masturbating in a public place but not directly towards any particular person. If unsure whether behaviour
constitutes a sexual advance then rate under item 13, socially unacceptable habits. Include discussions of a sexual nature only when they are aimed at provoking the other discussants – if not provoking then rate under odd or inappropriate conversations, item 3.

0. No inappropriate sexual behaviour or talk.
1. S is somewhat preoccupied with sexual matters (e.g. once or twice talked about sex in an inappropriate context in past month).
2. S more often exhibits inappropriate sexual behaviour (e.g. makes unwelcome sexual advances).
3. S exhibits markedly inappropriate sexual behaviour quite frequently (e.g. exposes self, makes unwelcome sexual advances in an embarrassing manner).
4. S exhibits behaviour as in (3) frequently (e.g. weekly). S’s behaviour is sufficiently marked and frequent to cause problems in his household or community.

(17). PERSONAL APPEARANCE AND HYGIENE
In making this rating, consider cleanliness, hair, changing underwear, incontinence. Also consider bizarre appearance. Take into account the amount of supervision S receives. If, for example, S is in a hostel, how S would care for himself if not in a supervised situation. (Do not consider fashionable disorder in dress).

0. Able to look after appearance and cleanliness appropriately.
1. Usually appearance is satisfactory but occasionally needs reminding. Or takes an interest in certain aspects of appearance but neglects others.
2. Quite often needs reminding about appearance (e.g. three times in past month). Or attends to appearance in an inappropriate manner so that appearance is bizarre.
3. Considerable self-neglect most of the time. Needs frequent reminding (e.g. more than once a week) and some supervision.
4. Gross self-neglect. No spontaneous care of clothes (e.g. clean underwear) washing hair, hygiene. Needs supervision in all aspects. Would smell if unsupervised. Would be incontinent if not reminded.
(18). SLOWNESS
This item is concerned with abnormal slowness (e.g. S sits abnormally still, walks abnormally slow or is delayed when performing movements). Make allowances for age and physical condition.
0. No abnormal slowness.
1. Moderately slow on occasions, but most of the time is not slow.
2. Moderately slow most of the time, even when stimulated.
3. Moderately slow most of the time with periods of extreme slowness as in (4).
4. Extremely slow – will sit or lie doing nothing if not stimulated, and even then very slow to move.

(19). UNDERACTIVITY
This rating concerns underactivity only. Bear in mind that S may be slow (item 18). Underactivity here is defined as a lack of spontaneous activity. If S is not stimulated will sit and do nothing (moderately underactive). When it is not possible to stimulate S into carrying out a task then rate as extremely underactive.
0. No abnormal underactivity.
1. Moderately underactive on occasions, but most of the time keeps active.
2. Moderately underactive most of the time even when stimulated.
3. Moderately underactive most of the time, with periods of extreme underactivity as in (4).
4. Extremely underactive. Will sit or lie doing nothing if not stimulated, and even then very slow to move.

(20). CONCENTRATION
Suggested prompts: Does S find it difficult to concentrate on a task even when he really wants to do so? On watching a TV programme? On reading a book? Is S distractible? Can S set his mind to something and do it, or does he find it impossible to concentrate long enough to do this?
0. S does not have problems with his ability to concentrate.
1. S has periods when he is unable to concentrate.
2. S can only concentrate for a few minutes at a time.
Appendix III: Social Role Performance Schedule

1. HOUSEHOLD MANAGEMENT (HM)
Include anything to do with maintaining the home environment (EXAMPLES OF SERIOUS PROBLEMS: Shopping has to be done by someone else. Meals are not provided, or are inedible. House is filthy unless cleaned by someone else. Clothes have to be sent to laundry by someone else).
Do not include moderate forgetfulness in shopping, or inefficiency in housework, or lack of expertise in cooking).

• Have you carried out your normal household duties in the past month? (What are you normally expected to do?).
IF NO SIGNIFICANT CONTRIBUTION IS MADE OR EXPECTED:
• Why not?
SPECIFY REASON ON CODING SHEET (e.g. wife does it)
  IF S IS NOT DISABLED BUT NOT EXPECTED TO DO HM, SPECIFY WHO IS CUT-OFF (1): RATE (9) ON 1 AND PROCEED TO SECTION 2
  IF SOME SIGNIFICANT CONTRIBUTION:
• How well have you managed with the housework, shopping and so on, during the past month?
• What about cooking, cleaning and laundry?
CUT-OFF (2): IF NO PROBLEMS, RATE (0) ON 1, PROCEED TO SECTION 2
IF THERE ARE ANY PROBLEMS, OR NO SIGNIFICANT CONTRIBUTION IS MADE:
• What sort of problem has there been with.................................?
  (CHECK: Shopping, cooking, cleaning, laundry, danger)
1. RATE HOUSEHOLD MANAGEMENT DURING PAST MONTH
  0. Fair to good: cut-off (2)
  1. Serious problem(s) on occasions but can sometimes manage quite well
  2. Serious problems most of the time
  3. Virtually no contribution to HM = staffed hostel
9. Cut-off (1): no significant contribution is expected but not because of S’s disability
8. Not known.
INTERVIEWER’S COMMENTS ON STATE OF HOUSE AND ANY PROBLEMS RATED SHOULD BE DESCRIBED ON CODING SHEET.

2. EMPLOYMENT (EM)
EXAMPLES OF SERIOUS PROBLEMS: S is constantly late for work, frequently takes time off, is extremely slow or turns out a poor quality of work, has frequent quarrels with others. In other words, S is in danger of losing job. If in sheltered employment with standards for time-keeping and production (e.g. Remploy) and functioning reasonably well, rate (2): if functioning poorly in Remploy, or if in Day Centre etc., rate (3). N.B. Where there are high levels of general unemployment or restricted availability of day facilities, code in accordance with ability rather than performance.

(Have you been doing any paid work during the month?)
(Include students on grants as employed)

IF NO WORK:
• Why aren’t you working?
   IF DISABILITY IS NOT THE CAUSE OF UNEMPLOYMENT SPECIFY
   (independent income, retired, housewife, between jobs, factory closure etc.)
CUT-OFF (1): RATE (9) ON 2 AND PROCEED TO SECTION 3

IF S HAS BEEN WORKING DURING MONTH
• What work do you do?
• Have you had any problems with getting to work on time, or have you been taking time off?
• Have there been any problems at work:
  Can you work as quickly as they expect?
  Have you made any mistakes?
  Have you had any problems in getting on with colleagues and/or supervisor?
CUT-OFF (2): IF NO PROBLEMS, RATE (0) ON 2, PROCEED TO SECTION 3

IF ANY WORK PROBLEMS OR S IS UNEMPLOYED:
What sort of problems has there been with...............................?

(CHECK: Timekeeping, unauthorised absences, output, quality of work, relation with mates, supervisors).

2. RATE FUNCTIONING AT WORK DURING PAST MONTH

0. Fair to good performance: cut-off (2)
1. Serious problem(s) on occasions but can sometimes manage quite well
2. Serious problems most of the time = sheltered employment and functioning reasonably well
3. Unemployed throughout the month (due to some disability). Day care or poor functioning in sheltered employment
9. Cut-off (1) = over retiring age, not working for other reasons.

3. MANAGEMENT OF MONEY (MM)

(EXAMPLES OR SERIOUS PROBLEMS: S spends very large sums on gambling, alcohol or unwise purchases, so that large debts are run up, or would be run up unless someone else handed out money a little at a time – rate (2)).

(Have you any income of your own?)

IF NONE OR VERY LITTLE

Why not?

IF BY CHOICE THE SUBJECT DOES NOT MANAGE HOUSEHOLD FINANCES AT ALL (and this is not because of incapacity) CUT-OFF (1): RATE (9) ON 3 PROCEED TO SECTION 4

IF ANY INCOME DURING PAST MONTH (INCLUDE BENEFITS)

- How do you manage with (your own) money? (Has there been any unwise spending?)
- What about household bills, rent, hire purchase payments and so on?

CUT-OFF (2): IF NOT PROBLEMS, RATE (0) ON 3 PROCEED TO SECTION 4
3. RATE MANAGEMENT OF MONEY DURING PAST MONTH

0. Fair to good performance: cut-off (2)
1. Serious problem(s) on occasions but can sometimes manage quite well
2. Serious problems most of the time = do some shopping, rent and bills taken care of
3. Income has to be completely managed for S = pocket money
9. Cut-off (1) = Subject does not manage household finances at all, not disabled
8. Not known.

4. CHILD CARE (CC)

(EXAMPLES OF SERIOUS PROBLEMS: Children are dirty, often miss meals, poorly clothed, not guarded against common dangers. S gives no affection, never plays with them, ill-treats them)

(Are there any children aged 15 or less in the house?)
(Do you have any children under 15 who are living somewhere else? If so, why are they not living with you?)

IF NOT RESPONSIBLE FOR ANY CARE, SPECIFY RELATIONSHIP
.............................................................................................................................

IF S NOT RESPONSIBLE FOR CARE, OR NO CHILDREN IN HOUSE CUT-OFF (1): RATE (9) ON 4 AND PROCEED TO SECTION 5

IF S IS RESPONSIBLE FOR SOME OF THEIR CARE

• How do you cope with the children?

(Have there been any problems with feeding, keeping them clean and well dressed, or keeping them out of danger?)

(What about showing them affection, playing with them, or disciplining them?)

CUT-OFF (2): IF NO PROBLEMS RATE (0) ON 4 PROCEED TO SECTION 5

IF PROBLEMS:

What sort of problems have there been with.................................?

(CHECK: meals, cleanliness, clothes, affection, play, discipline, supervision, school)
4. RATE CHILD CARE DURING PAST MONTH

0. Fair to good performance: cut-off (2)
1. Serious problem(s) on occasions but can sometimes manage quite well
2. Serious problems most of the time
3. Not able to help with child care at all = children in care
9. Cut-off (1) = not responsible for any children
8. Not known.

5. INTIMATE RELATIONSHIP (IR)

N.B. Section 5 considers intimate relationships. Include relationship between subject and spouse. (or cohabitee living in the same household). In other cases include a “steady” relationship if a sexual component would be expected, or would be likely to develop if the subject were not disabled. No introductory questions are listed since this is left for the interviewer’s judgement.

Section 5 is completed where an intimate relationship exists or could exist.

(Section 5 assesses the subject’s contribution or level of involvement in this relationship).

(EXAMPLES OF SERIOUS PROBLEMS: Subject shows no affection, gives no companionship, seldom considers partner’s needs, is hostile or violent, very suspicious or jealous, sexually inactive or only concerned with activities the partner reasonably finds obnoxious).

For single subjects or others where there is no spouse/cohabitee in the household select probe questions to determine presence of a steady relationship.

CUT-OFF (1): IF NO SUCH RELATIONSHIP EXISTS RATE (9) AND PROCEED TO SECTION 6.

- How well do you get on together
- Are you able to show affection and companionship?
- Are you considerate of X’s feelings?
- Can you give X good advice and support?
  (Have you lost interest in the sexual side of the relationship?)
CUT-OFF (2): IF NO PROBLEMS (past or present) RATE (0) OR (1) ON 5 AND PROCEED TO SECTION 6.

IF PROBLEM IN CONTRIBUTION TO RELATIONSHIP: (CHECK: Affection, companionship, support, hostility, odd behaviour, jealousy, sexual relations).

5. RATE SUBJECT’S CONTRIBUTION TO RELATIONSHIP IN PAST MONTH

0. Good contribution (close and confiding) or Fair contribution (cut-off 2)
1. Serious problem(s) in contributing to the relationship on occasions
2. Serious problems most of the time
3. Virtually no contribution
9. Cut-off (1) = no such relationship exists
8. Not known.

6. NON-INTIMATE RELATIONSHIP (OR)

N.B. Try to complete this section especially if section 5 was not completed, choose a person with whom the subject has most regular adult contact/friendship – if possible another adult living in the same household (parent, relative, friend), excluding intimate relationship in 5.

Assess only the subject’s contribution/involvement in the relationship.

(Who is the friend or relative with whom you have most contact?)
(Exclude intimate relationship in Section 5).

(Cut-off: IF NO RELATIONSHIP MENTIONED OR ELICITED (PAST OR PRESENT) RATE (3) ON 6: RATE (9) IF DUE TO PRESENT CIRCUMSTANCES NO SUCH RELATIONSHIP IS AVAILABLE TO RATE.

IF ANY RELATIONSHIP MENTIONED:

- How well do you get on together?
- Are you considerate of X’s feelings?
- Are you able to give X good advice and emotional support?
- Can X discuss his/her personal problems with you?
CUT-OFF (2): If fair to good involvement by subject or no problems (past or present)
Rate (0) on 6 and proceed to section 7.

6. RATE SUBJECT’S CONTRIBUTION TO RELATIONSHIP IN PAST MONTH
   0. Good contribution (close and confiding) or Fair contribution (cut-off 2)
   1. Serious problem(s) in contributing to the relationship on occasions
   2. Serious problems most of the time
   3. Virtually no contribution or no such relationship elicited (past or present)
   9. Cut-off (1) = no such relationship at present, subject was rated on Section 5
   8. Not known.

7. SOCIAL PRESENTATION (SP)
   (EXAMPLES OF SERIOUS PROBLEMS: S disappears whenever there are visitors,
   never seeks company, is rude or aggressive towards others, has no activities in or outside
   household (except wandering or pacing), plays gramophone very loudly for hours at a
   time many nights a week (much more than normal teenage lack of consideration), appears
   to others as very withdrawn or odd or aggressive. Do not take appearance into account
   unless so grossly unusual that many people notice it. Watching TV for hours is not
   regarded as a serious problem in this context).
   (N.B. This section should be completed for everyone. It is intended to cover social roles
   other than those at work, or with a close relative or close friend. It includes presentation
   of self in social situations, activities).
   • How do you get on with others in company?
     (Are you withdrawn, eager to get away, feel ill at ease)
     (* How do you occupy yourself in your spare time?)
     (* Do you have any outside activities or hobbies?)
   Try to elicit whether there is a circle outside the family, work or caring institution in
   within which S is socially acceptable and makes some social contribution.

CUT-OFF (1): IF NO PROBLEMS, RATE (0) ON 7, PROCEED TO SECTION 8
IF PROBLEMS:
What sort of problems have there been?

(CHECK: Friends, activities outside household, hobbies, avoidance of company, impression on others).

7. RATE SOCIAL PRESENTATION DURING PAST MONTH

0. Fair to good performance: cut-off (1)
1. Problem(s) on occasions but can manage quite well
2. Serious problems most of the time
3. S is virtually completely isolated and has no interests or activities
8. Not known.

8. COPING WITH AN EMERGENCY (CE)

(This section assesses how the subject would cope with a hypothetical crisis were it to occur now).

- I am interested in how you might manage with some unexpected emergency. Imagine for example that some friend or relative were taken ill and you were asked to look after their two school age children. How do you think you could manage?

(If S has own family responsibilities, assume there is someone to help in this respect)

8. RATE ABILITY TO COPE WITH CRISIS AT PRESENT

0. Would have no problem coping
1. Would have some problems coping but could manage
2. Serious problems coping
3. Could not cope at all
8. Not known.
Appendix IV: Devaluation-Discrimination Scale

1. Most people would willingly accept a former mental patient as a close friend.
   
2. Most people believe that a person who has been in a mental hospital is just as intelligent as the average person.
   
3. Most people believe that a former mental patient is just as trustworthy as the average citizen.
   
4. Most people would accept a fully recovered former mental patient as a teacher of young children in a school.
   
5. Most people believe that entering a mental hospital is a sign of personal failure.
   
6. Most people would not hire a former mental patient to take care of their children, even if he or she had been well for some time.
   
7. Most people think less of a person who has been in a mental hospital.
   
8. Most employers will hire a former mental patient if he or she is qualified for the job.
   
9. Most employers will pass over the application of a former mental patient in favour of another applicant.
   
10. Most people in my community would treat a former mental patient just as they would treat anyone.
   
11. Most young women would be reluctant to date a man who has been hospitalised for a serious mental disorder.
   
12. Once they know a person was in a mental hospital, most people will take his or her opinions less seriously.
Appendix V: Scale to Assess Unawareness of Mental Disorder (items 1 to 5 only)

1. **Awareness of Mental Disorder.** In the most general terms, does the subject believe that s/he has a mental disorder, psychiatric problem, emotional difficulty etc.?

<table>
<thead>
<tr>
<th>C(urrent)</th>
<th>P(past)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>Cannot be assessed.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Aware: Subject clearly believes that s/he has a mental disorder.</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Somewhat: Is unsure about whether s/he has a mental disorder but can entertain the idea that s/he might.</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Unaware: Believes s/he does not have a mental disorder.</td>
</tr>
</tbody>
</table>

2. **Awareness of achieved effects of medication.** What is the subject’s belief regarding the effects of medication? Does the subject believe that medications have lessened the intensity or frequency of his/her symptoms? (i.e. if applicable)

<table>
<thead>
<tr>
<th>C(urrent)</th>
<th>P(past)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>Cannot be assessed or item not relevant.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Aware: Subject clearly believes medications have lessened the intensity or frequency of his/her symptoms.</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Somewhat: Is unsure whether medications have lessened the intensity or frequency of his/her symptoms but can entertain the idea.</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Unaware: Believes that medications have not lessened the intensity or frequency of his/her symptoms.</td>
</tr>
</tbody>
</table>
3. **Awareness of the social consequences of mental disorder.** What is the subject’s belief regarding the reason s/he has been admitted to hospital, involuntarily hospitalised, arrested, evicted, fired, injured etc.?

<table>
<thead>
<tr>
<th>Current</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 0</td>
<td>Cannot be assessed or item not relevant.</td>
</tr>
<tr>
<td>1 1</td>
<td>Aware: Subject clearly believes that the relevant social consequences are related to having a mental disorder.</td>
</tr>
<tr>
<td>2 2</td>
<td></td>
</tr>
<tr>
<td>3 3</td>
<td>Somewhat: Is unsure about whether the relevant social consequences are related to having a mental disorder.</td>
</tr>
<tr>
<td>4 4</td>
<td></td>
</tr>
<tr>
<td>5 5</td>
<td>Unaware: Believes that the relevant social consequences have nothing to do with having a mental disorder.</td>
</tr>
</tbody>
</table>
4. **Awareness of hallucinations.**

Does the subject recognise that s/he has false perceptions. For example, a subject who believes that he is hearing the voice of his dead uncle is unaware of the false nature of this perception, i.e. that this is a hallucination. If he can consider this perception is internally produced, e.g. "I am under a lot of stress, I guess my mind might be playing tricks on me", he is somewhat aware. If he believes that his uncle can’t be talking to him and that these perceptions must be false, he is aware.

<table>
<thead>
<tr>
<th>C(urrent)</th>
<th>P(ast)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>Cannot be assessed or item not relevant.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Aware: Subject clearly believes that s/he has hallucinations.</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Somewhat: Is unsure about whether s/he has hallucinations but can entertain the idea.</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>Unaware: Believes that s/he does not have hallucinations.</td>
</tr>
</tbody>
</table>
5. Awareness of delusions.

Is the subject aware that s/he experiences delusions as such, i.e. as internally produced false beliefs?

<table>
<thead>
<tr>
<th>C(urrent)</th>
<th>P(ast)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>Cannot be assessed or item not relevant.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Aware: Subject clearly believes that s/he has delusions.</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Somewhat: Is unsure about whether s/he has delusions but can entertain the idea (e.g. acknowledging having “silly thoughts” or “my mind may have been playing tricks on me”).</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Unaware: Believes that s/he does not have delusions.</td>
</tr>
</tbody>
</table>
AN EXPLORATORY STUDY OF LONG-TERM PSYCHIATRICALLY
DISORDERED PATIENTS AND THEIR MOTHERS
WHO ARE LIVING IN THE COMMUNITY

by MELINDA JANE BUNYAN
UNIVERSITY OF SURREY, 1991

Submitted in part fulfilment for the requirements for the
Masters Degree in Clinical Psychology
ACKNOWLEDGEMENTS

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ABSTRACT

The study aimed to explore some of the ways in which families function who have a member with a long-term psychiatric disorder. Each family consisted of a patient living at home with his mother. Three variables were investigated. First was how the families functioned on the dimensions proposed in the Beavers-Timberlawn Model of Family Functioning (Beavers 1976, 1977) as a means of assessing how these families compared with the predictions of a fairly well established theory. Second was the level of social support that each family received and third was the degree of burden due to the son's disorder. Associations between these variables were explored.

The results went some way to confirming predictions from the model: the participant families tended towards a centripetal style of functioning with a limited capacity to adapt to pressures to change. The families were found to be socially isolated and lacking in social support in comparison to a mixed community sample. Without comparing the participants with a sample of normal single mothers and sons, it is not clear whether this finding reflects the isolating nature of being a single parent family. Alternatively, it may possibly reinforce previous work indicating the socially debilitating nature of mental illness for both the sufferers and their carers. Further, the mothers were found to be dealing with some difficulties due to the effects of their son's disorder but tended to find ways of coping without expressing distress or complaint, often being resigned to their situation.

No differences between families due to the chronicity of the psychiatric disorder were found in any of the variables. This seems to imply that patterns become established relatively early and tend to endure.

Some associations between the three variables were found. A centripetal style of functioning was related to a greater degree of resignation, less subjective burden and less social support amongst mothers. Less adaptable family functioning was associated with greater social support amongst sons. A greater experience of burden was found amongst the mothers whose sons had more social support.
These findings prompted some theoretical discussion regarding how a centripetal style of family functioning may decrease the degree to which families seek support and promote an attitude of resignation. Some explanations for the associations found between social support, family adaptability and burden were discussed.

In conclusion, these findings represent an exploration of some of the factors relevant to how families cope with long-term psychiatric disorder. Issues for theoretical discussion and areas for further research have been generated.
INTRODUCTION

The nature of long-term psychiatric disabilities dictates that those who suffer from them often require a considerable degree of care over a long period of time. The Office of Health Economics reported in 1979 that there were approximately 150,000 people affected by psychiatric disorders at any one time, more of whom are of working age than people suffering from other conditions and yet having equivalent life expectancy to the normal population. The major conditions, such as Schizophrenia, are often chronic and relapsing: Falloon et al (1984) estimate that some 25 to 30% of schizophrenics remain severely handicapped despite medication and social rehabilitation, whilst a third again will have periodic relapses; and it is often family members who take the brunt of caring for such people. A survey of schizophrenic patients carried out by Gibbons et al (1984) found one half to be living in supportive private homes, with either their spouse or mother.

Similarly, Goldman and Gatozzi (1981) estimated that overall some 60% of people with long-term psychiatric disorders live at home with their families. In the case of schizophrenia, male patients usually develop the disorder in adolescence before they have had a chance to establish their independence and, although female patients have a characteristically later onset with many already married, they exhibit a high rate of separation and divorce (Rutter, 1966). Hence, a great deal of the care of people suffering from long-term psychiatric disorders falls to their parents.

The existing tendency for family care of long-term psychiatric patients has been actively reinforced over the last decade by policies of Community Care (DHSS 1981), community services having been advocated for many years previously (Tooth and Brooke, 1961). Researchers have found, however, that families are often coping with little help from statutory services. Johnstone et al (1984), for example, found that out of a hundred and twenty people discharged from a psychiatric hospital, 27% had no contact with medical or social services, 14% were only in contact with Community Psychiatric Nurses and 24% only with General Practitioners.
The greatest distress for patients was found to be amongst those receiving no medical or social attention. The authors point out that services are often unevenly allocated and that there may be a high degree of unmet needs, especially amongst relatives. Earlier work concurs with this; several studies have noted that, due to the chronic nature of many psychiatric disorders, family members are often continuing to care for their relatives well into their own old age. Stevens (1972) for instance, commented that care is often provided by relatives who are in many cases "frail, ageing and coping only with great difficulty". The primary aim of this study is to increase our knowledge of how families manage in these circumstances.

The study of the family in relation to long-term psychiatric disorders began with its role in aetiology, with particular regard to schizophrenia, dating back to Freud's description of the Schreber case reported by Schatzman (1971). Subsequently a variety of theories have been developed. A major contributor was Lidz, who proposed that the parents of schizophrenics were variously disturbed, subjecting their offspring to a "training in irrationality" by behaving inconsistently and involving them inappropriately in parental problems (Lidz and Lidz, 1949; Lidz, Fleck and Cornelison, 1965).

Other studies, however, found schizophrenic families to be no different in terms of these variables to those in which one member had any kind of long-term physical or mental illness (see Farina & Holzberg, 1968). Bowen (1960) working from a family systems approach, described the schizophrenic family as characterised by marital discord and emotional turmoil. He conceptualised such a family as an "inter-dependent triad". The mother uses the child to stabilise the parental relationship, presenting as over-involved, experienced as rejecting by the child, and requiring that the child remain vulnerable in order to fulfil her emotional needs.

A similar theory, the "double-bind hypothesis", was proposed by Bateson and his colleagues during the 1950's (Bateson, Jackson, Haley and Weakland, 1956; Jackson, 1959). Conflicting messages delivered via verbal and non-verbal behaviour by the parents to the child were suggested as creating confusion and eventually psychosis in the child. Unfortunately, these theories have proved difficult to assess in practice. The idea that communication problems are associated with the aetiology of schizophrenia however,
was further developed by Wynne, Singer and colleagues. Wynne (1968) hypothesised that family communication abnormalities lead to faulty perceptual learning, which predisposes the child to develop schizophrenia. In their studies, they claim that prediction of later schizophrenia in a family member was achieved to a high degree of accuracy by assessing family communication patterns (Wynne et al, 1977). It is not clear that faulty communication is causal in the pathogenesis of psychosis however. Alternatively it may be a genetic marker for the disorder to emerge as a consequence of the disorder being present in one family member. Overall, aetiological studies have not been able to show conclusively that distorted family interaction is causal in the development of psychiatric disorders.

It has been consistently found, however, that families with a schizophrenic member exhibit high levels of marital discord, role distortions, confusing verbal and non-verbal communication and difficulty in attending closely to important issues. Therefore, the cause versus consequence issue continues to be debated. As Falloon et al (1984) conclude in their consideration of the literature, the familial nature of schizophrenia is "indisputable" although how environmental and genetic factors interact in its pathogenesis is still a matter of contention.

Current thinking on the aetiology of psychiatric disorders acknowledges the interplay between nature and nurture, both genetic factors (eg. Rosenthal, 1984) and environmental factors (eg. Dohrenwend and Dohrenwend, 1974) are indicated. The stress-diathesis model of schizophrenia (Kessler, 1980; Neuchterlein and Dawson, 1984) asserts that the disorder constitutes a stress-induced neurophysiological abnormality, appearing in an individual who has a hereditary vulnerability to this particular disorder. The stresses may be family tensions or life events (Brown and Birley, 1968; Jacobs and Myers, 1976).

Similarly, theories of the aetiology of anxiety and depression include hereditary factors, whilst asserting the importance of environmental factors such as early bereavement and lack of social support (Brown and Harris, 1978). Thus, despite inconclusive findings concerning their role in aetiology, research into family factors is still a crucial part of investigating psychiatric disorders. Recently, researchers have
focused on the role of the family in the course of psychiatric illness and prognosis for the disordered person.

The most influential series of studies has emerged from exploration of family communication styles in relation to relapse rates in schizophrenia. This was precipitated by the finding that de-institutionalised patients were generally better able to sustain community life if they moved into supportive lodgings with siblings or other relatives, rather than spouses or parents. The likelihood of re-hospitalisation increased with prolonged contact with the latter (Brown, Carstairs and Topping, 1958). In their subsequent study, having refined their approach, Brown and colleagues found that higher relapse rates were correlated with higher levels of "expressed emotion", consisting of a hostile and critical communication pattern (Brown et al, 1972). After developing an interview technique to measure expressed emotion (Brown and Rutter, 1966), it was found to be the best predictor of later symptomatic relapse in a nine month follow-up (Brown, Birley and Wing, 1972). Further evidence to support these results was provided by a study in which high expressed emotion was shown to cause physiological arousal, indicative of stress, whereas low expressed emotion had a calming effect (Sturgeon et al, 1981). Vaughn and Leff (1976) applied this theory to patients in both schizophrenia and depression with similar results. Thus, high relapse rates in both schizophrenia and depression are associated with family interaction patterns characterised by high expressed emotions. It appears to be an independent factor influencing prognosis alongside medication, with reduction in expressed emotion or in frequency of contact being protective factors.

Despite this seminal work the relationship between high expressed emotion and other factors is not yet clear. In reviewing this literature, Falloon et al (1984) point out that families exhibiting low expressed emotion may have a tendency to deny and avoid symptoms leading to social avoidance and social withdrawal of the whole family, as opposed to the pattern of crisis and relapse seen in high expressed emotion families. Brown and his colleagues, however, found that parents who were socially isolated, depending on the patient for much of their social interaction rather than outside contacts, were more likely to manifest high expressed emotion (although the opposite was true of
married couples). Vaughn (1977) also found that mothers exhibiting high expressed emotion tended to be over-indulgent and self-sacrificing in a non-contingent and over-involved manner, the patient being dependent on the mother and neither having many outside interests. They also had a less objective view of the patient and the disorder than low expressed emotion mothers, who tended to see the patient as "ill" and unable to alter their behaviour. These mothers were more often calm and accepting in the face of bizarre or threatening behaviour. Consequently, the relationship between the isolation of the family and the quality of their social supports is emerging as a central issue.

Brown's work did not consider the patient's level of social functioning, which may in itself be a more important factor than symptomatic relapse in successful recovery from psychiatric disorder. Experimental evidence has not yet clarified whether low-expressed emotion interactions foster apathy and social withdrawal or whether isolated and unsupported families exhibit high levels of expressed emotion and enmeshed relationships. Recent critical reviews of high expressed emotion tend to accede that it is one factor interacting with other important variables, and that these interactions promise to be more important in predicting outcomes than any single factor (Vaughn, 1989). The current study attempts to explore the nature of family functioning style in relation to the social contacts of such families.

In studying the nature of long-term psychiatric disorders, the interaction between the illness and the social context of both the patient and their carers must be considered. A wealth of literature has accumulated over past decades investigating the nature of social networks and their relationship to a variety of factors, including physical and mental health. The notion that social support is vital in promoting well-being is not new: Rogers (1942) proposed supportive behaviour as the key to his theory of psychotherapy and Likert (1961) suggested that supportive interactions are the core of a successful supervisory relationship (to give but two examples). More recently the concept of support through social networks has become prominent, referring to how individuals relate to others, how these others form groups and how these groups cluster together.

In reviewing this field, House and Kahn (1985) inferred that three inter-related dimensions of social networks have been identified. These consist of quantity, structure
and functional content, indicating that the type of relationships a person makes and how these are woven together are important variables. They report evidence for a consistent correlation between the quality of social networks and physical health.

With regard to mental health, again an important relationship between social networks and emotional well-being has been reported. Hirsch (1981), for example, has investigated how the effects of stressful life events may be mitigated by particular types of social networks in high-risk populations. Only a proportion of those at risk for psychopathology actually develop affective disorder (Brown and Harris 1978). Hirsch’s study attempts to identify factors which may protect the individual from developing the disorder despite experiencing the risk factors, in terms of social networks, which are defined as both actual and potential relationships.

It was found that "low density" networks, in which certain groups are fully separate from each other, such as having friends who are not in contact with one’s family, provided greater emotional satisfaction, more diverse feedback and a greater variety of possible social norms and roles were experienced. For women undergoing a major life event, low density networks were associated with greater satisfaction.

Specifically, better mood and less symptomatology correlated with the potential for cognitive guidance, that is receiving advice and the opportunity for discussion, and higher self-esteem was associated with the socialising aspects of relationships. Further, multidimensional friendships, in which more than one activity is shared, were more associated with psychological health than unidimensional ones. The authors conclude that this type of network allows for a less dramatic reorganisation of one’s life at times of crisis, as well as the opportunity for diversity of interests, the establishment of alternative social identities and a temporary refuge from reminders of family problems. They infer that "increasing the strength of particular non-family identities can serve as a coping mechanism" for high risk populations. This type of research highlights the importance of social networks as both protective and life-enhancing, especially at times of crisis when the risk of emotional ill-health is greater.

As Beels (1978) remarks, the more recent legal reforms promoting community care suggest that the least restrictive alternative to hospitalisation be provided and yet we still
have a very limited knowledge of the kind of social lives that people with long-term psychiatric disorders enjoy. Frequently the very nature of the disorder militates against social identities and networks being formed. The evidence that has been collected shows that the social networks of psychotics are generally smaller and denser than those of neurotics or normals (Pattison et al, 1975). The changes in the size and function of their networks tend to begin before hospitalisation (Tolsdorf, 1976). Similarly, Henderson et al (1981) found that people with affective disorders tended to have restricted networks. These restrictions may extend to the patient’s carers (Nelson et al, 1970) and many lose the opportunity to confide, being constrained to making decisions alone (Fadden et al, 1987). Other researchers have also found that there is a relationship between the size of the individual’s network and that the amount of help they receive, and tenure in the community (Cohen and Sokolovsky, 1978). In a study of patients discharged from a psychiatric hospital, Fairweather et al (1969) found that survival in the community depended in particular on being an active participant in a group of ex-patients set up before discharge. Again this implies the necessity of appropriate social support for successful community living.

What we do know of social networks and of psychiatric illness leaves us with a complicated picture of how the two may interact. In general, Brown and Harris (1978) have shown us the importance of a confidant as a protection against depression for women in Camberwell and how the strongly integrated support system evident on a Scottish island was helpful in preventing depression but exacerbated anxiety. The work of Brown, Birley and Wing (1972) indicated that low expressed emotion relationships are crucial in maintaining recovery from a psychotic episode, implying that a confidant may be an extremely problematic person for a schizophrenic rather than a help. Wing (1977) found schizophrenics to be particularly vulnerable to two types of social stress. Over-stimulation may lead to a return of symptoms and eventual relapse, whereas under-stimulation may lead to social withdrawal, under-activity, apathy and overdependence. As such, a schizophrenic person ideally needs not to be trapped in one environment with one level of stimulation but be able to move freely between different environments.
Making informal social contacts, outside of the formal contacts provided at home and work, would facilitate this.

Arenberg's Theory of the development of Social Relationships (see Beels, 1981) denotes the initiation of interaction as a central feature. The difficulties schizophrenics have in creating and maintaining social networks can be explained by this; as Beels (1981) comments, "Grace and resourcefulness in social initiatives are precisely the qualities schizophrenics do not have". Thus, the onset of a major mental illness may precipitate a social network crisis, which is perpetuated if the condition remains chronic.

Being chronic conditions prone to relapse, the major mental illnesses tend to occur alongside a failure to build the social supports expected during the life cycle, such as finding employment in the competitive market, initiating and maintaining oneself in an independent home separate from the family of origin, and finding a circle of friends. Thus, the interaction between the nature of the illness, its effect on social networks and vice versa, may be profoundly related to prognosis and not least to quality of life. The networks of psychotic patients are particularly prone to disintegration at times of crisis. They tend to have smaller networks consisting of fewer clusters, more unsupported connections and fewer connecting relationships between clusters (Hammer 1980). Unsupported relationships are more likely to be lost following hospitalisation (Hammer 1963/4).

Recently then, the family as the major context for the patient's life has been recognised as being vitally influenced by the family's own structure, context and attitudes, with several programmes that focus on the social context of the family being set up. Typically, the chronic psychiatric patient tends towards only having two environments of hospital and home available to them; as Pattison et al (1975) concluded, "The psychotic is caught in an exclusive, small, social matrix that binds him and fails to provide a healthy inter-personal matrix".

Morin and Seidman (1986) have provided a useful review in their attempt to develop a social network approach to preventing the chronic relapse-remission pattern of many psychiatric patients, that other treatments often fail to ameliorate. This approach is based on certain research findings. First, the size of a person's social network has been
found to correlate inversely with psychopathology (Pattison et al, 1975; Cohen and Sokolovsky, 1978; Hammer, 1980). Second, higher levels of social support pre-hospitalisation predict a better prognosis (Strauss and Carpenter, 1977) and community tenure depends on a strong psycho-social kinship network (Budson and Jolley, 1978). The network needs certain qualities however, in order to provide the appropriate support. If it is too fragmented it could cause confusion; key members such as mothers can become over-involved; if it is too dense, there may be intolerance of non-conformity leading to relapse. These points are inferred from Hirsch’s findings concerning the need for boundaries between relationships with friends and relatives, the findings on expressed emotion, and evidence that a lack of flexible, multiplex relationships can predict re-hospitalisation (Cohen and Sokolovsky, 1978). Thus, the authors conclude that a balance needs to be struck between flexibility, allowing for alternative social identities to be formed and for continuation of support despite conflict in one area, and stability, facilitating the continuation of support despite a break due to hospitalisation or the loss of a particular key supporter. They recommend that flexibility and stability in the networks of long term psychiatric patients be fostered by expanding the number of relationships and supporting existing connections.

Similarly, the President’s Commission on Mental Health (1978), in the USA, recommends that natural supports be recognised and strengthened, that potential social supports provided by existing institutions be identified, that links between community supports and mental health services be improved and research be initiated to increase our knowledge of informal and community support systems. As yet we know very little about which patients have enough support and thus can be left alone, which patients have no access to support and need help to construct it, and which patients may return to long-stay psychiatric hospitals despite the provision of good supports (Beels, 1981).

The question of how it actually feels to live with a family member who has a long term psychiatric disorder and what the difficulties might be, has been addressed in a series of studies considering the degree of burden experienced by carers. The concept of "burden" refers to both objective burden and subjective burden. The former concerns the effect on income, social life, routine, activities and mental or physical health that can be
observed by an investigator. The latter concerns the degree of distress and restriction as perceived by the carers (Falloon et al, 1984). Platt et al (1985) defined the concept as the degree of imbalance in performance due to one person’s inadequacies, leading to another taking on more than their fair share; this can only be viewed in relation to social expectations, however, therefore being open to reinterpretation.

A seminal study of burden was carried out by Creer and Wing (1974), who interviewed eighty relatives of schizophrenic patients. They found that some 80% of the patients exhibited moderate to severe behaviour disturbance and the two behaviours most problematic for relatives to cope with were identified. First, social withdrawal, normally attributed to the patient’s social incompetence, led them to avoid social contacts and to rely on family members for companionship. Mothers were often the target for these over-dependent relationships and in turn experienced restricted social lives. Second, socially embarrassing behaviour as well as threats of violence and suicide were difficult to manage. Approximately half of the families experienced serious detrimental effects to their health and well-being. These effects were characterised by worries about the future, concern over the patient’s unpredictability, frustration and feelings of helplessness about the patient’s passive behaviour, depression, guilt, family friction and severe disruption of household activities and routines.

A further study by Hoenig (1974) found evidence of objective burden in 86% of families. Only a quarter complained of the burden being severe, however, and a further quarter made no complaints at all. This finding highlights the discrepancy between objective and subjective burden and implies that many families may be coping in a difficult situation without complaint.

From investigations of the degree of burden evident in families with a member who suffers from depression, a similar picture has emerged (Fadden, Bebbington & Kuipers, 1987). Overall, there is a consistency in the type of symptoms described as problematic by relatives regardless of the disorder. Although the positive symptoms of psychosis, including delusions, hallucinations and aggression are reported as difficult to manage, relatives seem to complain most about negative symptoms. These include frustrating depressive symptoms, hypochondriacal preoccupations and self-neglect, which are
evident in both depression and schizophrenia (Mills, 1962; Grad & Sainsbury, 1963 a,b; Hoenig & Hamilton, 1966, 1969). Further, Vaughn (1977) did a content analysis of the criticisms made towards schizophrenics by relatives, finding that only a third concerned positive symptoms. Two thirds referred to negative symptoms such as lack of communication, affection and initiative, which were often perceived as voluntary and not part of the illness. In reviewing these findings, Fadden et al (1987) conclude that it is the "suppressive effects of mental illness on behaviour" which are most difficult for the family and that this is due in part to the "difficulty which relatives have in attributing such effects to mental illness".

Further work by MacCarthy et al (1969) supports this conclusion: in a study of a variety of long-term psychiatric patients, they found that diagnosis was not related to the degree of burden experienced by carers and that relatives rarely found their relationship with the patient rewarding in itself. The authors suggest that families may continue in such adverse circumstances because either they have very low expectations of family life, or the relationship fulfils some emotional need for themselves.

The literature demonstrates that many families continue to cope with a mentally ill relative despite the difficulties. Not surprisingly there is evidence that this has much to do with the family’s tolerance and attitude towards the disordered member. Freeman & Simmons (1963) found that the family’s ability to cope with disturbed behaviour was a major factor in maintaining the patient in the community. In a four year follow-up study of people with a variety of long-term psychiatric disorders, Greenley (1979) found that the family’s fear about the patient’s behaviour and their perceived ability to cope with it correlated positively with rapid re-hospitalisation, whereas the degree of psychiatric impairment did not. Thus, re-hospitalisation may not be directly related to severity of symptoms, role functioning, family stigma, friction, burden or history of violence. It does correlate with the family’s fears about their ability to cope, which may themselves be a consequence of previous violent and bizarre behaviour (Falloon et al, 1984).

Also, fears about ability to cope are related to negative attitudes towards the patient such as infantalisation, ambivalence or rejection, causing the family to be unable to cope with crises without professional intervention. Many families do not seek help, however,
because they feel too much shame and guilt, prefer to deny their difficulties, or have had bad experiences of seeking help in the past (Creer and Wing, 1974). Alternatively, they may assume that there is no effective treatment or help to be sought (Hoenig & Hamilton, 1966, 1969). In consequence, families often do not seek help until they are no longer able to cope at all (Wood, Rakusin & Morse, 1960).

Part of the explanation for families not seeking help until reaching a crisis point is that resignation and acceptance may protect carers from distress and reduce the tendency to blame the patient (Leff & Vaughn, 1985). Many people who suffer from a long-term psychiatric disorder become socially withdrawn in order to reduce stress (Lamb & Goertzal, 1971). Further evidence suggests that families containing a mentally ill member may themselves become socially withdrawn in order to cope with the patient’s behaviour and their dependence on family members to provide social contact. Social withdrawal may be especially marked where relatives are elderly (Leff et al, 1982).

Yarrow et al (1955) found that the fear of stigmatisation often caused relatives to isolate their families deliberately, a third of the families studied concealed the person’s illness "aggressively" and another third would only tell close family and friends. Also, many families seem to tolerate the disordered person without integrating them into their social activities, which no doubt detracts from the rehabilitative capacity of that family system (Evans, Bullard & Soloman, 1960).

Considering these findings alongside those regarding the restricted social networks of mentally ill people and their families (Cohen and Sokolavsky, 1978), it is evident that many families easily become socially isolated. Scott (1974) suggests that this may be due to the family’s major dilemma concerning their wish for the patient to expand their contacts but their fears regarding the consequences of this for the patient and themselves.

Several researchers have attempted to identify the kinds of behaviours that promote positive coping amongst relatives caring for a mentally ill person. Hatfield (1981) suggests that ineffective copers react to crises rather than planning ahead, perceive themselves as being unable to manage the disordered person and have few separate interests. In contrast, effective copers actively seek out information, have realistic expectations and tend to enjoy interests separate from the disordered person.
In a similar vein, the work of Andrews et al (1978) suggests that coping style, in relation to maturity of ego defence, and support substantially reduce the risk of psychological problems following a major life event. They found that only crisis support had a significant effect on the response to a life event, relating to the ability to seek help at times of need. A study carried out by Fontana et al (1972) concurs with this finding in that the ability to seek assistance during a crisis was found to determine admission to hospital for psychiatric patients. Exhibiting this kind of coping behaviour would depend first on the availability of other people to provide support and second on the family’s ability to recognise their needs and seek help accordingly.

Thus, a picture is emerging of a large number of long-term mentally ill people who live in a dependant manner with an often elderly relative, in a state of total isolation. The family’s ability to seek help in terms of social and professional support may be limited by fears of stigmatisation, resignation and high degrees of tolerance due to low expectations. Many are experiencing a high level of burden but also have the advantage of the person’s company and some help with household tasks (Stevens, 1972).

Hatfield (1979) notes that mothers usually take over much of the caring role, especially at times of increasing family stress. The concept of schizophrenia being linked to unusually symbiotic relationships between mother and offspring is most forcefully expressed in the theories of Bowen, Lidz and others (Bowen, 1960; Lidz, Fleck & Cornelison, 1965; Searles, 1959). They suggest that a lack of differentiation between self and world is linked to the early symbiotic bond between mother and child. Although this is a difficult concept to operationalise, several researchers have attempted measurement (Liem, 1980).

Summers & Walsh (1977) identified the characteristics indicating a symbiotic relationship with the mother that has continued into adulthood as the failure to differentiate between self and other, dependency, intrusiveness and separation difficulties. They found evidence that young schizophrenic adults had more symbiotic relationships than others both currently and in the past. In a second study (Summers & Walsh, 1979), they found that young schizophrenic adults perceived their mothers as more symbiotic
than others did. These findings must be viewed with caution, however, due to the problematic nature of the projective tests used and possible interviewer bias.

A further study by Walsh (1979), again using projective tests, investigated possible "child as parent" and "child as mate" interaction patterns in the families of schizophrenics. They found that the former was not in evidence, whereas the "child as mate" pattern occurred in schizophrenic families but no others. This is backed up by some anecdotal evidence of eroticised relationships between mothers and their schizophrenic offspring (Ledz, Fleck & Cornelison, 1965) and may in part account for the tendency for closely dependant mother-offspring dyads to develop, who live in relative social isolation.

Thus, the style of family functioning and the nature of interactions between members of families in which one person has a psychiatric disorder remains a matter of research interest. The current study attempts to address some of these issues by investigating the style of family functioning in relation to social isolation.

Alongside the work on psychiatric disorders and on social networks, investigations into styles of family functioning have accumulated providing a rich source of information. There are two models of family functioning which, over the past decades, have become "standards in the field" (Green, Kolevzon & Vosler, 1985) both of which are cross-sectional and process-orientated, providing a possible structure for family research (Beavers & Voeller, 1983). The "Olson Circumflex Model" (Olson, Sprenkle & Russell, 1979) was developed from an inductive clustering (conceptual not empirical) of the vast number of theoretical concepts proposed in the literature. Two factors are proposed as encompassing these concepts and as dimensions underlying them.

The first dimension, "cohesion", is defined as the emotional bonding members have with each other. High levels are conceptualised as enmeshment, characterised by over-identification and dependency. Low levels are conceptualised as disengagement, characterised by less bonding and more separation. They suggest that the dimension is curvilinear with a medium level being optimal for individual development, in terms of the ability to deal with stress and change. This hypothesis is supported by a variety of theories developed from working with disturbed families, usually referring to
schizophrenia (eg. Bowen, 1960; Stierlin, 1974) and from evidence that the work of most family therapists centres around improving individuation and autonomy of family members (Gad, 1970). In describing schizophrenic families, Wynne (Wynne et al, 1958) concluded that members often tended to fit together “at the expense of developing personal identities”. Karpel (1976) hypothesises that mature relationships are maintained through dialogue and distance, that is individuation, each process facilitating the other and forming the “I” and “we” of relationships. Hence a balance between too low or too high a level of cohesion is sought for healthy functioning.

The second dimension, “adaptability”, is defined as the ability of the family system to alter its power structure, role relationships and relationship rules in response to situational and developmental stress. This is again conceptualised as a curvilinear dimension, a balance between stability and change associated with healthy functioning. Thus families range from being “rigid” at the extreme low end of adaptability to “chaotic” at the extreme end of the scale. This is in line with Wynne’s (Wynne et al, 1958) assertion that a rigid status quo is indicative of pathology. Similarly, Wertheim (1973) distinguished between consensually un-adaptive families and those that are experiencing “forced morphostasis”, in particular schizophrenic families, where the nature of the disorder prompts them to respond by developing a rigid, unchanging system.

Experimental evidence supporting this model has been found. Russell (1979) found that high functioning families score moderately on adaptability and cohesion. Sprenkle & Olson (1978) found that non-clinical couples were characterised by moderate levels of adaptability, an egalitarian leadership style and responsiveness to attempts to change control in relationships. Killorin & Olson (in press) also found that chemically-dependent families exhibited extreme scores on both dimensions.

An alternative to the Circumflex model is the Timberlawn-Beavers model (Beavers, 1976, 1977) which was developed deductively from empirical data collected through clinical work with families. Interestingly, the two theories are generally similar despite their development by different methods, lending validity to both. The Beavers model, however, proposes the adaptability dimension of family functioning to be a continuum, in contrast with the curvilinear concept of Olson (Beavers & Voeller, 1983). The authors
suggest that autonomy is a developmental continuum, differentiation being an infinite search rather than an optimal midpoint. The concept of adaptability is defined, not as the amount of change experienced by the family, but their capacity to alter in response to change. Thus, they propose are infinite continuum for adaptability interacting with the curvilinear dimension of cohesion. This is in accord with the psychoanalytic theories of Spitz (1959), Mahler (1972) and others, who assert that a differentiated self can only emerge after clearly splitting good images from bad images of mother and self, and that once these are integrated the ego continues to differentiate progressively. The continuum of adaptability is conceptualised as beginning with chaotic invasive families with diffuse boundaries. Its midpoint refers to families exhibiting rigid controls, distancing and projection with some closeness. High adaptability denotes well-structured, integrated and autonomous individuals who share intimacy and closeness with respect for separateness, as well as flexible approach to stress and change.

Combining these two dimensions, an arrow shaped diagram is formed with nine basic family types (see Figure 1). The first dimension lies on a continuum and indicates family structure, flexibility and competence, whereas the second dimension is curvilinear, relating to family style. One end of this curve relates to a "centripetal" style, in which family members seek satisfaction from within the family, and the other relates to a "centrifugal" style, whereby family members seek satisfaction from external sources. Both extremes are conceived as maladaptive. The model is dynamic and families may change over time and circumstance; for example, families with young children may function well with a centripetal style but become more centrifugal as the children reach adolescence. Families which often produce schizophrenic offspring are characterised as extremely unadaptable and centripetal in style. The definition of the adaptability concept as a continuum rather than a curvilinear dimension has received support from the literature and empirical work comparing the two models (Lee, 1988). A self-report measure for the Beavers model has also been developed (Beavers, Hampson & Hulgus, 1985). In the current study this model is used to measure the style of family functioning, in order to explore its relationship with social support and burden.
The current study attempts to provide further information pertaining to these questions, by exploring the patterns of social contacts exhibited by a group of long-term psychiatrically disordered people living at home with their mothers, their level of satisfaction and perception of these, and how these interact with the functional style of the family itself.
Figure 1: **THE BEAVERS-TIMBERLAWN MODEL OF FAMILY FUNCTIONING** (from Beavers & Voeller, 1983)

- **Severely Disturbed**: Often Sociopathic Offspring
- **Borderline**: Often Borderline Offspring
- **Midrange**: Often Behavior Disorders
- **Adequate**: Mixed
- **Healthy**: Adequate
  - **Optimal**: Mixed

**Stylistic Dimension**

- **Centripetal**: Poor boundaries, confused communication, lack of shared focus, stereotyped family process, despair, cynicism, denial of ambivalence
- **Mixed**: Shifts from chaotic to tyrannical control, efforts, boundaries fluctuate from poor to rigid, distancing, depression, outbursts of rage
- **Centrifugal**: Relatively clear communication; constant effort at control; “loving means controlling”; distancing, anger, anxiety, or depression; ambivalence handled by repression
- **Optimal**: Capable negotiation, individual choice and ambivalence respected, warmth, intimacy, humor

**Note:** The diagram illustrates the relationship between family functioning and offspring behaviors across different dimensions. Each quadrant represents a different level of family functioning, with corresponding offspring behaviors and communication patterns.
AIMS OF THE STUDY

1. To explore the type of functioning displayed by the families, in relation to the Beavers-Timberlawn Model of Family Functioning (Beavers, 1976, 1977).

2. To investigate the extent of each participant’s closely involved social networks and assess their perception of the kinds of social support that they receive.

3. To investigate the levels of objective burden, subjective burden and resignation reported by the mothers’ in relation to the effects of the son’s psychiatric disorder.

4. To investigate whether there are differences between the type of family functioning exhibited by the group of patients with a longer history, compared to those with a shorter history of psychiatric disorder.

5. To investigate whether there is a difference between the perceived social networks of the group of patients with a longer history, compared to those with a shorter history of psychiatric disorder.

6. To investigate whether there is a difference between the degree of objective burden, subjective burden and resignation experienced by the mothers of patients with a longer history, compared to the mothers of patients with a shorter history of psychiatric disorder.

7. To explore whether the type of functioning that the family exhibits is related to their perceived social support.

8. To explore whether the type of functioning that the families exhibit is related to the degree of burden, subjective burden, or resignation that the mothers experience.
9. To explore whether the families' perceptions of the social support they receive is related to the degree of objective burden, subjective burden, or resignation experienced by the mothers.
METHOD

I. SUBJECTS

The participant group was sixteen families, consisting of a mother and her son, living together in their own home. All of the sons were diagnosed as chronically mentally ill, having spent at least one period in a psychiatric hospital in most cases, although for one diagnosis had been made as an outpatient. Fourteen of the patients were diagnosed as schizophrenic, whilst two were diagnosed with depression and anxiety including some psychotic features. The patient who had not spent time in a psychiatric hospital had been diagnosed as schizophrenic and was reported to have been displaying both active and passive psychotic symptoms over a period of many years, so it was decided that he could be included in the study despite this.

For the purposes of this study, a group of families who had been facing the difficulties of living with a psychiatric disability over a long period of time was sought. Families considered were those with a son who had always lived at home, or had spent only short periods of time away, ie. less than six months, and had subsequently returned. It was also decided that the participants be at least thirty years old and with a history of psychiatric illness of at least two years, in terms of their first contact with services.

In the actual participant group used, the son’s ages ranged between 31 and 60, with a mean age of 43. The mothers were aged between 52 and 85, with a mean age of 68. In relation to chronicity, the average time of onset of the illness was 12 years previously, with a range of 2 to over 21 years. The participants have been divided at the median length of psychiatric history, with is twelve years, to form two groups; the less chronic group having a psychiatric history of between 2 and 12 years, with a mean of 6.25 years (Group 1); the more chronic group having a history of between 13 and over 21 years, with a mean of 18 years (Group 2). In these cases the exact year of onset was difficult to recall and the records were unavailable. There are eight families in each of these two groups.
Most participants had minimal contact with services. Five had places at day centres but in all cases attendance was sporadic. Four were supported by a community rehabilitation team and two received regular visits from a community psychiatric nurse. The remaining five received no help from services, except receiving medication from their General Practitioner.

II. MEASURES

1. FAMILY FUNCTIONING

This was measured using the Self-Report Family Inventory (SFI) (Green, Kolevson & Vosler, 1985). This is a forty-four item self report measure administered to both mother and patient (see Appendix I). The scale was developed as a means of testing the constructs in the Beavers Systems Model of Family Functioning (Beavers, 1977) by self-report, this being easier to administer than the interview method also used by authors.

In a study carried out by the authors, four factors were derived from a factor analysis of the forty-four items on the SFI (Beavers, Hampson & Hulgus, 1985). The most prominent factor was termed Health with 33 items contributing. Others were Expressiveness, Leadership and Style, with 5, 2 and 3 items contributing respectively. All selected items have factor loadings of .35 or higher.

Items on the SFI have been compared with FACES II, a measure designed to access the constructs relating to the Olson Circumplex Model of Family Functioning (Olson, 1983), and the Bloom Family Functioning Scales (Bloom, 1985), with a non-clinical college population (n=256) (Beavers, Hampson & Hulgus, 1985). The Bloom Family Functioning Scales consist of a 75 item measure derived from factor analysis of existing, well- validated family functional assessments, and as such it is a useful referent. It was found that the SFI Health and FACES II Cohesion and Adaptability factors are highly positively associated (r=.8249 & r=.6410 respectively). The authors conclude from this and further, more detailed analysis, that family functioning is more directly related to a unidimensional scaling of health than the two measures used in FACES II. In comparisons with Bloom’s well-factored and statistically orthogonal scale, the SFI does
appear to measure important dimensions of health and that the Health factor comprises several important clinical constructs.

Using a clinical population (n=71), the authors made a further comparison between perceptions of health and style made by family members with those of outside raters (Beavers, Hampson & Hulgus, 1985). Moderately high correlations were found between inside and outside raters, but more importantly, the first two factors of the SFI were able to distinguish significantly between rated groups of high- and low-functioning families. The authors conclude that the SFI is a useful and easily administered means of detecting families at high risk for emotional and behavioural problems.

These investigations of the SFI are considered preliminary by the authors. Subsequently, some revisions of the measure have been made. Information regarding this was unavailable at the time of the current study and the original SFI has been used. Consequently, the results must be viewed with some caution.

For the purposes of this study, items of the first two factors of the SFI, Health and Expressiveness, are used to measure the level of adaptability and successful functioning in the families assessed. The range of possible scores is 33-99 for Health and 5-15 for Expressiveness, higher scores indicating less adaptable and less successful functioning. Items relating to the Style factor are used to assess how the participant families fall with regard to the “centripetal - centrifugal” style of functioning variable. The range of possible scores on this measure is 3 to 9; higher scores on this factor indicate a higher degree of centripetal functioning.

2. BURDEN

This was measured using subscales of the Social Behaviour Assessment Schedule (SBAS) (Platt, Hirsch & Weyman, 1983). This takes the form of a standardised, semi-structured interview with the patient’s carer, in this case the mother. It aims to assess the patient’s disturbed behaviour and altered social performance, whilst evaluating problems and difficulties suffered by the patient’s household and significant others, that is the burden on those involved with them (Platt et al, 1980). Objective burden is identified, based on the definition provided by Hoenig and Hamilton as “anything that occurs as a
disruptive factor in the informant’s life due to the patient’s illness” (Hoenig, 1968).
Subjective burden is also measured, referring to the subjective feelings and attitudes of
the informant (Hoenig & Hamilton, 1967).

In the current study, four sub-sections of the SBAS are used (see Appendix II). These include the patient’s behavioural difficulties, the patient’s social performance, adverse effects of the patient’s illness on the informant and the amount of social support received. Within each sub-scale, both the objective nature of the difficulties, as well as the degree of distress or resignation engendered in the informant are rated by the interviewer; hence the interviewer was not blind to factors such as length of illness when making the ratings. A composite score is obtained for the patient’s overall level of functioning, which includes a rating of the severity of the psychiatric illness, behavioural problems and the patient’s level of social performance. This gives an idea of the level of difficulties that the patient exhibits. The range of scores is between 0 and 68, a higher score indicating more difficulties. Combining this with a rating of the effects on the informant, a composite score for Objective burden is achieved, scores ranging between 0 and 84. Within each of the sub-sections, the informant’s level of distress is rated by the interviewer, and a composite score measuring Subjective burden can be obtained with a range of 0 to 96. Further, the degree of resignation exhibited by the informant in relation to each item is rated by the interviewer, and a composite score for Resignation can be calculated with a range of scores between 0 and 48 (see Appendix for full details).

In a study of inter-rater reliability, correlation coefficients of between 0.92 and 0.99 were achieved for all sub-scales (Platt et al, 1980). Section scores and individual items scores also reached high levels of internal reliability in the same study.

3. SOCIAL SUPPORT

In order to assess the extent of their immediate supportive network, the number of closely involved friends or family members was counted for both mother and son. These were people seen regularly and reported as offering support by the subjects.

The Interpersonal Support Evaluation List (ISEL) (Cohen et al, 1985) was also used to measure the subject’s perceptions of the resources provided for them by others (see
Appendix III). It includes four, ten item sub-scales purporting to cover the various functions that social support can serve (see theoretical justification for the categories in Cohen & McKay, 1984). The “Tangible” support sub-scale refers to instrumental aid; the “Appraisal” support sub-scale refers to the availability of someone to talk to about one’s problems; the “Self-esteem” sub-scale refers to the availability of a positive comparison when comparing oneself with others; and the “Belonging” support sub-scale refers to the availability of people one can do things with. The rationale for this measure is that the relationship between the stressfulness of an event and social support is cognitively mediated, that is, the stressfulness of a situation is mediated by one’s perception of one’s social support (Cohen & McKay, 1984; House, 1981).

The authors report that the ISEL has adequate correlations with other measures of social support, adjustment and self-esteem (eg. Barrera, Sandler & Ramsey, 1981). It has adequate test-retest and inter-rater reliability, and the sub-scales are largely independent of each other (Marmelstein et al. 1983a, b). It has also been found to correlate negatively with depressive and psychiatric symptomatology (Cohen & Marmelstein, 1985). It has been consistently shown to interact with measures of stress in a predictable manner, supporting the hypothesis that social support protects people from the pathogenic effects of stressful events (Cohen & Marmelstein, 1985).

A study carried out on a normal population (N=64) found that the mean ISEL scores measured on three occasions ranged between 32.9 and 34.4, with standard deviations between 4.96 and 5.98 (Marmelstein, Cohen & Lichtenstein, 1983). Scores obtained on the ISEL by participants in the current study, will be compared with these to assess how they differ from a sample of the normal population.

III PROCEDURE

After ethical approval for the study had been obtained, families fitting the inclusion criteria were located through a variety of channels including day centres, community psychiatric nurses and a community rehabilitation team. The families were either approached directly or following an introduction by a worker already known to them.
After explanation of the research procedure, signed consent was obtained for all participating subjects.

All interviews were carried out in the family home. The semi-structured interview administered to the mother, lasted between 60 and 90 minutes, sometimes split into two sessions as necessary. A further one or two visits were made to collect the questionnaire data. The questionnaires were filled-in under the supervision of and with help from the interviewer where necessary.
RESULTS

I. MAIN VARIABLES:

A. Family Functioning

The mean, standard deviation and range for scores on the SFI, measuring the type of family functioning, are shown on Table 2.

The scores on the Health and Expressiveness scales indicate the level of adaptability and overall functioning of the family; higher scores imply less adaptability and these two scales have been found to distinguish between high and low functioning families. The Style scale relates to the centripetal or centrifugal style of functioning that the family exhibits; higher scores indicate a more centripetal style of functioning.

This measure has not been standardised on the normal population, so there are no norms with which to compare these results. It may be tentatively concluded, however, that the participant families scored towards the higher end of the Health, Expressiveness and Style scales, implying that they may be characterised as centripetal in style and towards the less adaptable and poor functioning end of the continuum.
Table 1. Descriptive data on participant group
(Sixteen patients and their mothers)

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AGE (in years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Mothers</td>
<td>68.0</td>
<td>10.9</td>
<td>54-85</td>
</tr>
<tr>
<td>-Patients</td>
<td>43.0</td>
<td>9.7</td>
<td>31-60</td>
</tr>
<tr>
<td><strong>Length of Psychiatric History (years)</strong></td>
<td>12.2</td>
<td>7.2</td>
<td>2-21</td>
</tr>
<tr>
<td><strong>No. of family members closely involved</strong></td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>- with mothers</td>
<td>6</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>- with patients</td>
<td>7</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td><strong>No. of friends closely involved</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- with mothers</td>
<td>8</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>- with patients</td>
<td>7</td>
<td>9</td>
<td>-</td>
</tr>
</tbody>
</table>
Table 2. **Descriptive data on main measures**

(Sixteen patients and their mothers)

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>MOTHER</th>
<th>PATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D. *</td>
</tr>
<tr>
<td>SFI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>68.6</td>
<td>7.2</td>
</tr>
<tr>
<td>Health</td>
<td>59.3</td>
<td>7.9</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>9.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Style</td>
<td>6.8</td>
<td>1.4</td>
</tr>
<tr>
<td>ISEL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Tangible</td>
<td>6.8</td>
<td>2.0</td>
</tr>
<tr>
<td>Appraisal</td>
<td>6.4</td>
<td>1.7</td>
</tr>
<tr>
<td>Belonging</td>
<td>5.6</td>
<td>2.2</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>6.2</td>
<td>1.1</td>
</tr>
<tr>
<td>SBAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burden</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-objective</td>
<td>24.5</td>
<td>8.7</td>
</tr>
<tr>
<td>-subjective</td>
<td>16.0</td>
<td>7.9</td>
</tr>
<tr>
<td>Resignation</td>
<td>6.9</td>
<td>6.9</td>
</tr>
</tbody>
</table>

* Standard Deviation
B. Perceived Social Support

The means, standard deviations and range of scores on the ISEL, measuring perceived social support, are shown in Table 2.

Investigation of the ISEL on sample from the community, which consisted of a variety of adults taking part in a smoking cessation programme, found that mean scores for all respondents ranged between 32.9 and 34.4 with standard deviations ranging between 4.96 and 5.98 (N=64) (Marmelstein, Cohen & Lichtenstein, 1983). Using a t-test to analyse the difference between the smallest mean obtained from this sample of a community population (above) and the mean scores of the participants in this study, significant differences for both mothers (t=5.69; p<.001, two tailed) and sons (t=7.47; p<.001, two tailed) were found. This indicates that scores on the ISEL for participants in this study fall significantly below scores for a mixed sample from the community, implying that they perceive themselves as receiving significantly less social support.

C. Burden

The means, standard deviations and range of scores on the SBAS, measuring the mothers' ratings of burden, are shown on Table 2.

The authors of the SBAS have not prepared normative data with which to compare these results.

A significant difference, however, was found between the ratings of objective and subjective burden (Wilcoxon Signed-Rank Test: Ws=197.9, p<.002, two tailed). This indicates that participants were rated as expressing significantly less subjective burden than objective burden.
II. DIFFERENCES BETWEEN THE TWO PATIENT GROUPS WITH LONG AND SHORT PSYCHIATRIC HISTORIES:

The patients were divided into two groups by splitting them at the median length of psychiatric history; the shorter history group ranged from 2 to 12 years, whilst the longer history group ranged from 13 to 21 years of psychiatric history. Non-parametric tests of difference (Mann-Whitney U test) between the two groups were carried out on all the main variables measured.

As shown in Table 3, no significant differences between the two groups were found on any of the variables measured.
Table 3. Differences between short-and long-term psychiatric history group
(eight patients and their mothers in each group)

<table>
<thead>
<tr>
<th></th>
<th>MOTHERS</th>
<th>PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Mann-Whitney U values: N1 = N2 = N8)</td>
<td></td>
</tr>
<tr>
<td><strong>SFI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>36</td>
</tr>
<tr>
<td>Health</td>
<td>21</td>
<td>35</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>35</td>
<td>31</td>
</tr>
<tr>
<td>Style</td>
<td>36.5</td>
<td>21</td>
</tr>
<tr>
<td><strong>ISEL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>25</td>
</tr>
<tr>
<td>Tangible</td>
<td>19.5</td>
<td>15.5</td>
</tr>
<tr>
<td>Appraisal</td>
<td>26</td>
<td>32.5</td>
</tr>
<tr>
<td>Belonging</td>
<td>28</td>
<td>36.5</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>49.5</td>
<td>33</td>
</tr>
<tr>
<td><strong>SBAS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient’s Behaviour</td>
<td>18.5</td>
<td>-</td>
</tr>
<tr>
<td>Patient’s social behaviour</td>
<td>25</td>
<td>-</td>
</tr>
<tr>
<td>Objective burden</td>
<td>20</td>
<td>-</td>
</tr>
<tr>
<td>Subjective burden</td>
<td>27</td>
<td>-</td>
</tr>
<tr>
<td>Resignation</td>
<td>36</td>
<td>-</td>
</tr>
</tbody>
</table>

N.B. All results non-significant: U = 13 at P = .05
III. ASSOCIATIONS BETWEEN THE MAIN VARIABLES:

Spearman's rank correlation coefficients were calculated to assess the degree of association between the main variables measured, the "r" values are shown in Table 4.

A. Family Functioning and Perception of Social Support

A significant positive correlation (r=0.54; p<.05, two tailed) was found between the patients' "Total" scores on the SFI (relating to adaptability), and the patient's perceptions of their social support as measured by the ISEL. This implies that patients from less adaptable and successfully functioning families tend to experience better social support.

No other significant correlations between these variables were found. Although only approaching significance at the 5% level of confidence (two tailed), a negative association was found between the mothers' scores on the Style scale of the SFI and their total score on the ISEL. Although not conclusive, this may imply a tendency for mothers who experience less social support to come from families exhibiting a more centripetal style of functioning.
Table 4. Main Variables: Correlation Coefficients (Spearman’s rank correlation coefficients)

(Sixteen patients and their mothers)

<table>
<thead>
<tr>
<th>SBAS</th>
<th>ISEL - total</th>
<th>SFI - total</th>
<th>SFI - style</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective burden</td>
<td>-0.07</td>
<td>0.37</td>
<td>-</td>
</tr>
<tr>
<td>Subjective burden</td>
<td>0.16</td>
<td>0.5*</td>
<td>0.13</td>
</tr>
<tr>
<td>Resignation</td>
<td>0.11</td>
<td>-0.26</td>
<td>0.28</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SFI</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Mother</td>
<td>0.34</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>-Patient</td>
<td>-</td>
<td>0.54*</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Style</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>-Mother</td>
<td>-0.47</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>-Patient</td>
<td>-</td>
<td>-0.13</td>
<td>-</td>
</tr>
</tbody>
</table>

* Significant, p < 0.05.
B. **Family Functioning and Burden**

A significant positive correlation (r=0.56; p<.05, two tailed) was found between the Resignation scores on the SBAS and the Style scale of the SFI reported by the mothers. This indicates that mothers who tend to exhibit more a centripetal style of family functioning were rated as expressing more resignation concerning the effects of their son’s illness.

Although not significant at the 5% level of confidence, the negative correlation between subjective burden and SFI Style, as reported by mothers, is approaching significance. Tentatively, this may imply a tendency for mothers who exhibit a more centripetal style of family functioning to be rated as expressing less distress concerning their son’s illness.

No other significant correlations between these variables were found.

C. **Perceived Social Support and Burden**

A significant positive correlation (r=0.5; p<.05, two tailed) was found between the mothers’ ratings of Subjective Burden on the SBAS and the patients’ perception of their social support, as measured on the ISEL. This may indicate an association between greater subjective burden in mothers and greater perceived support in their sons.

No other significant associations between these variables were found.
DISCUSSION

A. AIDS OF THE STUDY:

Aim One

The results show that the families who participated in the study did show a tendency towards functioning in the ways predicted by the Beavers-Timberlawn Model (Beavers, 1976, 1977). Their scores indicate fairly low levels of adaptability and healthy functioning, with comparatively high levels of centripetal style. Since normative data on this measure is not available, it is impossible to make a comparison that would show how the participant families function in relation to other families. Hence, these conclusions can only be viewed tentatively and as indicating a tendency for these families to present in this way. The families do, however, seem to function in a way that is consonant with the theoretical hypotheses described in the introduction.

The relatively high centripetal scores indicate that the family members are closely involved with each other, relying on each other for social contact and satisfaction. Members report preferring to spend time with each other and having few interests separate from the family. Thus, they may be characterised as tending towards enmeshment. This suggests that the families studied exhibit the pattern of close interaction and social isolation found in previous studies.

The scores in relation to adaptability and healthy functioning may be viewed as low. This suggests that the participant families tend to find it difficult to effect change and tolerate the differentiation of members. This fits with the fact that the family has remained intact despite the difficulties presented by the patient's disorder and the age the patient has reached without seeking independence from the mother.

Essentially, as far as can be concluded from the measures used, these families do appear to function in the way predicted by the model. They may be characterised as tending towards being centripetal, or enmeshed, in style with a limited capacity to react flexibly at times of change.
Without normative data with which to compare these findings, it is difficult to know whether they merely reflect a kind of functioning common to single parent families, or whether they are specific to families facing the problems of psychiatric disorder in one member. In drawing implications from the model, Beavers suggested that the families of schizophrenics may function in a way similar to a mother and young infant, with a high degree of inter-dependence. The findings of this study support this prediction. To what extent this pattern can be conceptualised as a factor pre-dating and contributing to the person's disorder or prognosis, however, cannot be gauged. The pattern of functioning found may be a consequence of the nature of psychiatric disorder; a great deal of research has shown that these disorders generally lead to psychiatric disablement and social impairment, which militates against healthy family functioning (eg. Patterson, 1975).

Clinically, these findings may be useful in alerting those who work with similar families to the possibility that they function in this way. In such cases it would be important for clinicians to encourage families towards being less enmeshed in a non-threatening way, and to help them develop ways of allowing change within the family.

Aim Two

The findings regarding social networks and social support are consonant with the formulation discussed above. The numbers of family members and friends that were closely involved with the participant families appeared to be small. Overall, approximately two-thirds of the families reported being in regular contact with one or no close, helpful family members and friends. The relationships they did have were invariably too few to form clusters or to be supported by other relationships. At face value, this supports the hypothesis that families with a member who has a long-term psychiatric disorder have impoverished and limited social networks (Hammer, 1980).

Further, it was found that both the mothers and sons reported experiencing a much lower level of social support than that reported for a mixed community population (Marmelstein, Cohen & Lichtenstein, 1983). This indicates a high degree of social isolation in comparison. The sample used in the above study, however, was not made up
of single mothers and their sons, so it is not clear whether the degree of social isolation found in this study reflects the difficulties associated with this type of family or specific effects attributable to the son’s psychiatric disorder. It seems likely that any degree of social isolation normally found in mothers and sons living together would probably be exacerbated by the son suffering from a psychiatric disorder; previous studies have found evidence of stigmatisation and social disability in association with mental illness which would suggest that this is the case (Patterson et al, 1975; Henderson et al, 1981; Beels, 1981). Hence, the implication from the results that the participant families experienced an unusual degree of isolation may be tentatively accepted.

The level of social isolation found may also relate to the suggestion of a high degree of enmeshment amongst the families studied. In most cases, practical, tangible support seemed to be provided where necessary by only one person. The other types of support were also often provided by one person or were somewhat absent. Anecdotally, many of the participants commented that, although support might be available, they would not wish to ask for it but preferred to manage alone. This implies that some of the isolation experienced is self-imposed. This may be understood in a variety of ways; it may, in part, be an attitude of stoicism stemming from fears about stigmatisation, or related to the enmeshed style of the families in which outside influences would be unwelcome.

The nature of the factors underlying the high degree of social isolation found in families with a psychiatrically disordered member would be a useful area for further investigation. Whether the level of social support is related to particular experiences of seeking support in the past, particular attitudes or personality variables would be of interest.

Evidence has been found to suggest that social support is important in promoting psychological health (Hirsh, 1981) and is a determinant of prognosis in mental illness (Strauss & Carpenter, 1977). The findings of this study indicate a need for clinicians to be aware of the degree of social isolation likely to be found in single mothers and their psychiatrically disordered sons and implies a need for clinicians to foster support for these families.
Aim Three

In terms of burden, since there is no normative data available, it is difficult to comment about the levels of burden experienced. On inspection, the scores reported for objective burden fall well below the highest possible score. This implies that in most cases these patients did not have very severe behaviour problems and reduced social performance.

Considering that the patients were managing to live in the community with limited support, this is not surprising. It is notable, however, that the mothers were generally rated as expressing a lesser degree of subjective burden, that is distress about the problems they were having to face, than their level of objective burden would lead one to expect. From the interview material, this seemed to reflect the fact that most of the families had devised ways of coping with these problems on a day-to-day basis, and were tolerant of the difficulties associated with psychiatric illness. A number of mothers were characterised by a particularly resigned and stoical attitude. Interestingly, approximately half of the mothers felt that their sons might be needing more help in the future, but few had ever considered seeking more help or support for themselves. Of the two who had, one had become a keen and active member of the relevant support group, whereas the other reported finding it extremely unhelpful to talk about the difficulties she was facing. These findings appear to support previous work which indicates that the families of the long-term mentally ill are often coping without complaint and with very little help (Stevens, 1972).

Clinically, it may be unhelpful to assume from the findings that these mothers experience less subjective burden, rather that they tend to cope with the difficulties they face by resigning themselves to the situation. As such, the results of this study imply a need for clinicians to be alert to this way of coping and not to assume therefore that families are functioning well and not in need of help. Because a mother finds it difficult to recognise or admit the difficulties, and remains uncomplaining, this does not mean that there are no problems.
Aims Four, Five and Six

The analysis of differences between the participant families when divided into two groups according to their length of psychiatric history, produced no significant results on any of the variables measured. This may be due to the small size of the sample. It seems more appropriate to interpret this as indicating that the groups did show a similar pattern or responses to assessments, implying that there are no meaningful differences in family functioning, perceived social support or burden that occur in relation to the length of psychiatric history. This finding would be more conclusive had the two groups been formed by patients with a distinct difference between their length of psychiatric history; splitting the patient group at the median length of history could only show a tendency and differences might have been found had the groups been more distinctly divided. Since none of the difference values were even approaching significance, however, it would be reasonable to accept this finding.

The lack of differences found suggests that in fact the patterns shown by families with a member who has a long-term psychiatric disorder, in terms of family functioning, social support and burden, do not alter significantly over time. The shortest history of any of the participants was two years, and it may be that this is a long enough time for behaviour patterns to become established and ways of coping to be devised which continue relatively unchanged. Alternatively, it may be that this finding reflects long established patterns that pre-date the illness in line with some theories. For example, the Beavers-Timberlawn model conceptualises the families of schizophrenics as exhibiting certain long-standing styles of interaction which predispose them to produce psychotic members, whilst other theorists, such as Bowen (1960) suggest that an overly close and abnormal relationship between mother and son contributes to the genesis of the disorder. Many studies have found that the families of psychiatrically disordered people show abnormal types of communication and interaction; whether these pre-date the illness or are a consequence of it is unclear. As Wertheim (1973) has suggested, the family may be forced into developing a highly rigid way of functioning in order to cope with the particular difficulties presented by living with someone who is psychotic. It may be safe
to assume, however, that even if the patterns found are a consequence of and post-date the onset of the illness, they could well have become established within two years.

In terms of studies concerning social support, it has been found that the social isolation experienced by most psychiatric patients tends to begin during the early stages of illness, or at least when the patient enters hospital and many contacts are broken. None of the patients in this study had achieved independence from their family of origin or developed a separate life away from the family house. As a number of studies have demonstrated, passive symptoms and social inadequacy tend to be enduring features of psychiatric illness (Creer & Wing, 1974); this may in part explain why these families did not establish stronger networks and more social support once the patient had left hospital. The tendency for these families to interact in a centripetal style would also militate against them creating outside contacts, whether this style is seen as a consequence of the illness or a contributing factor.

As such, it is reasonable to conclude that this style of living demonstrated by these families becomes established quite early on and changes little over time. Again this finding is concordant with the tendency towards functioning in an unadaptable way that is exhibited by these families: this would enable one to predict that they would be unlikely to change once they had found a way of coping that suited them. Comparing families made up of mothers and sons before the onset of the psychiatric disorder and during the earlier stages of the illness with families facing chronic problems would be a way of researching these issues.

In terms of clinical practice, these findings suggest that ideally families need to be reached during the early stages of the illness if they are to be supported in developing healthy ways of coping. At this stage, families may be more amenable to education, the building of social support to prevent isolation and an examination of the way the family functions. It may be easier to set up realistic expectations at an earlier stage, before ideas and ways of coping become entrenched.
Aim Seven

The relationship found between social support and family functioning is somewhat complicated. The overall rating of healthy functioning made by the patient was found to be associated with their perceived social support, indicating that less healthy family functioning is associated with greater social support. Further, the results suggested that the more centripetal the family is in interaction style, the less social support the mother tends to experience. Significant associations between these factors were not found for the other members of the family. It is unclear why different factors are related for the different family members. At face value, it seems to make sense that mothers who rate themselves as centripetal in their style of interaction, implying reliance on the family for support, would experience less social support from outside contacts. It may also be that an unsatisfactory life at home motivates patients to seek more support from outside contacts, or causes them to view the external support they do have more positively. Why similar associations between healthy family functioning and increased social support for mothers, and cohesiveness and decreased social support for sons, were not found is unclear. One explanation is that these factors are a particularly important influence for each. It may be that the mother role, implying that one is the carer, interacts with a centripetal functioning style, making it less likely that one seeks care for oneself, whilst the role of son may be more flexible, allowing the patient to seek further support from outside the family. No firm conclusions could be drawn without further research; an exploration of the relationship between centripetal versus centrifugal family style and role expectations might provide useful insights.

Aim Eight

The exploration of the relationship between family functioning, burden and resignation produced some results that support the hypothesis described above; a higher level of resignation was found to be associated with a centripetal style of functioning.
This suggests that mothers in families where the style of interaction was characterised by a high level of cohesiveness and mutual reliance tended to be more resigned to the nature of their problems in dealing with the patient’s difficulties. As such they may not seek outside help but try to deal with difficulties within the family and feel resigned to this situation. During the interviews, many made comments about just accepting the way things were and implied that they were duty-bound to tolerate the effects of the illness without complaint; for most, this seemed to be a very important part of motherhood. An interesting area of further study would be to assess how such personality and attitudinal factors influence the way that mothers cope with the difficulties of living with a psychiatrically-disabled son.

The overall degree of healthy functioning exhibited by the family was not found to relate to the level of burden experienced by the mother. It seems that in this sample cohesiveness in family relationships was a more influential factor than the ability of the family to adapt in response to change. It may be that these relatively self-sufficient dyads were able to maintain themselves by avoiding the need to change. One possible explanation is that remaining in relative isolation from outside contacts enables the family to avoid pressures to alter. This would need to be established by further investigation, in particular, how social networks are related to pressures to change and how families who have a centripetal and unadaptable style of functioning to cope with these pressures.

**Aim Nine**

The degree of objective burden reported by the mothers, their experience of distress concerning the effects of the illness and their level of resignation were not found to be associated with their perceived social support. One might have assumed that having greater support would decrease the level of distress felt; the findings of this study do not suggest this. It may be that a particular kind of support does influence the degree of burden felt, further investigations analysing how different types of support influence burden might clarify this. Alternatively, it may in part be explained by anecdotal evidence gathered during the interviews that the mothers were unlikely to ask for or use
support even when it was available. In many cases, they seemed to assume full care of the patient and were unwilling to involve others in helping the family. Again this may relate to their tendency towards an enmeshed style of family interaction, implying an ethos of family self-sufficiency.

Again, a further study, looking at how attitudinal and personality factors interact with the use of social support and how this relates to burden and resignation, might help to clarify these issues. It is possible that asking for help is more difficult for these families than continuing to cope with the effects of the illness alone. If this were found to be the case then the way clinicians attempt to provide support for these families would be very important; one would need to be aware that asking for and receiving help may feel very threatening for them.

B. CONCLUSIONS:

In general, the results of this study support the findings of previous studies concerning the nature of family life for those living with a member who has a long-term psychiatric illness. The families included in the study represent an often elusive group of people; they were chosen for the very fact that they represent a population that tends to seek little help from statutory services. As the findings of this study imply, and in agreement with previous work, they tended to view visits from “outsiders” as unwelcome and were generally unfamiliar with being interviewed and investigated. They are an important group for study, however, since they represent what seems to be a fairly typical situation for many people who suffer from mental illness and their carers. These families are also often the ones who do not come to the attention of services and investigators. Importantly, the sons may need help when the mother is no longer able to care for them, and with the continuing implementation of community care policy, it is important for clinicians to have a wider knowledge of these families in order to provide the appropriate services to fulfil their needs.
The results of this study indicated that the participant families may tend to function in a way characterised by cohesiveness and a lack of ability to adapt to change, which the Beavers-Timberlawn model would predict for the families of schizophrenics (although without normative data these findings cannot be conclusive). The families studied were also found to live in relative isolation, to lack social support, and to be experiencing a degree of burden without complaint, although often with an attitude of resignation. This is very much what would have been predicted from earlier work and lends support to theoretical ideas about how chronic psychiatric illness and family life interact.

No differences were found between the participants in relation to the length of time they had been psychiatrically ill, implying that patterns are established relatively early and tend to persist. This finding could be related to the poor capacity to adapt to change shown by participant families; further investigation might show that families who are less centripetal in style or more adaptable do not show such enduring patterns. It may also be that these families would not have remained living together and in such social isolation. An investigation of the style of family functioning in those families of long-term psychiatrically ill patients who have separated or received higher levels of social support would make for an interesting comparison.

The style of family functioning was found to be associated with both burden and social support, and the results imply that the mothers of long-term mentally ill patients, who display a centripetal functioning style, are likely to lack social support, be uncomplaining and resigned. Their apparently stoical attitude may be maintained only at the expense of developing outside supports. Which produces the other is debatable. The concept of a centripetal style of functioning, however, contains within it the idea of a need to gain satisfaction and support from inside the family. This in turn might lead to a denial of difficulties within the family and a reluctance to seek outside support, implying that the highly cohesive style of family interaction is maintained at the expense of being able to express distress and seek remedies. Alternatively, the centripetal style may be a consequence of the actual lack of support available to these families and their experience of unsatisfactory help in the past.
In the sense described above, the patterns found in the families investigated may well reflect coping mechanisms which they have developed due to the difficulties they face. Earlier intervention might help to reduce the degree of isolation and burden found, if clinicians are aware of the possible relationships involved, as shown in this study. For families who have been dealing with a member who has been chronically psychiatrically-disordered for a number of years, it would be particularly important for clinicians to be aware of the great difficulty they may have in altering and how threatening change may be, due to the specific style of coping that they have developed.

Overall, the results of this study represent a consideration of some of the factors relevant to how a particular type of family deals with mental illness.

Unfortunately, it was only possible to study a fairly small group of families, which only allows for tentative conclusions to be drawn. The results do have some implications for clinical practice, however, and ideas regarding further research have been generated. A further investigation including role expectations, motivational, attitudinal and personality factors would be especially relevant. Also, longitudinal studies would help to clarify some of the issues concerning causation and progress over time.
REFERENCES


APPENDIX I: The Self-Report Family Inventory

Respondents answer either "YES" (fits our family very well), "SOME" (fits our family some) or "NO" (does not fit our family) to the statements below:

1. Family members pay attention to each others' feelings.
2. Our family would rather do things together than with other people.
3. We all have a say in family plans.
4. In our family, the parents expect to help the children out of trouble.
5. We think and feel so much alike it's hard to disagree.
6. We have many outside interests and friends.
7. The grown-ups in this family understand and agree on family decisions.
8. Grown-ups in the family compete and fight with each other.
9. There is a closeness in my family but each person is allowed to be special and different.
10. We accept each others' friends.
11. There is confusion in our family because there is no leader.
12. Our family members touch and hug each other.
13. Family members put each other down.
14. We speak our minds, no matter what.
15. In our home, we feel loved.
16. Even when we feel close, our family is embarrassed to admit it.
17. We argue a lot and never solve problems.
18. Our happiest times are at home.
19. The grown-ups in this family are strong leaders.
20. Making a good impression on others is important to our family.
21. The future looks good to our family.
22. We usually blame one person in our family when things aren't going right.
23. Family members go their own way most of the time.
24. Our family is proud of being close.
25. Our family is good at solving problems together.
26. Family members easily express warmth and caring toward each other.
27. In our family it's o.k. to be sad, happy, angry, loving, excited, scared or whatever we feel.
28. It's o.k. to fight and yell in our family.
29. One of the adults in this family has a favourite child.
30. When things go wrong, we blame each other.
31. We say what we think and feel.
32. Our family members would rather do things with other people than together.
33. Family members pay attention to each other and listen to what is said.
34. We worry about hurting each others' feelings.
35. The mood in my family is usually sad and blue.
36. We argue a lot.
37. The grown-ups in this family have friends or relatives who really care.
38. Without asking, we are sure we know what others in our family are really thinking.
39. One person controls and leads the family.
40. My family is happy most of the time.
41. Each person takes responsibility for their own actions.
42. The grown-ups in this family keep to themselves and don’t talk much.

Respondents answer the final two items by making a rating on a scale of 1 to 10 as to:

43. How well my family functions.
44. How independent family members are.
APPENDIX II: The Social Behaviour Assessment Schedule

Section B - Patient's Behaviour

Includes items on:-
1. Misery
2. Withdrawal
3. Slowness
4. Forgetfulness
5. Overdependence
6. Underactivity
7. Indecisiveness
8. Worry
9. Fear
10. Obsessionality
11. Odd ideas
12. Overactivity
13. Unpredictability
14. Irritability
15. Rudeness
16. Violence
17. Parasuicide
18. Offensive behaviour
19. Heavy drinking
20. Complaints about bodily aches and pains
21. Self-neglect
22. Odd behaviour

Section C - Patient's Social Performance

Includes items on:-
1. Household tasks
2. Household management
3. Spare time activities
4. Informant - Patient Relationship
   - Everyday conversation
5. - Support
6. - Affection
7. Work/study
8. Decision making

Section D - Adverse Effects on Others (Informant)

1. Physical ill health
2. Emotional ill health
3. Social life
4. Leisure time
5. Disposable income
6. Work performance
7. Time off work
8. Disruption of informant’s life

Section F - Support to Informant

1. Support from relatives
2. Support from friends
3. Support from services
4. Housing situation
APPENDIX III: The Support Evaluation List

Respondents answer TRUE or FALSE to the statements below:-

1. If I were ill and needed someone to drive me to the doctor, I would have trouble finding someone.
2. There is someone who I feel comfortable about going to for advice about sexual problems.
3. I don’t often get invited to do things with others.
4. I think that my friends feel that I am not very good at helping them solve problems.
5. If I decided on a Friday night that I would like to see a film that evening, I would be able to find someone to go with me.
6. I am more satisfied with my life than most people are with theirs.
7. I feel that there is no-one with whom I can share my most private worries and fears.
8. In general, people don’t have much confidence in me.
9. There are few people whom I trust to help me solve my problems.
10. If I needed a quick emergency loan of £100, there is someone I could get it from.
11. If I got stranded 10 miles out of town, there is someone I could call to come and get me.
12. If I wanted to go out of town for the day, I would have a hard time finding someone to go with me.
13. There is at least one person I know whose advice I really trust.
14. There is someone I could turn to for advice about changing my job or finding a new one.
15. When I need suggestions for how to deal with a personal problem I know there is someone I can turn to.
16. Most people I know don’t enjoy the kind of things I do.
17. If I had to post an important letter at the Post Office by 5pm and could not make it, there is someone who could do it for me.
18. If I were ill, there would be almost no-one I could find to help me with my daily chores.
19. If for some reason I were put in prison, there is someone I could call who would bail me out.
20. If I had to go out of town for a few weeks, someone I know would look after my home.
21. I have someone who takes pride in my accomplishments.
22. If a family crisis arose, few of my friends would be able to give me good advice about handling it.
23. I have a hard time keeping pace with my friends.
24. If I needed a lift to the airport very early in the morning, I would have a hard time finding anyone to take me.
25. When I feel lonely, there are several people I could call and talk to.
26. There is no-one I could call on if I needed to borrow a car for a few hours.
27. If I needed some help in moving into a new home, I would have a hard time finding someone to help me.
28. Most people I know think highly of me.
29. I am able to do things as well as most people.
30. There are several different people with whom I enjoy spending time.
31. I feel that I am on the fringe of my circle of friends.
32. There is really no-one I can trust to give me good financial advice.
33. No-one I know would throw a birthday party for me.
34. I regularly meet or talk with members of my family or friends.
35. I am closer to my friends than most people are to theirs.
36. If I wanted to have lunch with someone, I could easily find someone to join me.
37. Most of my friends are more successful at making changes in their lives than I am.
38. There is really no-one who can give me objective feedback about how I am handling my problems.
39. Most of my friends are more interesting than I am.