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PRACTITIONERS, CONSUMERS & APPLIED RESEARCHERS***

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The Incidence of Anxiety among Spouses of Breast Cancer Patients.

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Abstract:

The diagnosis of breast cancer may provoke various emotional disturbances in patient's spouses and anxiety is one of them. **Objective:** To observe the incidence of anxiety in spouses of breast cancer patients. **Subjects:** The spouses of 100 breast cancer patients, who have gone through mastectomy and were receiving curative chemotherapy, were interviewed. **Design:** Tailor Manifest Anxiety Scale was used to observe the incidence of anxiety. The patients were also assessed to record their performance status by using Karnofsky Performance Status Scale. **Results:** 64% spouses of breast cancer patients were presented with anxiety. Anxiety was more common among spouses belonging to lower socioeconomic status (43.8%) and among those having schooling of ten years or less (46.9%). It was also observed that 50% of spouses with anxiety belonged to the blue-collar jobs. **Conclusion:** It is concluded that factors like educational and socioeconomic status of spouses need to be taken into consideration when planning care for women and their spouses.

Background:

Research surveys show that depression and anxiety are almost as common among patients' partners as among patients themselves. This means that about half the partners will have some symptoms, and in up to a quarter these will be severe. There

tends to be concordance between patient and partner; that is, if one is emotionally distressed, the other is likely to be so too. However, this distress has often not been shared because each partner is trying so hard not to upset the other ^{1,8}.

The partner's emotional response may be complicated by anger or guilt, often indicating some past conflict in the relationship. Sometimes cancer acts as the catalyst for resolution of longstanding marital problems, but sometimes a shaky marriage breaks down completely under the extra strain ³.

If emotional problems in patients themselves are frequently not recognized, this is even more likely to be so for those in their carers, who often feel obliged to keep cheerful and put on a brave face. It is helpful if carers can be seen alone from time to time, perhaps by the family doctor, asked how they are coping and invited to talk over any emotional distress.

The presence of anxiety in family members especially in spouses of breast cancer patients is natural, as they are more close to the patients. It is not strange for spouses to feel anxious because other than hospitalization they have to carry out other responsibilities and there is also the question of their self-satisfaction which involves sexual relationship ⁶. The most common causes of anxiety in spouses may include inadequate knowledge about disease, outcome of the therapy, financial problems, family problems like illness in other family members, family conflicts, etc. ⁴.

The aim of the study was to observe the incidence of anxiety in spouses of breast cancer patients in relation to their age, education, occupation, chemotherapy cycles, number of children and performance status their patients.

Methodology:

The spouses of 100 breast cancer patients who have gone through mastectomy and were receiving curative chemotherapy were interviewed. Spouses with previous history of psychiatric illness or spouses of those patients receiving palliative chemotherapy were excluded from the study. Taylor Manifest Anxiety Scale was used to identify the spouses with anxiety (A score of 19 or above was used to determine the presence of anxiety). The patients were also assessed to record their performance status using Karnofsky Performance Status Scale. Data regarding socioeconomic variables was recorded on data capture form.

Statistical Issues:

Categorical data was analyzed using chi square test for independence of variables. 5% level of significance was set to test hypotheses.

Results:

Data on one hundred female cancer patients diagnosed with Breast Cancer stage I or II was recorded for the anxiety among their spouses. Median age for the patients was 45 years (Mean±SEM: 44.310±1.118) while same recorded for the spouses was 36 years (Mean±SEM: 37.040±1.2222). Spouses were evaluated for the anxiety against their age, performance status of their patient, number of children, chemotherapy

cycles already administered to the patient and non-illness related concerns. All patients were on chemotherapy.

Among 64 (64%) spouses of the patients anxiety was found beyond the cut-off point of 19 on Manifest Anxiety Scale. Anxiety was more common among the spouses having schooling for ten years or less (46.9%) than those who were illiterate (29.7%, p value: 0.017). Least number of spouses (3.1%) was found exhibiting anxiety beyond cut-off point among those who had post graduate level of education.

We subdivided our population of spouses among four occupational categories viz. White Collar, Blue Collar, Service and Farm Workers. Fifty percent of the spouses (32 individuals) with clinically significant level of anxiety belonged to the blue-collar professions (45 individuals) with p – value = 0.01035.

Although 64% of the patients belonged to the families categorized as lower middle class or poor, anxiety was more common among Lower Middle Class (43.8%) compared to those who were poor (P value: 0.0168). Only two families could be categorized as either belonging to Upper Class or Upper Middle Class.

No significant interdependence was observed among the observed anxiety and age, performance status of their patient, number of children, chemotherapy cycles already administered and non-illness related concerns. The multivariate analysis of data was also carried out. No significant interaction for any other variable explained in multivariate analysis was observed.

Discussion:

The diagnosis and treatment of breast cancer in women may provoke various emotional disturbances in their husbands; the feeling of anxiety during investigation period and during the course of treatment is very common among spouses of breast cancer patients. Omne – Ponten, Holmberg, Bergstrom, & Sjoden (1993) have reported emotional disturbances in 48% of husbands during investigation period. In our study, 64% of spouses were presented with anxiety. This rate of is high when compared to Omne – Ponten et. al. (1993) because all patients in our study were receiving chemotherapy which is thought to be a major source of tension and anxiety in patients and their family members⁹.

The onset of a life threatening disease results in significant changes in role and responsibilities of patients' spouses due to which they may become over concerned about the financial condition and their families' well-being. In our society domestic affairs like raising children, house-keeping etc. is considered to be the job of female partners whereas husbands govern the responsibilities outside the house. The diagnosis and treatment of breast cancer increases the responsibilities of male spouses. In these circumstances they have to take care of the children, house keeping and other domestic chores along with their own responsibilities like earning bread and butter for the family. This burden becomes multifold when they also have to attend their partners diagnosed with a disease they know not very much about it^{4,10}.

This anxiety is understandable as the onset of a life threatening disease may jeopardize emotional stability, emotional associations and physical boundaries of a couple's relationship^{2,3}.

The uncertainty of treatment outcome and side effects of chemotherapy could be another source of anxiety among spouses as majority of our sample population attributed their anxiety to the uncertainty about treatment outcome and side effects of chemotherapy.

Among spouses with anxiety, 31.25% of them were belonging to the age group of 30 – 40 years whereas 25% were falling in age range of 20 – 30 years. But overall we observed no significant interdependence between anxiety in spouses and their age (Table: 1).

Table I Anxiety in spouses and their age, number of children, chemotherapy cycles and performance status of patient. Values are numbers (percentages)

	(n = 64)	(n = 36)
Age		
Below 20	2 (40%)	3 (60%)
20 – 30	8 (33%)	16 (67%)
30 – 40	12 (37%)	20 (63%)
40 – 50	6 (35%)	11 (65%)
50 – 60	7 (39%)	11 (61%)
Above 60	1 (25%)	3 (75%)
Performance Status		
Till 50	1 (20%)	4 (80%)
Above 50	35 (37%)	60 (63%)
Number of children		
Issueless	3 (30%)	7 (70%)
Single	5 (45%)	6 (55%)
Two to six	22 (36%)	39 (64%)
Six and above	6 (33%)	12 (67%)
Chemocycle		
One to four	22 (36%)	39 (64%)
Five to eight	11 (33%)	22 (67%)
Nine and above	3 (50%)	3 (50%)

Footnote Table 1:

Table 1 is showing no significant interdependence between anxiety in spouses and age, number of children, chemotherapy cycles and performance status of patient.

The majority of breast cancer patients were enjoying better performance status as 95% of them had above 50 score on Karnofsky Performance Status Scale. As far as anxiety in spouses of breast cancer patients with better performance status is concerned 63.25% showed anxiety whereas 36.75% had no features of anxiety. There was no significant relationship between patients' performance status and anxiety in their spouses (Table: 1).

It has also been observed that number of children and chemotherapy cycles patients have already received had no significance in relation to anxiety in spouses (Table: 1). Our findings regarding age, performance status of patients and number of chemotherapy cycles (Treatment) are in agreement with earlier findings of Glasdam, Jensen, Madsen, Rose (1996) who reported no significant difference between anxiety in spouses and age, patients' diagnosis, treatment and performance status of patients

Among spouses presented with anxiety, 29.7% were illiterate, 46.9% had schooling for 10 years or less. Least number of spouses with anxiety (3.1%) was found among those who had schooling for more than 14 years. We found significant

interdependence between anxiety in spouses and their educational status. It seems that educated spouses have better communication with physicians and are better able to understand the physicians' briefings regarding patient's disease, treatment and any other matter relating to the patient management during the course of illness and treatment. Secondly, the educated spouses, of course, can handle their day-today affairs (changes in role and responsibilities) better and can manage their patients more effectively when compared with less educated spouses. Because of that, they feel less anxious than the other spouses do (Table: 2).

A significant interdependence between spouses' anxiety and their occupation was also observed as 50% of spouses with anxiety belonged to the blue-collar professions like machine operators, assemblers, inspectors, equipment cleaners, helpers and laborers. 25.56% were doing white-collar jobs i.e. executive, administrative, and managerial, and professional specialty occupations and 23.44% were farm workers whereas no spouse with service providing job was found with anxiety. This can be attributed towards the fact that persons with schooling for less than 14 years can hardly find a white-collar job in Pakistan (Table: 2). This fact can also be related to the spouses' socioeconomic status because there is an obvious relationship between person's education, profession and socioeconomic status. In our study majority of patients were belonging to poor or lower socioeconomic class. 31.25% were poor and 43.75% were from lower socioeconomic class whereas only 23.44% were belonging to the middle class and 1.56% to the upper class (Table: 2). Here we can not ignore the fact that this is a medical centre based study and has obvious limitations in terms of patient selection because majority of patients being treated in this hospital are from lower socioeconomic class. The anxiety in spouse resulting from breast cancer in wife was more common among people from lower socioeconomic class, as they are more prone to develop emotional disturbances¹¹. In all we have observed that majority of the spouses with anxiety were from lower socioeconomic class; with schooling for less than 10 years and were belonging to the blue-collar professions.

Table 2 Educational background, occupation and socio-economic status of the patients with clinical manifestation of anxiety. Values are numbers (percentages)

	(n = 64)	(n = 36)
Educational Status *		
Illiterate	19 (29.7%)	3 (8.3%)
Till Grade 10	30 (46.9%)	16 (44.4%)
Graduation	13 (20.3%)	12 (33.3%)
Post Graduation	2 (3.1%)	5 (13.9%)
Occupation **		
White Collar	17 (26.6%)	20 (55.6%)
Blue Collar	32 (50.0%)	13 (36.1%)
Farm Workers	15 (23.4%)	3 (8.3%)
Socio-economic Status ***		
Upper Class	1 (1.6%)	0
Upper Middle Class	0	1 (2.8%)
Middle Class	15 (23.4%)	19 (52.8%)
Lower Middle Class	28 (43.8%)	9 (25.0%)
Poor	20 (31.3%)	7 (19.4%)

* p = 0.01709

** p = 0.01035

*** p = 0.02101

Conclusion:

It is concluded that anxiety is common among spouses of breast cancer patients belonging to blue collar jobs and lower socioeconomic status. They need special attention of physicians to take care of their emotional and informational needs and to refer them for professional help at proper time.

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Biases towards Individuals with Psychiatric Disabilities as related to Community Integration

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Abstract

Work, housing opportunities and community integration (in general) for individuals with psychiatric disabilities or substance related disabilities are significantly severed by societal stigmatic attitudes (Weiner et al., 1988 as cited in Corrigan et al., 2000). Literature continuously demonstrates that discriminative attitudes vary and come from varied directions. As suggested by literature the ill treatment toward the mentally ill comes from health practitioners as much as from the general population (Spiro, McCrea Curnen, Peschel, & James, 1993; Carling, 1995; Michener, 1998; Sheehan, 1982). The purpose of this Current essay is to observe community integration as influenced by client-other relationships. We will look at three elements of integration: therapeutic inequalities, Community acceptance, and job involvement as related to attitudes toward diagnosed individuals within communities. These realms of involvements will be explored deeply for better understanding of the unfortunate trends; so better awareness can be developed in mental health practices.

Introduction

Historically, western attitudes toward people with the label of “mental illness” have been mostly negative. Though one might think that the nature of attitudes have changed over the decades, reality strongly assures that that is not the case (Spiro et al., 1993; Carling, 1995; Michener, 1998 & Heginbotham, 1998).

Such attitudes contribute more to inequalities, segregation, and discrimination than any other. Negative attitudes stand as a barrier to community integration as well as to job retention and job terminations (Carling, 1995; Corrigan et al., 2000). Successful integration is dependent upon cooperation between professionals in psychiatric hospitals, Community services, families, self-help programs, and the recipients of care (Carling, 1995). When biases invade the practices the practice of care, successful integration is at risk (Carling, 1995).

The teachings of care serve as a backbone to health care code of ethics (Corey, Corey & Callahan 1998; Jonsen, 1991 & Spiro et al., 1993). Even with the existence of such teachings there is a growing literature, from the 60's to present times that portray a different atmosphere in the relationship between health providers and consumers (Green, 1964; Laing, 1965; Sheehan, 1983; Spiro et al., 1993; Adams, 1993; Lown, 1996 & Michener, 1998).

First barrier: Therapeutic inequalities

Thomas Mann once said that we must behave as though the world was created for human beings (Mann cited in Lown, 1996). Mann's classical quote strongly suggests Humane Etiquette in relationships. Lown expand his discussion when he brings a dialogue he had with a soviet physician. What was the essence of doctoring for her he asked, she replied: "every time a doctor sees a patient, the patient should feel better as a result" (Lown, 1996, pp.88). The Soviet Physician response is a reflection of the ideal in the health care relationship.

An intensive look into the clients' literature and reports suggest something else rather than the ideal (Sheehan, 1982; Michener, 1998 & Nehls, 1999). It reveals a great deal of Dissatisfaction of health recipients. Most of the complaints are strictly linked to inequalities within the therapeutic milieu. Some of the complaints include the feeling of being invisible almost non-existent which is a direct product of an unequal relationship (Leete, 1988 as cited in Carling, 1995)

Being invisible

Literature reports that many consumers facing health providers develop a feeling of being invisible, or not important. As suggested by Carling, consumers with mental illness often report a feeling of 'invisibility' as they enter the conditioned therapeutic relationships rather than unconditioned ones; they sense that their views and desires do not matter. Esso Leete (Leete, 1988 as cited in Carling, 1995) commented that he can make suggestions, but these are not being taken seriously, even when describing personal experiences these are often seen as delusions.

As we observed Attitudes in general are based on behavioral observations (Laing, 1967; Kohlenberg & Tsai, 1991; Hayes, Strosahl & Wilson, 1999). Therapeutic communication that is based on behavior alone without a regard to the client inner-experiences may perpetuate the illness in which it supposes to treat (Laing, 1967; Szasz, 1976 & Carling, 1995). When consumers' inner-experiences are not met, when clients' autonomy is being compromised, the recipient feels alienated and often identifies with the role of the 'patient' as a result and that may also bring to learnt helplessness and hopelessness which are strong barriers to healing and rehabilitation (Laing, 1965; Carling, 1995 & Torrey, 1995).

The act of perceiving the client as invisible also projects on the disbelief toward ones condition. Much has been written in the literature about the nature of therapeutic disbelief toward an individual with chronic illness (Bowman, 1991; Thorne, 1993; Lovgren,

Engstorm & Norberg, 1996, as cited in Thorne, Nyhlin, & Paterson, 2000). Based on literature reports and the analysis by Thorne, Nyhlin & Paterson The attitudinal patterns of professionals toward individuals reinforce existing dysfunction within the health care relationship. Convincing a disbelieving professional of the seriousness of symptoms creates a context in which the client is viewed, and labeled as complaining, over anxious, or obsessed with the condition (Benner, 1994; Johansson et al, 1996; Malterud, 1992, 1993, as cited Thorne, Nyhlin & Paterson, 2000).

Studies continue to show the direct impact of unequal relationship on the feelings of the client. In a study measuring disagreement with general practitioners, groups 4 and 5 complaints were mainly based on poor care from the general practitioner. 10% of the disagreements within these groups (n=29) reported that they felt that the general practitioner didn't take them seriously. Other (12%) reported other forms of complaints such as feeling that the doctor is unsympathetic. The remaining disagreements were related to a rude approach toward the consumers (Annandale & Hunt, 1998).

Medicating over Dialoguing

Current progress in health care technology and research brought great knowledge and improvement in the life of consumers (Callahan, 1990; Spiro et al., 1993). Such advances gave also birth to a great dilemma in health care. With the biological etiology to illnesses there is the growing assumption that psychotropic interventions are the superior solution for curing an illness (Spiro, et al., 1993; Cousins, 1979, Adams, 1993 & Callahan, 1990). Actually Current research shows that a holism within health care approach as reinforcing better outcomes (Cousins, 1979; Adams, 1993 & Comer, 1998).

Second Barrier: Community lack of Acceptance

At the community level, negative attitudes have become structured into social pattern of segregation, discrimination, and lack of support for mental health services. For people with psychiatric disabilities, these attitudes may result in economic marginality, segregation and repeated relapse (Carling, 1995).

People whose lives have been disrupted by a psychiatric diagnosis and who lose their jobs, homes or status, as students will have great difficulty achieving these opportunities back once they were labeled (Carling, 1995). Since the attitudes are in the core level of society, community centers will have trouble seeing the potential for integration that lies within individual with psychiatric disabilities (Laing, 1967; Zipple et al., 1988).

Pattern of community discriminations can manifest themselves in the refusal of landlords to rent an apartment or to offer a job (Carling, 1995). The attitudes can also include minimizing leisure activities for people with psychiatric disabilities, such as insisting that the person with mental disability will use only certain facilities in certain hours in which the staff is present, or not inviting them to social gatherings after work (Carling, 1995).

Education: Discrimination in Among Students

A study led by Corrigan and Colleagues revealed an unequal treatment to ward people with several of disabilities (Corrigan et al, 2000). The Community college students (N=152) strongly stigmatize individuals with disabilities unequally; Students viewed people with psychosis, cocaine addictions and other psychiatric disabilities more negatively than people with physical disabilities (Corrigan et al, 2000).

This study strongly demonstrates that discrimination towards people with psychiatric disabilities is still a breathing process within community. Since community life offers less and less for individuals with mental illness, blame and avoidance become a reality for our clientele. A study done by Corrigan and colleagues has showed in a comprehensive study that the attitudes of avoidance and blame are strong towards people with cocaine addiction (0.74, 0.80). Blame and avoidance are also strong towards people with psychosis (0.82, 0.64). Such feelings demonstrate that attitudes of sort can be a significant contributor to the creation of a milieu that indulges inequalities and segregation in educational systems (Corrigan et al, 2000; Carling, 1995).

Community Social Dysfunction towards People with Mental Disabilities

Social dysfunction and loss of opportunities experienced by individuals with severe mental illness are greatly exacerbated by the societal stigma (Farina, 1998; Carling, 1995; Link, Cullen, Struening & Shtrout, 1989). Research suggests that employers are less likely to hire persons who are labeled mentally ill (Bordieri & Drehmer, 1987; Farina & Felner, 1973& Link, 1987). Inside the community people with mental illnesses have two options regards work: one is to remain unemployed and the other is having an entry level positions with low pay and little chance of advancement (Carling, 1995). At the employers level, some have false expectations related to the performance level of the person with psychiatric disability (Brown & Saura, 1996).

Third Barrier: Work related Issues

When coming to discuss the issue of Job termination few aspects should be considered, one comes from the Employers level, the other from the client domain (Becker et al., 1998; Cook, 1992). Studies report that many of the termination of jobs are the result of employers' initiation the employer (40%) in comparison to 14% that left the job themselves without another position (Fabian & Wiedefeld, 1989). Some explanations to consumer low tenure in jobs suggest that lack of proper attendance can be the cause (Lagomarcino, 1990 in Becker, 1998). That low attendance is doesn't exist within a vacuum since some

of it is related to client unsatisfactory job experience or poor employer accommodation (Becker, 1998). Becker's study shows that 58% of the terminations were due to problems in interpersonal relationships (Becker, 1998).

Conclusion

Successful community integration is strongly dependent upon true collaboration among professionals, community agents, and the state mental facilities. Inequalities in all forms, from the most innocent one (lack of education regarding what is mental illness) to the more severe one (observed discriminations in community, employment, and selective empathy by professionals) lay as barricades that may prevent individuals with mental illness in succeeding within their communities.

Suggestions might include better preparation former to integration. The preparations not only will involve enhancing social skills, and the life skills of people with mental illness but also will educate and enrich community agents with the knowledge prior to the clients' arrival to community. Even the most competent individual might fail when community agents instead of embracing the knowledge of the nature of the illness and care embraces the knowledge of old stereotypes and myths (Carling, 1995).

QRC, quality rehabilitation and counseling must involves better assessment and better interventions regarding vocational counseling in communities and in pre-employment services (such as supported employment). Such understanding is the conclusion that follows current research regarding job terminations among people with mental illnesses participating in supported employment programs (Becker et al, 1998; Cook, 1992; Bond & Dietzen, 1993).

Such terminations in jobs suggest that the clients were not prepared properly to employment. Bond & Dietzen (Bond & Dietzen, 1993) have found that consumers lacked job readiness. Cook (Cook, 1992) has found that consumers that terminated their job were unable to do job tasks. Such finding suggests that pre-employment programs must enhance skills in such consumers.

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The efficacy of music therapy in effecting behaviour change in persons with Cerebral Palsy

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Abstract

A music therapy program using specialised musical instruments specifically chosen to meet the individual needs of five persons with Cerebral Palsy, was implemented using a multiple baseline research design. An empirical evaluation revealed statistically significant changes in group behaviour following the introduction of the programme. Further statistical analysis using DMITSA 2.0 (Crosbie & Sharpley, 1991), a statistical programme specifically developed to analyse data from interrupted time-series designs, revealed statistically significant changes in the individual target behaviours of all five participants. The findings are discussed in relation to previous research.

Introduction

The efficacy of music therapy has been investigated with individuals with a wide range of disabilities, including for example: Autism (Wager, 2000), dementia (Korb, 1997), acute brain injury (Nayak et al., 2000), Parkinson's disease (Pacchetti et al., 2000), Alzheimer's disease (Aldridge, 1998), attachment disorder (Brotons & Pickett-Cooper, 1996; Burkhardt-Mramor, 1996), chronic schizophrenia (Zhang & Cuie, 1997), depression (Suzuki, 1998), and multiple sclerosis (Davis, 1998). The positive outcomes reported in the majority of these studies suggest that it is an efficacious treatment. Furthermore, a meta-analysis of 21 empirical studies which used music therapy as an intervention with a total of 336

participants with dementia, demonstrated that its effect was highly significant (Koger, Chapin, & Brotons, 1999). More recently, a review of clinical music therapy (see Tervo, 2001) provided additional support by showing how music, and in particular rock music, can give adolescents “the possibility to express, be in contact with and share among themselves feelings of anger, rage, grief, longing and psychological disintegration”.

Case studies appear to be the most frequently reported music therapy based interventions. For example, Burkhardt-Mramor (1996) reported that insight-oriented music psychotherapy addressed the attachment problems of an 11-year old male with a history of physical and emotional abuse. In an innovative music therapy study, Krueger (2000) incorporated the use of information technology with a 10th grade student with behavioural problems, to allow him to “eventually be able to focus on music making for 45 minute periods”. Music therapy has also been shown to be effective with older individuals. For example, Wager (2000) found music therapy was a “valuable on-going leisure activity” for a 36 year old male with autism and mental retardation, while Davis (1998) reported that music therapy created closer family bonds and improved psychosocial and spiritual well-being for a 48 year old male with multiple sclerosis.

Larger scale group evaluations of music therapy have also demonstrated its effectiveness as a treatment. For example, in one recent study (Pacchetti et al., 2000) weekly choral singing, voice exercises, and rhythmic and free body movements were used with a group of 16 individuals diagnosed with Parkinson’s disease. Improvements were subsequently noted in their emotional functions, daily living and quality of life. Similarly, other studies using music therapy intervention have demonstrated significant improvements in: the social interactions, mood and participation rates of groups of individuals with traumatic brain injury and stroke (Nayak et al., 2000); and emotional states of persons with schizophrenia (Zhang & Cuie, 1997). Reductions have also been shown to occur in the agitation behaviours associated with Alzheimer’s patients (Brotons & Pickett-Cooper, 1996), and in depressive symptoms in elderly adults (Suzuki, 1998) as a consequence of music therapy programs.

Although studies confirm the efficacy of music therapy as an intervention with a wide range of disabling conditions, it appears that limited studies utilise statistical analyses, and that of those which do, none to date appear to have utilised a time series approach. That is, pre and post test group data tend to be analysed, with no focus on the behaviour of individual participants over time. The present research sought to address this by implementing a multiple baseline research design and by using DMITSA 2.0 (Crosbie & Sharpley, 1991) to examine the efficacy of music therapy with individuals with Cerebral Palsy (CP). DMITSA 2.0 is a statistical programme specifically developed to analyse data from interrupted time-series designs. This programme allows tests of statistical significance to be made on data which have been collected over time and which may be divided into at least two sections (i.e., baseline and intervention).

In addition, the specific aims of the present research were to determine: (i) the effectiveness of music therapy with people with CP; and (ii) the suitability of matching specialised musical instruments on an individual basis in a music therapy program to achieve specific outcomes.

Method

Participants and setting

Five individuals (three males and two females) whose ages ranged from 20 to 45 years participated. All had received a clinical diagnosis of Cerebral Palsy (CP) by medical personal; the consequent degree of disability varied across the individuals. Of the five participants all were confined to wheelchairs with the exception of one female.

The study was undertaken at one residential hostel, which forms part of The Cerebral Palsy Association of Western Australia. One large room in the hostel was set aside without interruption for the duration of the study. All Musical Therapy sessions were conducted in this room by the first author.

Research Design

A multiple baseline research design across participants was used in the research. According to Barlow, Haynes, and Nelson (1986) the multiple baseline is probably one of the best designs available for practitioners. It does not require withdrawal, it is fairly simple, and applied opportunities for its use abound once systematic measures are being taken (Barlow, et al. 1986). All observations of participants undertaken during baseline and intervention phases were recorded on videotape. A frequency count was subsequently obtained for each participant's target behaviours per session. The convention used was that where continuous or repetitive behaviour occurred a tally of one was recorded. If there was a five-second break between the target behaviour(s) and then it was re-initiated it was counted as a new behaviour.

Baseline

As can be seen in Figure 1 the number of observations for each participant varied due to the nature of the research design. For Participant 1 there were five baseline observations, for Participant 2 eight, for Participant 3 ten, for Participant 4 fifteen, and for Participant 5 twenty. Each observation session was 45 minutes in length. Hence, the total amount of observation time varied for each participant, ranging from 3.75 hours (Participant 1) to 15 hours (Participant 5). During baseline participants were observed in their regular group activity of listening to the first author play his guitar and sing a selection of songs. Participants were then randomly assigned to the order in which they received the intervention.

Intervention

Following baseline observations the intervention phase comprising Music Therapy was introduced. Participants were provided with specific musical instruments commensurate with the activities required to remediate their inappropriate behaviour(s) (see Table 1). Observations, each of 45 minutes duration, continued as follows: Six 45 minute observations for Participant 1, eight for Participant 2, and 10 for Participants 3, 4 and 5. Thus the total amount of video recordings obtained during intervention ranged from 4.5 hours (Participant 1) to 7.5 hours (Participants 3, 4 and 5).

Table 1. Participant's target behaviour and specialist musical instrument used in the programme.

Participant	Behaviour	Target behaviour and instrument
1. Male 45 years Restricted movement in lower torso.	Reduced frequency of hand movements	Using a drum, beater and go go bells to increase hand movements.
2. Female 23 years Little movement in lower torso. Impaired communication.	Poor hand-eye co-ordination when using compic board to (tap) communicate with others	Using a Bungbun to facilitate specific downward hand movements in extended regular motion similar to skill required for compic board.
3. Male 28 years Doubling over at the chest which creates pressure on lungs and serious potential respiratory problems	Difficulty with hand-eye co-ordination. Failure to attain an upright posture (leading to possible respiratory problems).	Using a castanet to facilitate a definite movement backwards to an upright position, thus correcting posture.
4. Female 29 years Limited control over body movements particularly as excitement level increases.	Waving of arms and feet in an erratic uncontrolled manner.	Using bells with hands to perform controlled shaking motion and movement of feet to beat of music.

The Music Therapy Intervention Programme

The theme of the music therapy intervention program was emotions, specifically "happiness". The number of sessions varied across participants with the minimum number of sessions being six and the maximum 10. Each session, which attempted to encourage participants to use their instrument(s) to express happiness, began with the music therapist (first author) playing a bright melody on a guitar. Each 45-minute music therapy intervention session was divided into three movements or activities, each lasting 15 minutes. When an individual began the intervention phase the first 15 minutes involved the therapist

playing passive melodies to assist him/her to relax. The second 15 minutes introduced activities where he/she was encouraged to respond and participate either vocally or through hand movements (clapping etc.). The therapist stopped playing the guitar at specific points and moved into a phase which consisting of vocal type chanting and singing. The basis of this was percussive sounds to encourage variations in responses from the participant. In the final 15 minutes the individual used the chosen instrument fundamental to achieving their specific goal (refer to Table 1 for a description of the instruments assigned).

Procedure

Consent to participate was obtained from the relevant University Departmental committee, the Cerebral Palsy Hostel personnel, and from the participants themselves. For each session the therapist met with participants on a group basis. Once each participant's series of baseline observations had concluded the music therapy intervention was introduced. Individuals with lengthened baselines continued in the sessions but did not participate in the vocal and body movements (second 15 minutes) and use of musical instruments (final 15 minutes). Rather these individuals continued listening to the activities without active participation. All sessions were video recorded and these were viewed and scored by the therapist at a later date.

Inter-rater reliability

To establish the reliability of the therapist's observations a second person not involved in the research, but trained in the use of behavioral observation, viewed all of the video recorded sessions. When an instance of agreement occurred a tally was made and an identical procedure was followed with disagreements. The level of inter-rater reliability was calculated as the number of agreements divided by the number of agreements plus the number of disagreements. This value was then converted to a percentage. For this study the inter-rater reliability was calculated to be 97%

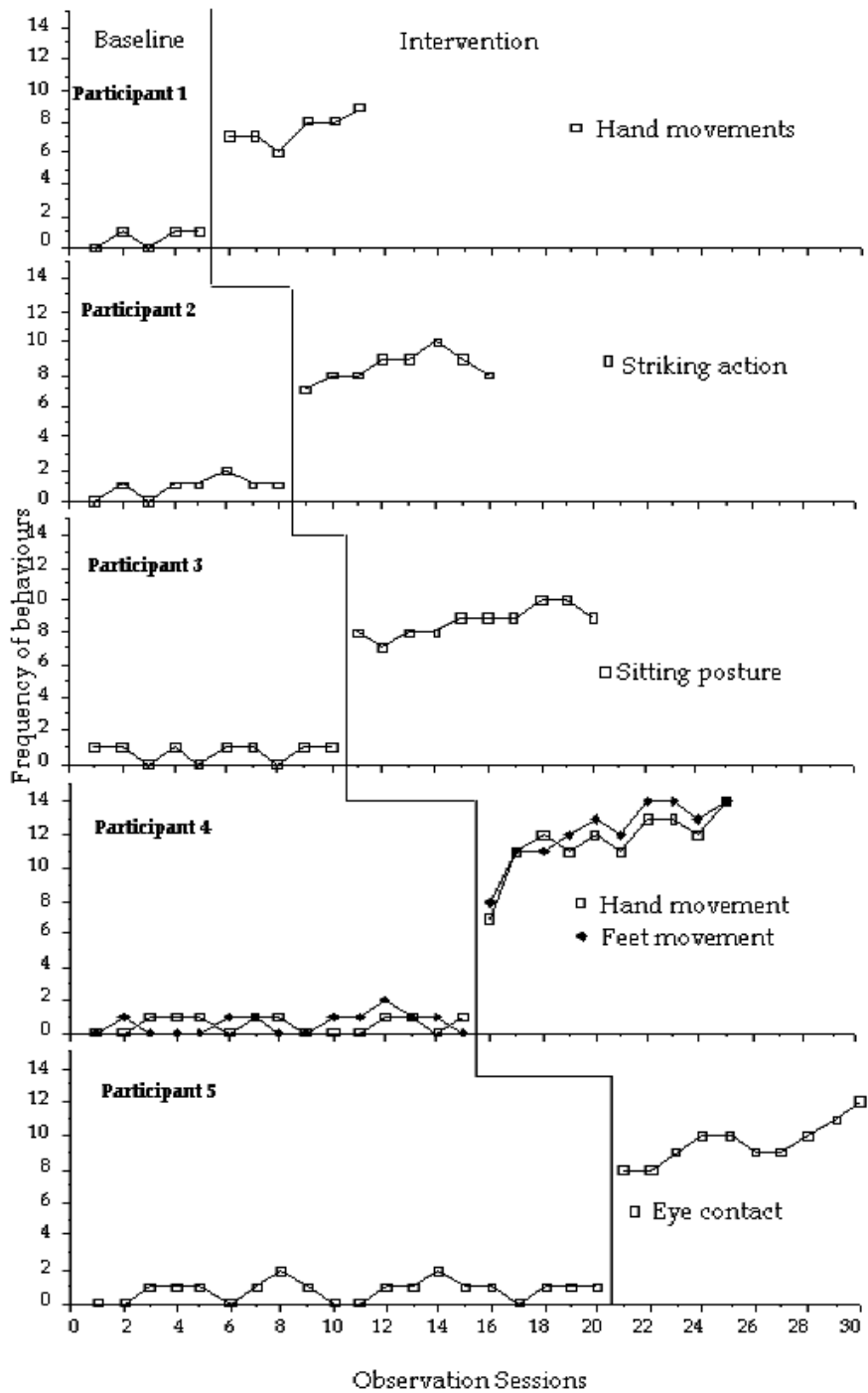
Statistical Analysis

Data were analysed in two ways. First, the Wilcoxon signed rank test was used to examine whether there was a significant increase in target behaviours from baseline to intervention. Second, data for individual participants were analysed using DMITSA 2.0 (Crosbie & Sharpley, 1991) which is a statistical programme specifically developed to analyse data from interrupted time-series designs. This programme allows tests of significance to be made on within-subject data which have been collected over time and which may be divided into at least two sections (i.e., baseline and intervention).

Results

As can be seen in Figure 1 the baseline trends for all five participants are relatively stable with the frequency of desired behaviour(s) being low (occurring between 0 and 2 instances per 45 minute session). This stability continued irrespective of the length of baseline. When the music therapy intervention was introduced the frequency of target behaviours appeared to increase for all participants since the trends depicting the frequency of behaviours are all ascending. It should be noted, however, that in the case of participants 2 and 3 there is some tentative evidence of a plateauing effect if not a descending trend in behaviour as the intervention continued.

Figure 1: Frequency of behaviours across baseline and intervention



In only three of the five 45 minute baseline sessions conducted for participant 1 was the target behavior (hand movement) observed and then only once in each session. Following the introduction of music therapy the frequency of hand movement increased to seven per session, culminating in nine in the final 45-minute period. Similarly, low frequencies of the target behaviours i.e., zero or 1 to 2, were recorded for participants 2 and 3 during baseline. An apparent increase in the frequency of the target behaviours appeared to occur following the introduction of music therapy. For participants 4 and 5 (participant 4 was observed for two desired behaviours i.e., hand and feet movement) there was an increase in target behaviours when music therapy was introduced (from 6 to 14 for participant 4, and from 8 to 12 for participant 5).

Statistical Analysis

The results of the Wilcoxon signed ranks test provided evidence to suggest that the mean ranks of the target behaviours from pre-intervention and post-intervention were not equivalent ($p = .028$). More specifically, there was a significant increase in observed target behaviours from pre- to post-intervention, with means of 0.75 and 9.62 respectively. This suggests a significant increase in the frequency of target behaviours for the group following the introduction of music as a therapy.

Individual Data

Data for each individual participant's target behaviour are presented in Table 2. As can be seen the frequency of target behaviour per minute was low for all participants during baseline. Participant 4's second behaviour (feet movement) was the least frequently occurring of all behaviours at .008 instances per minute. However, following the introduction of music therapy this behaviour exhibited the greatest increase in occurrence rising to .296 instances per minute. The DMITSA analysis, which is shown in Table 2, indicated that there was a significant increase in the frequency of all participants target behaviours.

Table 2. Frequency of individual's target behaviours across baseline and intervention mean rates per minute

Participant	Baseline mean rate/minute	Intervention mean rate/minute	F DMITSA	p
1.	.022	.167	13.887	$p < .009$
2.	.019	.189	32.511	$p < .001$
3.	.015	.193	109.702	$p < .001$
4i	.013	.175	41.845	$p < .001$
4ii	.008	.296	51.149	$p < .001$
5	.017	.213	49.280	$p < .001$

Discussion

The results of this research provide support for the efficacy of music therapy in bringing about significant changes in specific behaviours of persons with Cerebral Palsy, a disability which has yet to be reported in the music therapy evaluation literature. This provides additional support to the current evidence pertaining to a range of disabilities (e.g., Autism, dementia, acute brain injury, Parkinson's disease, Alzheimer's disease, attachment disorder, chronic schizophrenia, Depression, Down's Syndrome, and multiple sclerosis).

Unlike previous research the present study analysed data on each individual's behaviour change over time, in addition to that of group change. Overall, there were significant changes in group behavior and in the behavior of all participating individuals following the introduction of Music Therapy. This provides

support to previous research which has adopted a case study approach (e.g., Burkhardt-Mramor, 1996; Wager, 2000; and Davis, 1998), or has involved group evaluations (e.g., Pacchetti et al., 2000; Nayak et al., 2000; Brotons & Pickett-Cooper, 1996; and Suzuki, 1998).

The therapist in the present study carefully matched the target behaviour(s) of each individual with a central program theme (emotions, with an emphasis on happiness) and to specialised musical instruments to increase the likelihood of specific outcomes (i.e., behaviour change) being achieved. That this approach was effective in changing a range of target behaviours (e.g., hand eye coordination, head movements, and torso position) provides strong evidence of the importance of program planning. It should be noted, however, that the therapist in the study was very experienced and conversant with the variety of instruments utilised. Furthermore, the combination of musical skills, therapy skills and personal relating skills he used enhanced the success of the program. Inexperienced music therapists or therapists with excellent therapy based skills, but limited knowledge of such specialist instruments, may not be so successful.

At the conclusion of the program the participants communicated to the therapist that the approach adopted was very important because it allowed them to be more fully involved and to achieve the targets set. The participants also communicated that the length of the music therapy sessions and the intervention itself were slightly too long, and that at times participation became arduous. Future interventions should therefore address this issue.

In conclusion, the present research adds further support for the effectiveness of music therapy in bringing about significant changes in the behaviour of persons with a disability, in this case Cerebral Palsy.

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Pain and Disability: The Personal Experiences of a Clinical Psychologist

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Abstract:

The author presents a personal account of his experiences with physical disability. In addition to the problems of pain and adapting to limited life style, and any psychological problems like depression that this could bring, the experiences present insight on the medical treatment provided. In sum, the medical treatment was often inadequate, and frequently failed to deal with anything other than the direct symptom. Psychological issues and secondary physical problems were mostly ignored.

Introduction

For the past several years I have often experienced daily pain. Bad pain. Pain like I have never experienced before. It is the result of having lumbar spinal stenosis, in which my spinal canal is shrinking or not being properly protected any more. I also have spondylosis, which, as I understand it, is cracks, degeneration, or bony ridges on the spine. This is my story of how I did not know what was causing the pain, how the medical doctors helped some, but not nearly enough, and how I have learned to cope with it all. I am an academic clinical psychologist, teaching in various universities, and my psychology insights have helped a lot. Also, ironically, years ago, for three years I had yearly \$100,000 federal research grants, to study prejudiced attitudes toward the physically disabled. My knowledge of how people look at the physically disabled has also helped me cope with my own disability. Physical problems can be intimately related to psychological problems such as anxiety, depression, and others (Crystal, Watanabe, & Chen, 1999; Dew, Switzer, & DiMartini, 1998; Dohrenwend, 1998; Lanyon & Goodstein, 1997; Rodin, Craven, & Littlefield, 1991). How we deal with the physical problems relates to how well our psychological adjustment is going to be.

This article tells how I have dealt with disability and terrible pain. Also, I think it serves as a condemnation of the medical treatment I have received, or, more properly, did not receive. As

a result of my experiences, people experiencing pain or disability can be forewarned about what to expect. And, medical doctors can learn that more needs to be done for the patient.

In Louisiana: Exercise Always Hurts

About the time I turned 54 years old, in 1994, I was living in Louisiana, and a strange thing happened. Exercise always hurt. At that time I was undiagnosed with any disability, but in retrospect, I can see that the effects were starting to show. But, I had no understanding of what was occurring. I only knew that every time I did any exercise, no matter how gradually I did it, I experienced pain. As a youth, I had been on the baseball team in high school and on the tennis team in college. I love sports, although with age I was becoming more of an observer than a participant. But, I still did some exercise on occasion: sit-ups, push-ups, bending down to touch toes, walking, and my beloved tennis. I went to my doctor, who gave me a paper with different back exercises. Most of my physical pain was in my back and legs. I did some of the exercises, but not most of them. For some reason, I was not motivated to perform the exercises.

One day was the last day I ever played tennis. When I got home after playing, my back hurt incredibly, and I could not move enough to get out of my car. I wondered, "How am I going to be able to get out of my car and get into my house?" Eventually, I was able to move enough to get to my house. I went to a doctor, who put a heat pad on my back. That reduced the symptoms. But, I never played tennis again.

Shortly before leaving Louisiana to move to a new college job in Kentucky, I started a program of walking. I did it incredibly gradually, walking 5 minutes the first day, then 7 minutes the next day, then 10, etc. I finally got up to walking for an hour. But, then my legs started hurting so bad I had to give up walking. I got to the point that I gave up all exercise. There seemed no point to cause myself pain, which exercise was always doing. Already overweight, I probably have gained about 20 more pounds since I stopped all exercise.

I Am Diagnosed in Kentucky

In Kentucky, my back and leg pain increased. I called a doctor's office for an appointment. They asked about insurance. I checked and saw that my insurance from my new job would not kick in until two weeks later, when the semester began. My dilemma was to wait two weeks, enduring the pain, and be covered, or go right away and have to pay from my own money, but perhaps get relief from the pain. I decided that because of the pain, it was not worth waiting, so I went right away. They x-rayed my back in various places, but found nothing. So, I had to pay, but got no diagnosis or relief.

Months later, as the pain increased, my regular doctor arranged for two diagnostic procedures to be performed on me. One was an ultrasound, to see if the very structure of some things in my body were off. They were, I was later to find out, but the ultrasound was negative. Nothing was discovered. Next, I was sent to a specialist to see if I had problems with nerve conduction. He tested this by inserting needles into the bottom of my feet, into my legs, and into my buttocks. Then, he sent electricity into my body, and got recordings of the nerve conduction. I read that it was not a painful procedure, and the nurse told me, in response to my question, that it was not painful. Wrong! It was incredibly painful. The needles were only inserted a little and did not hurt, but the electrical stimulation was either painful or extremely painful. When it was extremely painful I felt as if I was being burned, for several

seconds at a time. The doctor concluded that I did have nerve conduction problems, especially in my left leg. I felt that I was better prepared to endure torture, should it ever occur. At this point, despite the positive findings of nerve conduction deficits, there was no recommendation for treatment or for medication. Instead, I got referred to a neurosurgeon.

I went to the neurosurgeon's office only once, where I had to wait for what I think was two hours before I was seen. He asked me questions about my condition, had me bend over and try to touch my toes (which I could no longer do), and came up with a diagnosis: lumbar spinal stenosis. He said the protective covering for my spinal canal was eroded or eroding. The only proper treatment, he said, was a back operation. I was resistant to a back operation. I had heard bad things from people about back operations. When I lived in Louisiana, there was a national television news program on people in the city in which I lived, who had undergone back operations, using a new procedure, and were now suing. Instead of the operation making them better, it was alleged that they now had horrible, daily pain. The neurosurgeon said my condition was progressive, that it would only get worse. I remained adamant about not wanting a back operation. He said of my position "It is like being tortured with thumb screws. At first, you refuse to talk. But, as they make the thumb screws tighter and tighter, eventually you give in and talk." He was telling me that as my condition got worse and worse, I would eventually agree to an operation. Only recently have I seen evidence that he is incorrect. A recent newsletter report from the Mayo Clinic says that research shows that 70% of people with spinal stenosis (as they refer to it) remained the same after five years, not getting better or worse. Fifteen percent got better, and fifteen percent got worse.

So, I believe I may have been misled by my neurosurgeon about the need for an operation. I once read that if you give a child a hammer, the child discovers that everything needs hammering. Perhaps it is the case that if you give someone neurosurgeon training, they believe everything requires an operation. Also, advocating an operation does two things for the surgeon: 1. It protects him from legal consequences if a person get worse and sues, saying that an operation should have been recommended; and 2. As a medical doctor friend pointed out to me, doing surgery provides big surgical bucks. This medical doctor advised me not to have an operation on my knee years ago, when I injured it, but told me that if I went to a surgeon, I would be told to have an operation. I followed his advice and did not have an operation and, years later, the knee seems fine.

The neurosurgeon did do one wonderful thing for me. He prescribed Celebrex. This had done wonders in reducing my pain. It does not eliminate the pain, and if I have to walk any distance at all the pain is there. Shopping is especially bad, perhaps because I do more walking in a store than I would otherwise do. At times, I am bent over in pain in the checkout line. But, for most parts of everyday life, the Celebrex, which I take only once a day, in the morning when I get up, has reduced the pain. Another thing he did was have me get a lumbar MRI. He was going to use this, I think, as further evidence to get me to consent to an operation. But, after the lumbar MRI was performed and the report written, I got a call from one of the neurosurgeon's nurses, who told me "The doctor says you do not have to have an operation. Just keep taking the Celebrex." I never knew if this was because he knew I would not consent to an operation, or if the lumbar MRI showed less damage than he expected. Or, some combination of the two.

Life in Texas

This neurosurgeon is very busy, and difficult to contact. After I moved to Texas for a new university job, I needed a report from him to justify my getting a campus handicapped parking sticker, and a state of Texas handicapped license plate. A colleague had recommended to me that I get a campus handicapped-parking sticker, since the regular parking spaces are often full. And, since almost any walking is painful for me, I was unable to go anywhere on the campus, unless I could drive there and park. I tried walking, both for exercise and to see if I could do it. I could only do it if I was willing to experience great pain. So, I almost never went to the library, the school cafeteria, or any of the other places on campus. But, it had not occurred to me to apply for a handicapped sticker, since I do not mainly think of myself as physically disabled. It is just not a main part of my self-concept, except when I stop and think about it, as in writing this article, or when I want to do something but cannot. However, I usually am not thinking "I am physically disabled."

In one case, when I walked to the Student Health Center to show the nurses my lumbar MRI report, in order to get the campus handicapped sticker, I almost passed out from heat stroke. I suspect I do not walk as easily as most people, since walking puts unusual demands on my body. I have not only the stress on a body that is overweight and has not had much recent walking or exercise, but also the stress of a body that is not responding normally to the demands of walking. I once tried to run, but was unable to get my body to respond. So, I left phone messages at the neurosurgeon's office about needing a statement that I had lumbar spinal stenosis, but never received anything, not even a return phone call from a nurse.

Fortunately, I had a photocopy of the lumbar MRI report that said I had lumbar spinal stenosis and spondylosis. This was good enough for the campus handicapped sticker, but after waiting in line for the state of Texas (which is very difficult for me; I have to lean over onto a lectern when I teach, or sit in a chair), they said I needed an original note from my doctor. Since I have a local doctor, I asked her to write such a statement. But, she said she wanted the original x-rays and documents, before she could write such a statement. So, I was back to speaking to a nurse for the neurosurgeon, who, some days later, told me that the neurosurgeon's office did not want to send the materials to my doctor. Fortunately for me, my local doctor was, under the circumstances, willing to write a statement based on the lumbar MRI report. I got the Texas handicapped license plate, which was require to extend my campus handicapped-parking permit, which was expiring in couple of days.

Secondary Symptoms

I think a lot of my pain may be secondary symptoms. I have the main problems of lumbar spinal stenosis and spondylosis. But, as a result, my body does things to cope, and ends up with more problems. Most of the leg pain is in my right leg, so, without realizing it, I tend to lean to the left. Perhaps as a result of that, I have had horrible pain in the front of my right thigh. Or, perhaps the right thigh pain is what causes me to lean to the left. In any case, I asked my local doctor if something could be done to help treat the pain in my thigh. At times I have terrible back pain, but the pain that is there

everyday is the pain in my right thigh. She said nothing could be done. She also said an operation on my back would not be fruitful. She implied that I have these conditions and will just have to live with them.

I suspect that some of my problems are secondary to the original physiological problems. But, no doctor seems willing even to address such secondary possibilities. For that matter, no medical doctor has addressed any of the psychological problems that are sure to occur with physical disability and pain, such as anxiety and depression. Fortunately, I am a clinical psychologist and have a good understanding of these issues. But, what if I were not? My doctors do not avoid dealing with anxiety and depression because I am a clinical psychologist. They just do not deal with them because they do not see the big picture, or do not see themselves as having a role in the big picture. So, secondary physical problems are not even considered, nor are anxiety or depression.

Getting Better

In the last two months, my pain has been greatly diminished. I even wondered if I could go for a walk, which I never do any more. But, the other day, while shopping, both my legs felt like they were "falling asleep" and I felt that one or both of my legs might not support me. The same old feelings back again. By the time I was in the checkout line, my legs were hurting, and I was hoping the line would move swiftly, so I could get to my car and sit down. However, for the most part, I experience much less daily pain than I used to. Could I be one of the 15% of people in the Mayo Clinic report who actually get better over time? I sure hope so.

I have experienced the anxiety of fearing how much pain I will endure, and the depression of knowing that lots of things I used to do are no longer available to me. But, I have dealt with them as well as could be expected. I am surprised how little I feel sorry for myself. I would think that having such major changes in one's life, including daily pain, would damage one more than it has. I just cope with what has to be coped with, whether it is getting out of bed slowly in the morning when I feel pain in my back, or not doing things I used to do because they will cause intense pain, or experiencing daily, intense pain. I do not say "Why me?" or feel sorry for myself. What has happened is horrible, but dwelling on that does no good, whatsoever. I have a disability and physical pain. I try to make the best of it. Perhaps writing this article will help others who suffer, and will provide people who do treatment a better understanding of the need to treat the whole person.

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The role of empathy in quality therapeutic Engagement for increasing motivation for change in schizophrenia

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Abstract

The traditional scientific paradigm in the helping professions of counseling, psychology and medicine emphasized the importance of therapeutic neutrality. Significant proportion of graduate training programs in psychology and counseling are founded on the scientist-practitioner model, known as the Boulder Model. Science has enriched our lives as practitioners but has also created an evident side effect in the form of a moral paradox. In that educational process analytical and cognitive skills have relegated the human aspects behind the delivery of care to a secondary role. The current article will explore the core condition of empathy as manifested in client- helper dialogue in the case of schizophrenia. Contemporary trends in health delivery for individuals with borderline personality disorder and schizophrenia will be explored for clarifying unfortunate therapeutic trend. The article will demonstrate therapeutic change as related to deep empathic engagements, which will provide evidence on the vitality of empathy in change, healing, and recovery.

Introduction

Science is a way of understanding the world around us. Scientific processes are done through the establishment of knowledge regarding phenomena's (Kazdin, 1998). A significant proportion of graduate training programs in psychology and counseling are founded on the scientist-practitioner model, known as the Boulder Model (Dellario, 1996). Our infatuation with knowledge and science has prioritized the delivery of a compassionate care over values such as neutrality and objectivity (Spiro, 1993; Jordan, 2000).

The promise of instrumental control given by scientific knowledge serves as a paradox to the etiquette of care and can become a blind passion (Lewin, 1996). In others a words, Western knowledge lays it's foundations on Baconian notions of mastery over nature, objectification of the known, instrumentally; ironically these notions stands in contrast with other epistemologies that rely more on knowing through joining, through a compassionate unity of empathic care (Keller, 1985 cited in Jordan, 2000).

Seventeenth century science had attracted the brilliant minds in the industrialized age up to this day. Today however, centuries later, we have found ourselves in the need for a new science, the need for a humanistic science of man as a foundation for the applied science and art of social reconstruction (Fromm, 1976; Krishnamurti, 2000).

The current essay is an attempt to explore, clarify and demonstrate the significance of mutual empathy as a component in relationship enhancement and therapeutic change. The main aim of the current attempt is to increase awareness to current trends in health care education and the clinical practice that follows.

The art of care and the crisis

Hippocrates counseled: “ for where there is the love of man, there is also love of the art. For some patients, though conscious that their position is perilous, recover their health simply through their contentment with the physician” (Hippocrates cited in Lown, 1996, pp. 3). The patient, the client, as a recipient of our care can grow immensely by being able to see, know and feel that the counselor/ therapist is being touched by him/ her (Jordan, 2000).

However there is an enormous discrepancy between the ideal and the real. There is a growing literature of consumers as well as practitioners who report a failure in the caring –empathic dimension (Laing, 1965; Green, 1964; Sheehan, 1983; Lewin, 1996; Lown, 1996 & Michener, 1998).

Relational therapy as well as social phenomenology has dedicated their efforts to understand the nature of therapeutic connection/disconnection (Laing, 1967; Miller & Stiver, 1997 as cited in Jordan, 2000). Disconnections are ubiquitous; people misunderstand one another, fail one another empathically. However, if mutual empathy is not met in relationship the disconnection from acute will become chronic, and the therapeutic relationship will lose their authenticity, vitality and eventually effectiveness (Jordan, 2000).

The nature of empathy

The word empathy entered the English vocabulary as a translation, after the Greek *ematheia*, of the German *Einführung*, a word brought into being by Lipps’ as he discusses aesthetic experience (Spiro, 1993). Empathy is phenomenological state that stands in contrast to other “scientific” observational knowledge.

Empathy has two faces: the esthetic and the personal (Gauss, 1973 as cited in Spiro, 1993). On the esthetic dimension empathy is visual. The physician visually observes the symptoms, and the pain of the consumer. The personal dimension is however more than just knowing what we see. Empathy is a vicarious experience in which the empathizer ‘tastes’ the recipients’ experience (Zderad, 1969 as cited in Spiro, 1993). As the empathy process occurs the person who empathizes, abandons himself temporarily; he relives in himself the emotions of another person (Ehmann, 1971). Empathy is a bridge from the objective to the subjective (Katz, 1963). Empathy requires living as well as knowing. If sympathy requires compassion, empathy adds to the formula also passion.

In the therapeutic arena empathy becomes a crucial elements behind the wheels of self-growth, recovery and change (Rogers, 1951, 1961; Miller & Rollnick, 1991).

Client centered therapy research indicate that therapists attitudes rather than their knowledge, theories, or techniques facilitate and personality change in the client (Rogers,

1951, 1961 as cited in Corey, 1996). Empathy as a vital component of the Rogerian approach is an active, synchronized and continuous process (Rogers, 1951).

Pathways to therapeutic change

The major responsible ingredient in determining whether therapeutic change has occurred is the quality of Helper-Client relationship (Frank, 1961 as cited in Kanfer & Goldstein, 1983). Even psychotropic interventions have been shown to serve their purpose efficiently, as better rapport has been established (Kanfer & Goldstein, 1983; Torrey, 1995).

On the other end of the paradigm of change stands resistance to change, or non-compliance (Miller & Rollnick, 1991). Resistance to change often occurs when the clients feels, or perceive the caregiver as a formal, 'cold', unconnected agent (Laing, 1965; Patch, 1993; Carling, 1995).

Non-compliance is an evident phenomenon in Schizophrenia for example. Many Individuals who live with the diagnosis of Schizophrenia neither recover nor improve (Modrow, 1996). Studies show that 70% of the clients who live with the diagnosis of Schizophrenia are noncompliant with medication treatment. Torreys' last explanation of the therapeutic noncompliance was doctor-patient relationships (Torrey, 1995).

Borderline personality disorder and Schizophrenia offer health professionals great deal of challenge due to their unusual or even disruptive behavioral pattern (Laing, 1965; Spiro, 1993; Nehls, 1999).

Contemporary trends in the treatment of BPD

The major characteristic of BPD is unstable self, major mood swings, and impulsivity. Many that hold that diagnosis are engaging in self- mutilation and suicide (Margo & Newman, 1989 as cited in Comer, 1998). The combination of these symptoms makes relationship unstable (Barrat & Stanford, 1996 as cited in Comer, 1998)

Individuals with borderline personality disorder are often viewed not only as challenging but also as a burden (Nehls, 1999). Nurses have expressed less empathy to ward people with BPD than towards persons with schizophrenia (Gallop, Lancee, & Garfinkel, 1989 as cited in Nehls, 1999). The emotional expression of pain was aggravating health providers causing a misperception of self-mutilation as a way of the consumer to seek control or attention (Nehls, 1999).

Contemporary trends of care in the treatment of Schizophrenia

Schizophrenia is another condition challenging current health providers due to the variety of non-normative nature of its symptoms (Laing, 1965, 1967; Provencher & Mueser, 1997). Selective empathy was recognized as one of the misfortunes some physicians possess (Spiro, 1993). Selective empathy for example could be easily recognized when the same physician gives empathic care to a person with physical condition and less of it to the person with Schizophrenia, Anxiety disorders or Obsessive-compulsive disorders (Spiro, 1993).

Learning how to listen to issues involved in psychotic states have been perhaps the most difficult challenges psychoanalysts have ever had (Hedges, 1996). In that challenging condition only few therapists with unique amount of patience and skills would show success in the therapeutic process. They also stated that building close relationship with the individual, that had Schizophrenia, is essential to psychotherapy (Fromm-Reichmann, 1950; Sullivan, 1962).

When change occurs

Joan's case as presented by Laing offers valuable information regarding therapeutic engagement with the client (Laing, 1965). Laing view of the therapeutic engagement is that the therapist must allow the pieces come together. In that process of engagement the therapist's love for the wholeness of the client, an acceptance of the client's being is vital to the therapeutic process (Laing, 1965)

In the initial encounter with the psychiatrist Joan reported that his attempt to focus mainly on the schizophrenic symptoms (Hallucinations and delusions) simply caused her to continue with the mixed speech. When meeting a person that really cared, Joan's feelings of alienation, and being lost slowly disappeared (Laing, 1965).

At one point Joan revealed the mere essence in which empathy operates, this time through the eyes of a patient that yearns for care: " Meeting you made me feel like a traveler who's been lost in a land where no one speaks his language. Worst of all, the traveler doesn't even know where he is going. He feels completely lost and helpless and alone. Then suddenly, he meets a stranger who can speak English. Even if the stranger doesn't know the way to go, it feels so much better to be able to share the problem with someone, to have him understand how badly you feel. If you are not alone, you don't feel hopeless anymore" (Laing, 1965, pp. 165).

Empathy is the antidote to loneliness and alienation. Joan stopped feeling alone, there was somebody there, feeling her pain as both walk the path toward healing. Even though she regarded the helper as a 'stranger' she still allowed a room for 'the traveler', the therapist, in her home and as Harris puts it, empathy is "a feeling of being at home with the object contemplated", as a friend (Harris cited in Hogenson, 1981, pp. 69). At that point the therapist have succeeded to enter Joan's realm of illness, her home, with the golden key of empathy.

Jung has gone further in describing the power that lies behind empathic therapeutic engagement. Jung's statement that the schizophrenic ceases to be schizophrenic when he meets somebody by whom he feels understood best describes the quality effect of truthful empathic relationship (Jung as cited in Laing, 1965).

Discussion

Hannah Greens' portrayal of Deborah whom was diagnosed with schizophrenia describes 'schizophrenia' as an agent that provided release and relief from normality. When the psychosis occurred green was sent to the child psychiatrist, but her condition got worsen. After her third session Deborah said:" am I not what you wanted? Do you have to correct my brain too?"(Green, 1964, pp.39).

Deborah's feelings reflect on a condition treated behaviorally with disregard to experience. There is an obvious division between the psychiatrist and Deborah. This division is a product of an exhibited sympathy of 'I wants to help you' versus a needed Empathy of 'I am you'. Therapeutic communication that is based on behavior alone without a regard to the client inner-experiences may perpetuate the illness in which it supposes to treat (Laing, 1967).

When Conditions of deep empathic and compassionate care are authentically embraced and applied by health practitioners a climate of change and self-actualization will be created (Laing,

1965, 1967; Rogers, 1951, 1961). But Empathy must remain an authentic state of symbiosis between the professional and his client, when it's becoming a technique for rapport building, when empathy becomes as Jordan's says a way of knowing, the component of love evaporates from it (Jordan, 2000).

Dr. Frankl, the father of logotherapy, announced in the conclusion for 'Man's search for meaning': "love is the only way to grasp another human being in the innermost core of his personality. No one can become fully aware of the very essence of another human being unless he loves him. By his love he is enabled to see the essential traits and features in the beloved person; and even more, he sees that which is a potential in him, which is not yet actualized but yet ought to be actualized. Furthermore, by his love the loving person enables the beloved person to actualize these potentialities (Frankl, 1984, pp. 116).

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This article is dedicated to Pedro, may our roads be crossed again.

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Intimacy in People with Chronic Pain

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Abstract

One of the major problems of people with pain is a decrease in intimacy. Intimacy can be defined as a reciprocal relationship in which innermost thoughts and feelings are shared. This is different than nurturance, which implies one person being dependent on another. Intimacy is here conceived of as an egalitarian relationship. Nurses would seem especially well-trained to engage in intimacy-fostering interactions with patients. This can be especially helpful to pain patients, whose pain often results in others backing away from them, or in the person with pain withdrawing from others. The loss of intimacy is thus a further burden to the pain patient, in addition to the already negative realities of pain.

Background

Meeting the human need for intimacy is particularly difficult for people who experience chronic pain, whether or not that pain results from a terminal disease. In a classic study, LeShan [1] reported that persons with chronic pain live in a universe comparable to a nightmare where (a) terrible things are being done to the person and worse are threatened; (b) other people or forces are in control; and (c) there is no time limit, no predictable end. Studies of people with chronic pain support the aptness of this analogy. How, then, can someone who inhabits this alien universe of

chronic pain begin and sustain intimate interpersonal relationships, whose essence is trusting self-disclosure to someone we expect will understand and accept us [2].

Discussion

Personal Experiences With Pain

The third author has undergone a major lifestyle change since becoming physically disabled with lumbar spinal stenosis and spondylosis. Not only has diagnosis and treatment often been inadequate, but when it occurs it is often limited only to the main disorder, and takes no account of the secondary physical symptoms which come from walking in an awkward fashion, or of the psychological issues of depression and anxiety that a major disability brings [3]. Some do get good treatment for pain, especially if they go to a hospital where pain issues are paramount. For example, Comley and DeMeyer [4] found over 90% satisfaction with the pain treatment received at Baylor University Medical Center, which tries to follow the pain guidelines of the American Pain Society and of the Agency for Health Care Policy and Research. But most people probably do not receive adequate diagnosis or treatment for pain, so in the real world, pain treatment is often inadequate [5].

The Role of the Nurse

Nurses would seem to be especially suited to work with patients experiencing pain. Nurses are educated to "listen altruistically" [6]. Nurses are also educated for privileged intimacy governed by professional ethics. And how can someone with chronic pain endure life without interpersonal intimacy? The loss of interpersonal intimacy is a major lifestyle change, which most professionals never address. The nurse is in a position, based on the nature of the nurse's job and the skills possessed, to help pain patients, regarding problems of intimacy. The mutual exchange of ideas and feelings can result in a person feeling greater dignity and respect [7].

Intimacy

Intimacy can be distinguished from nurturance, which involves care taking and implies dependency. In contrast, intimacy is a reciprocal relationship through which one person wishes to know another's inner life and to share one's own [8]. In Maslow's original hierarchy of human needs, intimacy can be seen as an aspect of the need for affiliation- to love and belong [9]. In Maslow's later revision of the hierarchy, intimacy can also be inferred as an aspect of the higher level need for growth [10].

Intimacy and self-disclosure have been seen to be an integral part of human psychological wellness according to Shaughnessy [11] and a major aspect of human growth and development according to Shakesby and Shaughnessy [12], and as part of the human experience. The quest for and celebration of, intimacy, is a major theme in classical and contemporary literature and the arts. Intimacy can include such areas as sexual or emotional, and they may stand alone as areas or are mixed together [13].

The human expression of intimacy is varied and complex, including bold behaviors as well as subtle nuances in speaking or being silent with another person, looking at or away from them, touching them during the ordinary routines of the day or the more intense times of romance and sexual passion. We have known for decades that infants who are not touched, fail to thrive and elderly people tell us how they miss being touched by cherished ones no longer

alive, and by the people currently in their lives who only touch those fitting the youth-oriented cultural norms of beauty. Frankl [14] has indicated that "in the impersonal climate of industrial society, even more people obviously suffer from a sense of loneliness- the loneliness of the "lonely crowd". Understandably the intense wish emerges to compensate for this lack of warmth to compensate for it with closeness.

People cry for intimacy" (p.72) And when is this cry for intimacy most apparent? When people are suffering and are in relentless and unremitting pain. For some their pain is simply the day to day aches and stiffness in the joints. For others, it may be cancer and for others it may be on going migraine headaches and arthritis. In whatever scenario, people do not want to feel alone and isolated and lonely. They would prefer human contact and warmth and understanding and self disclosure. And what may be most horrible is not to have a person with which to share their pain and, for those who are dying, to have no one to share their last moments on this earth. Here is an example from Frankl [14]

" for half a year my very dear father was seriously ill with cancer. The last three months of his life he lived in my house—looked after by my beloved wife and myself. What I really want to tell you is that those three months were the most blessed time in the lives of my wife and me. Being a doctor and a nurse , of course, we had the resources to cope with everything, but I shall never in my life forget all the evenings when I read him sentences from your book. He knew for three months that his illness was fatal...but he never had a complaint. Until his last evening I kept telling him how happy we were that we could experience this close contact for those last weeks, and how poor we would have been if he had just died from a heart attack lasting a few seconds. Now I have not only read about these things, I have experienced them, so I can only hope that I shall be able to meet fate in the same way my father did"

In this example, the father was able to share his last moments on earth surrounded by those who cared for him and loved it.

No Family, Just the Hospital Staff

Sadly, in our current society, with the breakdown of the family unit, individuals are not always surrounded by loving family members, but I.C.U. nurses and orderlies. And it is to these individuals that many people in pain turn. For example, the third author has been advised by his cardiologist to receive cardiac catheterization, as an assessment procedure to check for possible problems. He has no family in the state that he can be with, or who can take him to or from the hospital. So, he will go to and from the hospital in a taxi, since he was told he cannot drive after the procedure. The only people he can turn to for support will be the hospital staff on duty when he undergoes the procedure.

Chronic Pain

The International Association of the Study of Pain defines pain as " an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" [15]. Pain is generally classified on its physiological basis as nociceptive or neuropathic. But, practically speaking, we typically take the person's word for

it: pain is
whenever a person reports being in pain.

Chronic pain is a major health problem affecting a large number of the U.S. population and literally millions around the globe. "Chronic" is defined as pain which persists over time, and experts differ in citing the amount of time, usually one to six or more months since the onset of pain, according to Bral [16]. The chronicity of pain is linked with the concept of suffering which

includes (a) threats to one's integrity, one's wholeness; (b) predominance of negative emotions such as fear; (c) overwhelming helplessness and decreased ability to cope, partly because resources are depleted by the very persistence of the pain; and (d) accumulated losses including appearance, way of life and quality of life [15].

The loss of intimacy is central to a decreased quality of life. There is no way of telling how much the diminished emotional support contributes to premature mortality. Those in the family become irritated by the constant complaining of pain from the family member. The spouse or significant other is constantly hearing about the type of pain, where the pain is occurring, and how they are attempting to cope with the pain. Some family or friends become desensitized to the pain, and consequently tend to ignore the person in pain and their requests for attention, or support or analgesics. Children often avoid parents in chronic pain as they are no longer the loving, tender and nurturing individuals they once were, and may even vent their frustrations and anger on the children. They may be less able to tolerate noise, discomfort or even the presence of children.

One major and dismal consequence of living in a chronic pain universe is increased personal and social isolation which further decreases the potential for intimacy [17]. Chronic pain is often "invisible" to others. This leaves the person in chronic pain with a unique dilemma when attempting an intimate relationship: " How can I convey the realities of my pain to this other person without frightening them away, or trapping them with me in this universe of pain?" In addition, physical disability is a threat to the person's usual behaviors, including sex role behaviors. The sense of oneself as a man or a woman may be negatively impacted by pain or other disability, that makes usual life activities difficult or impossible [18].

Also, as with any disability, others may not know how to react. People sometimes fear that they might appear too solicitous if they offer help. On the other hand, they may also not know what to do to help, and fear seeming foolish if they offer help, or callous if they do not offer the right kind of help. So, the problem is resolved by avoiding the deviant person [19], in this case the person in pain.

Finally, chronic pain constrains the expression of intimacy in many activities including sex. Schlesinger [17] reporting on her in depth interviews with 28 women in chronic pain, elicited (a) client's and/or partner's fear's of increasing pain; (b) varying amounts of willingness to learn non-painful/less painful intimate behaviors; and (c) the "dampening " effects of chronic pain on sexual desire. Even something as rewarding as sex is not going to be seen as desirable if it always involves chronic pain, or if the chronic pain makes the person unable to function well in their sexual behavior.

Chronic pain can actually cause strife and feelings of frustration and exasperation in marital relationships as the management of pain becomes an all consuming issue. Spouses have to transport their loved ones to oncology centers for treatment, administer injections of drugs and they become surrogate nurses. Cundiff [20] has indicated that physicians are not often well trained in treating chronic pain, managing chronic pain, and that the efforts of well trained physicians are often thwarted by HMO's and hospital administrative procedures.

These barriers to effective pain management are experienced by enlightened compassionate physicians and nurses attempting to manage chronic pain whether it is due to cancer or a non malignant disease such as multiple sclerosis or arthritis. As noted by Bral [16], the most essential aspect of the medication regimen is to individualize it according to the changing needs of the patient.

The medications are broadly divided into categories : **Opioids** such as morphine and fentanyl, which act exclusively to relieve pain; and adjuvant drugs, which in addition to relieving pain, treat concurrent symptoms from the disease and/or the treatment itself. Examples of adjuvant drugs include Corticosteroids which are used in the short term to decrease bone and neuropathic pain, improve appetite and mood NSAIDs- Nonsteroidal anti-inflammatory drugs- such as ibuprofen (e.g. Advil) which relieve inflammation. **Tricyclic antidepressants**, such as amitriptyline (e.g. Elavil) given not in anti-depressant doses, but to relieve neuropathic pain characteristic of Multiple sclerosis and other diseases. **Anticonvulsants** , used to control neuropathic pain and to prevent migraine; **Spasmolytic agents** to control colicky pain. Others include : **Antacids** for gastritis and dyspepsia; **anti-emetics** for nausea and vomiting; anxiolytics for anxiety and hypnotics for insomnia that persists after pain is relieved.

Cundiff [20] indicates that Corticosteroids, and nortriptyline are "helper pain" medications. Currently, Phenergan aids in the enhancement of Demerol and Vistal is another drug that assists. Cundiff [20] recommends Trilisate and Disalcid for cancer pain and Dilaudid, Dolophine, and Duragesic for pain of moderate severity are often used in chronic pain cases. Although the patient may be drowsy and sleepy initially, this generally subsides. At a more fundamental level, many chronic pain patients have found that the caffeine in coffee assists with pain relief , particularly in conjunction with their medications.

There are several new developments in pain management. **OXYCONTIN** has been used with osteoarthritis pain, back pain, cancer pain and is appropriate when ATC (Around the Clock) pain management is imperative. This is available in 10, 20, 40, 80 and 160 mg dosages. In this world wide web age, there is even a web site entitled www.partnersagainstpain.com. There is also available at the American Academy of Pain Management website, <http://www.aapainmanage.org>. Opioids may also be effective in pain management, according to work at the Johns Hopkins Pain Treatment Center, which seems to indicate that opioids allow for improved daily activities and functioning.

Khatami [21] has investigated the use of logotherapeutic procedures for those in chronic pain. Whiddon [22] has offered new hope for people in chronic pain. His work focuses on the fact

that people in chronic pain lose meaning in life and in the very things that may make life meaningful for them—interpersonal relations, hobbies, work, and their lives.

By helping clients to maximize their interests, aspirations, and relationships many clients and patients recover new hope and overcome discouragement. Individuals who are living in chronic pain need assistance in optimizing their pain free periods, be they morning, afternoon or evening, and coping with those periods when the pain is most intense. They need to be taught coping skills, to manage not only the psychological trauma of chronic pain but use available strategies such as the application of heat, or cold or ice to deal with the immediacy of pain, available themselves of hot tubs, whirlpools and the like and employ heat, or heating pads or Capsaicin or ice or whatever other natural options are open to them. Individuals should seek out those mutually enjoyable activities which bring the greatest degree of pleasure and enjoyment. This may involve eating out, movies, television, listening to music or reading. Alternative attempts at intimate communication can be attempted. A note, a card or a brief comment may be what is needed to assist individuals in their intimate attempts at communication.

Communication via the world wide web may be better for some individuals since one does not have to see the shrunken body of friends and cope with the odors of hospital rooms and corridors. Distraction, hypnosis and biofeedback are all alternative approaches to pain management, and may enable individuals to share some intimate moments with loved ones. Reading has been found by some to alleviate or act as a distracting agent. A comfortable chair may also facilitate pain management.

The Nurse and the Person in Chronic Pain

Nurses are accurately acknowledged as the health care providers who have the most frequent and on going contact with people who become patients. Nurses are educated to listen altruistically [2]. They are also educated for privileged intimacy and function as the cornerstone of pain management [23]. What are the implications of these facts for nurses whose enlightened compassion enables them to recognize the need for intimacy in persons who live in the nightmare universe of chronic pain?

Nurses are the health care providers who may interact with patients with the most intense pain, and the most chronic pain. Further, they are the professionals who may be most available when patients are at their most vulnerable and at a time when those patients most need to share their innermost thoughts and feelings. Intimacy may be an important part of the therapeutic relationship. Indeed, intimate sharing of thoughts, and feelings and memories may serve as a distraction or even as a meaningful experience.

Nurses are frequently the last persons that people near death are going to encounter. Geriatric patients may have outlived their children or siblings. Asterminally ill patients who are in chronic pain enter the last stages of their lives and engage in a review of their lives, the nurse is often the last person who is available to share one's thoughts, feelings and emotions with. The nurse is in a singular position as a fellow human being who cares about mankind and who has experienced life, suffering and hopefully meaning.

Nurses may become quite exasperated or frustrated with the on going pain experiences of their patients that do not seem to respond to palliative doses of medication, or when physicians do not seem to respond to the cries for help from their patients. Even more exasperating may be the utterances of suicidal ideation, requests to "end it all" and free them from the agonizing pain that they are experiencing. As chronic pain patients approach death, their desires to share thoughts about their lives, their loved ones and their families come to the fore. Nurses must recognize that this desire is a wish to bring closure to their lives. If no family members are around, or if family members have predeceased them, nurses may be the only compassionate caring individuals available. Some nurses may be uncomfortable in this role, as patients reflect on what they have done right or wrong, or the mistakes that they have made or their fears about meeting their maker or God. They may express anger toward relatives and family members or toward their doctors and hospitals.

Can the Sharing of Pain be Meaningful?

The discussion of one's pain can indeed provide nursing and medical practitioners with subjective and objective data regarding the titration of medication and the appropriateness of medication. If by administering an analgesic, the patient has experienced some relief from their suffering the nurse has performed a meaningful act. The two have shared an existential moment. Physicians need to be aware of the all consuming nature of pain, and the subjective nature of pain and of the fact that many individual's pain varies depending upon the time of day, and other salient factors. If an individual has helped another individual manage their pain, cope with their pain or distract them from their pain, they truly have performed a meaningful act.

Nurses and physicians who enter the nightmare world of the person in chronic pain do so to alleviate the patient's immediate suffering and to learn what may help other patients. To this encounter, professional caregivers must bring not only clinical competence but the human compassion which is the hallmark of an authentic self.

The caregiver's expertise and the humanity must be clearly evident to the patient in pain, who, because of his or her suffering is in a state of greatly heightened vulnerability, yet needs to participate as fully as possible in the experience. Only by being authentically present to the patient can the professional caregiver bridge the chasm between the world of health and the nightmare world of chronic pain. This has to do with being authentic when the nurse enters the world of that person in chronic pain. Being an authentic presence, human to human, rather than nurse to patient, whether or not the nurse has a pain medication to deliver at that moment is critically important.

The nurse must genuinely encounter that person in their terrifying nightmare world of unrelenting, pain. After assessing the patient's needs for pain management, with input from the patient and determining how to effectively meet those needs, the caregiver must ensure that the needs are met promptly. This is essential for the integrity of the patient and the caregiver, and is the core of a genuine therapeutic relationship in clinical practice. Within that context, the actual treatments to mitigate pain, medications or non-pharmacological modalities such as relaxation techniques, massage, guided imagery- may be augmented.

Summary

This paper has attempted to investigate two realms: that of the physical, which encompasses pain, and that of the emotional, which encompasses the need for intimacy. Critical care nurses, and nurses in general, are in a crucial position to provide support and help patients to procure an intimate emotional relationship with a caretaker who may soon see them depart from this world.

While nurses are typically trained in pain management, they are not often trained to help patients meet their emotional needs in extremis, at the point of death.

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List of Abbreviations Used--mg for milligrams

Declaration of competing interests---None reported

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MASS HYSTERIA AMONG LEARNERS AT MANGAUNG SCHOOLS, IN BLOEMFONTEIN, SOUTH AFRICA.

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Abstract:

When learners, particularly girls, at schools in Mangaung and Heidedal, in the Free State Province presented with itching, where contamination was by line of sight, they were treated at various clinics and hospitals with Calamine Lotion (anti histamine), Allergex (anti histamine) and bathed in a Jeyes Fluid (antiseptic) solution. No organic cause was found, for the itching. Entomologists, were also unable to find a definite cause for the itching. The schools were closed and fumigated, when the learners went back, the headmasters set limits and the itching stopped.. The diagnosis of hysteria is, often fraught with controversy, it is sometimes seen, as an outmoded cultural prejudice against women or it is used to refer to a histrionic personality. The diagnosis of Anxiety Mass Hysteria was given for this outbreak.

1. Introduction

During the period 14 -25 February, 2000, about 1430 learners at various schools in Mangaung and Heidedal townships in Bloemfontein, experienced some itching. The Grades that were mostly affected were Grade 8, 9 and 10. A small group of Primary school children were affected as well. It was, however, difficult to get the actual numbers that were affected, as no reliable statistics was kept.

The itching lasted an average of six days Entomologists, in their analysis of dust samples collected at the schools, found a number of book lice. These, however, did not pose any threat to human health. The entomologists also suspected that some of the children could have been infected by itch mite but this was based purely on the presenting symptoms. No organic cause was found. A few teachers mainly female reported experiencing some itching also.

2. Aim of the Study:

For this study, only thirteen schools in the Mangaung and Heidedal area were included. The aim of this study was:

- To document the experience and nature of the itching and to establish if there was any psychological explanation for it.

- To formulate a plan for dealing with such problems in future.

3. Method:

Learners at the affected schools were grouped by the teachers into those who were affected and those who were not affected. A representative sample was then selected randomly from each group. Three psychologists interviewed the learners in English, Sesotho, Xhosa and Afrikaans using a questionnaire guide that had been designed to elicit; symptoms, thoughts and feelings about the itching, what made the itching feel better and what seemed to exacerbate it. The learners were also asked how they got to know about the itching, what else happened when they were itching. Questions aimed at eliciting the presence of verbal and/or visual hallucinations were also asked.

A total of 192 learners were interviewed in group settings, using tape recorders. Groups averaged fifteen learners, twelve from those who were affected and three from the group that was not affected. Individual interviews with three of the affected teachers were conducted.

4. Results:

The tapes were transcribed and the information gathered during the interviews grouped into four themes, physical symptoms, social impact, psychological effects and interventions.

4.1 Incidence of Itching:

The incidence of itching in the schools differed. The learners seemed to be aware of which school was the first to be affected in the Mangaung area. The itching was experienced as soon as the learners entered the school premises. Very few reported itching and scratching at home. Learners who first reported the itching were taken to the principal's office or the staff room. The other learners went to observe what was happening and then their own itching started. Others reported that the itching started when they watched others scratching themselves at assembly, in the classroom, at the clinics or at the hospital.

4.2. Physical Symptoms:

The itching started after they felt a gush of hot air, then hyperventilation, headache, pins and needles, dizziness, chest tightness were amongst the symptoms reported. Oxygen had to be administered to some.

Itching was reportedly worse when any liquid was applied. This, they agreed was due to the open sores that had formed as a result of the scratching. The learners used items such as stones, walls, scrubbing brushes, rulers and pens for scratching

4.3. Social Impact:

The itching was perceived to be contagious; this resulted in rejection by family and society. Taxi drivers would not stop for them, some parents refused to let them play with the other siblings or friends. Some of the learners who were not affected thought that although there were some who really were affected, there were others who were shamming.

4.4 Psychological Effects:

Fear of being affected was reported by most who had not experienced any itching and this caused some anxiety. The rejection that those who were itching experienced angered them. They felt they were not responsible for their condition. Rumours abounded as to what the cause of the itching was. Satanism was blamed for the itching, others said there were two boys who were seen sprinkling some white powder in the girls' toilets.

There were rumours that two learners had died but this was never verified. It appears that the source of some of the rumours, were members of the public who phoned the local radio station chat shows to discuss the itching.

4.5. Intervention Strategy:

The itching was mostly treated with Calamine lotion (an anti histamine), after a bath in a Jeyes Fluid solution (an antiseptic). Some reported drinking the Jeyes Fluid mixture while others reported applying several lotions that had been prepared by their grandmothers "*iirati*" (home remedies), even petrol

Table 1

Physical Symptoms	Social Impact	Psychological Effects	Intervention Strategies
<input type="checkbox"/> Itching	<input type="checkbox"/> Rejection by Family	<input type="checkbox"/> Fear	<input type="checkbox"/> Calamine Lotion (anti histamine)
<input type="checkbox"/> Hyperventilation	<input type="checkbox"/> Rejection by teachers, the Public and other learners	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Allergex (anti histamine)
<input type="checkbox"/> Pins and Needles	<input type="checkbox"/> Being ostracised by Taxi drivers, not being allowed onto the Taxi, if wearing uniforms from certain schools	<input type="checkbox"/> Sadness	<input type="checkbox"/> Jeyes Fluid, (Antiseptic) for washing or as a drink.
<input type="checkbox"/> Dizziness		<input type="checkbox"/> Anger	<input type="checkbox"/> " <i>iirati</i> " (home remedies)
<input type="checkbox"/> Feeling hot		<input type="checkbox"/> Cognitive Impairment (unable to concentrate in class)	<input type="checkbox"/> Prayers
<input type="checkbox"/> Chest Tightness		<input type="checkbox"/> Belief systems challenged	<input type="checkbox"/> Water that had been blessed by a faith healer.
<input type="checkbox"/> Headache		<input type="checkbox"/> Visual hallucinations	<input type="checkbox"/> Scratching
<input type="checkbox"/> Fainting		<input type="checkbox"/> Hyperventilation	<input type="checkbox"/> Cool Air
<input type="checkbox"/> Sores			

At the clinics and hospitals some learners were given some Allergex (an anti histamine). Faith healers used prayer to intervene, but some learners reported that prayer made the itching worse.

When the principals set limits after schools reopened after the fumigation; that if there were any who were still itching they should go home and come back when healed, no further reports of itching were received.

5. Discussion

Commonly in sudden and dramatic situations such as these where there is widespread illness whose causes are obscure or unknown, chemicals that are present in the environment in minute concentrations are summarily and misguidedly targeted as likely culprits. Once mass anxiety hysteria is in progress participants seize on any suitable excuse, be it gas or food poisoning, for rumour is rife when an air of uneasiness pervades any collectivity¹. A white powder was identified as the source of the itching in this study, but this fact was never

verified. It could also not be explained why it only affected learners when they entered the school premises and why it affected girls mostly.

Hysteria remains a controversial term. Modern authors tend to view it in its narrower psychiatric sense. Central to this is the implication that hysteria should involve the adoption of symptoms that are not explained by physical disease, but corresponding to a notion of physiological or psychological dysfunction. Secondary gain may occur but it is indistinguishable from the advantages of the sick role² Illness behaviour can be learned³. This social learning theory could explain why the learners developed itching after watching their friends scratch.

There exists no satisfactory definition of mass hysteria. Some⁴ believe that mass hysteria is a form of abreaction to resolve conflicting situations. This explanation is, however, not valid for group behaviour. A wide variety of crazes, panics and abnormal group beliefs etc. have all been labelled as mass hysteria. The boundaries of collective behaviour and mass hysteria have yet to be drawn. Mass Hysteria has been defined as a constellation of symptoms that are suggestive of an organic illness, but do not have an identified cause, in a group of people with shared beliefs about the cause of the symptom⁵.

Episodes of mass hysteria can be taxomised into these broad categories⁴:

- the explosive type
- typically appearing in small institutionalised, social networks,
- large diffuse outbreaks in which false rumours and beliefs overwhelm the community.

Mass hysteria involves imitable disease characteristics that appear suddenly among persons near one another, which disappear within a few days^{7,8}. The diagnosis of mass hysteria is not properly a default diagnosis, that is, it is inappropriate to decide that mass hysteria has caused an illness merely because pathogenic organisms and toxic chemicals appear absent^{6,9,10}. Some¹¹ thought that contagion worked through the "sympathetic induction of emotion, that one person experiences when witnessing the facial expression and manner of others". Contagion is a function of the suggestibility of crowds "the individualities in the crowd who might possess a personality sufficiently strong to resist the suggestion are too few in number to struggle against the current"¹². Hysterical contagion consists of a quick dissemination within a collection of people of a symptom, or a set of symptoms for which no physical explanation can be found¹³.

Mass hysteria is a social phenomenon often occurring among otherwise healthy people who suddenly believe they have been made ill by some external factor. These people often have shared beliefs about the cause of the symptom⁶. In another study, conducted in South Africa¹⁴, it appears that common beliefs in witchcraft as the cause of the mass hysteria were what held the group together. In societies where there are two or more medical systems that are used to explain disease, it is possible that illness that cannot be explained can be attributed to witchcraft and sorcery. In our study, however, beliefs in witchcraft and sorcery did not come up, as the main cause of the itching was said to be some white powder.

Mass hysteria spreads by sight and or sound. It also occurs most often among adolescents or preadolescents. In groups of students, its incidence is reportedly, higher among girls than boys^{6,7,9}. In most cases "victims" return to a normal state of health soon after being

convinced that the illness is over or never existed¹⁵. Individuals continually engage in reality testing by comparing their perceptions with those of others round them. Since individuals are more dependent upon others and less on themselves in their construction of social reality, an opinion, attitude or conviction is correct, valid and proper to the extent that it is anchored in a group of people with similar beliefs, opinions and attitudes¹⁶.

Information on the diagnosis of mass hysteria is incomplete. Whether such psychosocial factors as school morale affect the likelihood of it developing is unknown. The Bronx school where the mass hysteria developed in 1999 is reportedly in a poor neighbourhood. The same could be said of the neighbourhoods in which the incidents of itching were reported, in the Free State. None of the suburban schools were affected.

Mass hysteria, should be regarded as a phenomenon with certain characteristics⁷:

1. First, it is an outbreak of abnormal illness behaviour that cannot be explained by physical disease.
2. Secondly, it affects people who would normally not behave in this fashion.
3. Thirdly, it excludes symptoms deliberately provoked in groups gathered for that purpose as occurs in many charismatic sects.
4. Anxiety is always present but is not a prominent feature. Mass anxiety hysteria covers outbreaks demarcated by the phenomena of anxiety, abdominal pain, chest tightness, dizziness, fainting, headache, hyperventilation, nausea and palpitations.

Further consequence of the proposed definition of mass hysteria is the support it gives to the view that such behaviour is maladaptive⁷. The loss of internal restraints permits the release of previously suppressed behaviours¹⁷ and contagion can make people do things that they would not do under normal circumstances. Some of the learners in our study reported taking off their clothes so that they could scratch themselves. Cool air reportedly made them feel better. Under normal circumstances this would be considered exhibitionist behaviour and would be considered socially unacceptable

Although the methodology used in this study differs from that used in the other studies^{7,9,14}, the authors do note, however, that symptoms such as headaches, anxiety, hyperventilation, chest tightness, and nausea were also reported by the learners in their study. It is significant that few reports of mass anxiety hysteria contain any reference to external stress or tension. The occurrence of collective behaviour cannot itself be taken as proof of pre-existing tension, it can be inferred if emotional difficulties or stresses are identified prior to the outbreak⁷.

What is communicated in mass anxiety hysteria is not any single behaviour or a fantasy idea but a collective feeling - anxiety. It is not the idea of anxiety that is contagious, but anxiety itself⁷. Mass hysteria can be divided into two syndromes⁷ thus:

- Mass anxiety hysteria: consists of episodes of acute anxiety, occurring mainly in school children. Prior tension is absent and the rapid spread is by visual contact. Treatment consists of separating the participants and the prognosis is good.

- Mass Motor hysteria: consists of abnormalities in motor behaviour, occurs in any age group and prior tension is present. Initial cases can be identified and the spread is gradual. Treatment should be directed towards the underlying stresses but the outbreak may be prolonged.

5. Conclusion:

It appears that what is common in all reported cases of mass anxiety hysteria is the transmission of the outbreak along "line of sight". Those who never witness the outbreak are never involved⁷. Mass hysteria should disseminate more rapidly when the social group is unified than when it is subdivided. Similarly, the majority of cases should occur in public places¹⁷. Some researchers showed that relapses of a fainting epidemic occurred whenever the girls assembled at school, but never at home. Others have reported how the outbreak spread during break periods when the victims were lying in the corridors, in the canteen, the playground, during lunch break and in a hospital waiting area^{18,19,20}. These circumstances were true of the itching epidemic in our schools. This phenomenon is described as an explosive spread⁵. The episodes are always benign in nature, lasting no more than a few hours. Further episodes may occur in a similar explosive fashion within a few days, but only if the group recongregates. When the learners in the affected schools congregated during assembly, on entering the school premises, during break, at the clinics and at the hospital, the itching started again.

The learners in our study reported symptoms, such as fear of being affected. These could be associated with anxiety. The illness was sudden, dramatic and explosive. The learners were mostly affected at school. The spread appears to have been definitely by line of sight - they developed symptoms when they saw others scratching. There is no evidence of any preexisting tension and the majority of the learners were female, under the age of eighteen. When the principals set limits, no further outbreaks were reported. It seems evident; therefore that although the DSM IV nosology does not include collective or mass hysteria, the diagnosis of Mass Anxiety Hysteria be adopted to explain the itching that was experienced in these schools.

Recommended Intervention:

Researchers on Mass Hysteria^{6,7,9}, seem to agree that, cases of Mass Hysteria should be handled thus:

1. Time should not be wasted in a fruitless search for environmental precipitants, which by reinforcing behaviour may serve to prolong the episode. Mass hysteria should not be a diagnosis of exclusion, after all the physical, chemical and biological factors have been ruled out then it should be made.
2. Group anxiety should be reduced.
3. Statements denying the role of the presumed agent should be made by those in authority. Public health statements can help terminate these epidemics. A temporary school closure may be necessary. Separating learners and minimising contact among those affected and those not affected may be successful. This strategy was adopted by one of the headmasters in the affected schools and no further reports of itching were received.

4. Setting of limits. Some headmasters in our study, set limits to the itching and told those who were still itching to stay at home until it stopped.

5. No further reports of itching were received from the learners in their schools. It seems clear that because of the psychological nature of this epidemic, only psychological interventions will be effective. Trying to find an organic cause for the epidemic will not only waste valuable time but scarce resources as well.

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Treatment of Depression in Older Adults

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Abstract

This article reviews the rationale for concentrating mental health system and therapeutic resources on the treatment of depression in aging populations. Etiological factors/clinical formulation, biopsychosocial treatment strategies, and therapeutic outcome evaluation are examined and presented as rationale for a renewed concentration on treatment for both dementia and non-dementia related depression in the elderly. The authors conclude that although the older adult depressive patient has special needs and conditions that require specialized psychosocial care, they are no different than any other special needs population. A lifetime accumulation of stress, specific catastrophic events, and failing physical conditions contribute to reduced coping, but are all conducive to treatment. Accepting a normative view of older adult depression and considering it a normal function in the life cycle, is categorically flawed and thus, unethical as well. Instead, clinicians should be concentrating their efforts on expanding systems and techniques/models that have proven efficacy for these patients.

Introduction

Depression in older adults has been associated with and is closely related to the aging process. The accumulation of a lifetime of depressing events, such as bereavement, painful illness, etc., coupled with the effects of physical illness, decreasing mental, and diminished physical energy place older adults at risk for depressive symptoms (Stuart-Hamilton, 2000). These etiological factors are so common among older adults that they appear to normative and a part of the normal aging process.

On the surface, a normative view of older adult depression may lead to the conclusion that we should strive to understand this obviously normative phenomena and not concentrate our efforts on treatment of depression. However, this viewpoint is only possible if one assumes a normative etiology for depression in these individuals. A more comprehensive understanding of causes and presentations of depressive conditions among the elderly, and the various therapeutic intervention strategies that can be employed, clearly demonstrates

that treatment not only works, but works well for this population and can greatly enhance the lives of the elderly.

Etiology and Clinical Formulation

Although some healthy aging persons maintain very high cognitive performance levels throughout life, most older people will experience a decline in some cognitive abilities. This decline is usually not pathological, but parallels a number of common decreases in physiological function that occur in conjunction with normal aging processes. For some older persons, however, declines go beyond what may be considered normal and are relentlessly progressive, robbing them of their memories, intellect, and eventually their abilities to recognize spouses or children, maintain basic personal hygiene, or even utter comprehensible speech. These more malignant forms of cognitive deterioration are caused by a variety of neuropathological conditions and dementing diseases.

However, even the depression associated with dementia and other organic depression is often a function of decreased coping skills and thus, in some measure, amenable to treatment. The inability to cope with increasing stressors due to both medical conditions and older adult stress issues, place these patients in the same position as those who suffer from depression without organic complications (Lezak, 1994) In the majority of older adult depression cases, cognitive deterioration is not directly associated with specific organic lesions or processes, but is more diffuse and psychosocially based (Stuart –Hamilton, 2000). The difficulty with treatment of these clients lies partly in the differential diagnosis and clinical formulation of the presenting symptomology of these patients.

Depression in elderly persons can often mimic the effects of dementia (Kaszniak & Christenson, 1994). Psychomotor retardation and decreased motivation can result in nondemented persons appearing to have pathophysiologically determined cognitive disturbances in both day-to-day functioning and on formal neuropsychological testing. Depression can also cause non-demented persons to over-report the severity of cognitive disturbance. Consequently, it is important to perform a careful assessment for depression when evaluating for dementia and age-related cognitive decline, and determine what coping strategies exist and ways in which coping can be modified to more fully integrate the older client to his/her environment and reduce their distress.

Depression is best assessed during an interview so that the clinician can obtain a full range of behaviour, mood, cognition and social interaction patterns. Formal mood scales (e.g., Beck, Ward, Mendelson, Mock, & Erbaugh, 1961 ; Yesavage et al., 1983) can also play an important role in assessing for depression and have the advantages of quantifying and facilitating the assessment of changes in mood over time. Sociocultural factors may cause some older persons to underreport depressive symptoms.

In many patients, depression and dementia are not mutually exclusive. Depression and dementia or age-related cognitive decline frequently coexist in the same person. Depression can also be a feature of certain subcortical dementing conditions, such as Parkinson's disease (Cummings & Benson, 1992 ; Youngjohn, Beck, Jogerst, & Cain, 1992). However, even in cases of concomitant neurological difficulties, depressive patterns and their maintaining mechanisms can often be assessed apart from the underlying neurologic difficulties and aggressively treated (Kaszniak & Christenson, 1994)..

Depression constitutes the most common emotional disorder found in older people (Butler, Lewis, & Sunderland, 1991). Estimates of the prevalence of major depressive disorder in the elderly range from 2% to 10% (Blazer, Hughes, & George, 1987), with milder forms of depression such as dysthymia and dysphoria affecting 20% to 30% of older adults (Butler et al., 1991). Moreover, the clinical significance of depression in the elderly is underscored by the consistent finding that suicide occurs more frequently in the elderly than in any other age group (Rich, Young, & Fowler, 1986).

The symptoms and conditions listed in Table 1 have been demonstrated to be associated or not associated with dementia and organic processes. As part of the American Psychological Association's Guidelines (1998) for the treatment of dementia, this table demonstrates a wide range of variation in cognitive difficulties for the elderly that may or may not be due to organic deficits. Though it may be widely agreed that conditions due to organic functional deficits are very difficult to effectively treat, the symptoms and conditions listed under "Those less likely to become demented" may not be solely due to organic factors and are therefore seen as more conducive to psychotherapy and other psychosocial treatments (APA, 1998; Arean et al, 1993; Stuart-Hamilton, 2000). These symptoms and conditions have also been associated with clinical depression (Beck, 1961)

While it may be said that a minority of patients with organically derived depressive symptoms receive little benefit from treatment, the majority of patients do not fall into the category and respond well to biopsychosocial treatment strategies (Arean, et al. 1993, Stuart-Hamilton, 2000). Once a comprehensive differential assessment of organic and psychosocial factors associated with both dementia and depression has been performed a clearer understanding of the necessary components of an effective care plan can emerge for these individuals. The major difficulty with this population lies first in the comprehensive assessment and formulation. This leads to an appropriate intervention strategy that will take all bio-psycho-social factors into account in an integrated treatment framework.

The causes for depression in later life are not limited to cognitive factors but are also associated with a wide range of psychosocial stressors and negative events. Depression that merits clinical attention is long-lasting and severe enough to interfere with normal functioning. In addition to a chronically depressed mood, the patient typically lacks both mental and physical energy, has irrational feelings of worthlessness and/or guilt. They may also have preoccupations with dying and suicide. Older patients also report a greater number of physical complaints, which contributes to their depressed mood and feelings of helplessness. Bereavement is also known to cause depressive symptoms and older adults report more 'loss' than younger patients. In short, older adults are exposed to a higher proportion of depressing events in their lives, including bereavement, painful illness, institutionalisation, loss of income, etc., and are more likely to be at risk for both depression and/or pseudodementia (Blazer, 1997). Kasl-Godley, Gatz and Fisk's (1998) estimate that as many as 11 percent of dementia cases actually suffer from pseudodementia and depression.

Biopsychosocial and Symptom Specific Treatment Strategies

In 1992, a consensus development panel of the (U.S.) National Institutes of Health (NIH; 1992) urged vigorous treatment of depressed elderly with somatic therapies (i.e., drugs,

electroconvulsive therapy [ECT], or both). Psychosocial therapies were recommended as secondary or supplemental interventions. Members of this NIH panel noted that, in comparison with the substantial research base supportive of somatic therapies (for a review, see Gerson, Plotkin, & Jarvik, 1988), there still is little evidenced based research on the benefits of psychological treatments for depression in the elderly (Alder, 1992).

On the other hand, Stuart-Hamilton (2000) reports that there is little difference in treatment effects between younger and older patients. Kasl-Godley, Gatz and Fiske (1998) along with Tuma (1996) and Burville et al (1995) conclude that psychotherapy and associated psychosocial treatments for depression in older adults are highly effective for depressive symptomology and reduce the presentation of pseudodementia as well. They report that as many as 60 percent of depressive patients who were treated aggressively recovered; with only a 20 percent relapse rate. These high rates of recovery suggest that older patients who have been effectively assessed and identified as suffering from the effects of age related or major depression can be effectively treated with lasting effects. Given this, the central question in treating this population become what strategies work for which patients under which circumstances.

Various psychological conceptualizations have been proposed to explain and to treat depression in the elderly. These range from the developmental-existential perspective of reminiscence therapy (RT; Butler, 1974) to the social reinforcement formulation of behavior therapy (Teri & Lewinsohn, 1982). Although the research literature on psychotherapy outcome for depression in the elderly is not extensive, several controlled studies have supported the effectiveness of various psychosocial treatments, including RT (e.g., Goldwasser, Auerbach, & Harkins, 1987), psychodynamic psychotherapy (e.g., Steuer et al., 1984 ; Thompson, Gallagher, & Breckenridge, 1987), behavior therapy (e.g., Brand & Clingempeel, 1992 ; Gallagher & Thompson, 1982), and cognitive therapy (e.g., Beutler et al., 1987 ; Steuer et al., 1984). Additional research is warranted by the scope and seriousness of depression in the elderly and by limitations of the existing research base (i.e., few studies, small samples, failure to include measures specific to the nature of depression in the elderly, and an over reliance on self-reports as outcome measures). Research on psychological interventions is also needed because somatic therapies are contraindicated in the treatment of many older adults, particularly those who are medically ill and cannot tolerate the side effects of antidepressant medications or ECT (Butler et al., 1991 ; Winstead, Mielke, & O'Neill, 1990).

Because age-related psychosocial factors often contribute to the occurrence of depression in the elderly (Ruegg, Zisook, & Swendlow, 1988), successful treatment (and prevention of relapse) requires modification of those psychological factors that are etiologically related to depression in later life. Nezu and his colleagues (Nezu, 1987 ; Nezu, Nezu, & Perri, 1989) have proposed a problem-solving model of unipolar depression that may hold particular relevance for understanding and treating depression in older adults. Within this formulation, social problem-solving encompasses the processes by which people develop effective means of coping with stressful life events; deficits in problem-solving skill serve as one important vulnerability factor for depression. When deficits in problem-solving lead to ineffective coping attempts under high levels of stress (emanating either from major

negative life events or from continuous daily problems), depression is likely to ensue (Nezu et al., 1989).

Many of the changes that occur in later life often constitute significant stressors. For example, declining socioeconomic status, deteriorating physical health, and the loss of loved ones can each have a powerful impact on overall mood and self-esteem (Butler et al., 1991 ; Ruegg et al., 1988). Whether such stressors precipitate a major depression may be determined, in part, by the individual's ability to cope effectively with the major and minor problems posed by these life changes (Lazarus, 1991 ; Nezu et al., 1989). Indeed, some recent research has found that depressed older adults show deficits in social problem-solving ability—deficiencies that may impair one's ability to cope with stressors related to depression (e.g., Fry, 1989).

One corollary of the conceptual model proposed by Nezu et al. (1989) suggests that problem-solving training will lead to decreases in depressive symptomatology. Two outcome studies (Nezu, 1986 ; Nezu & Perri, 1989) have provided a direct test of this hypothesis and have demonstrated the clinical effectiveness of problem-solving therapy (PST) in middle-aged adults with unipolar depression. Only one study (Hussian & Lawrence, 1981) directly tested the effectiveness of PST in depressed older adults. Hussian and Lawrence found that PST was superior to a social reinforcement approach for reducing depression in institutionalized older adults. Although the results of these studies provide initial support of the problem-solving model of depression, additional research is needed regarding the effectiveness of PST as a treatment for depression in older adults and as compared with other treatments derived from alternative conceptualizations of depression in the elderly.

Reminiscence Therapy (RT), a commonly recommended psychotherapy for older adults, is based on the premise that life review constitutes a normal developmental process brought about by increasing awareness of one's mortality (Butler, 1974). A failure to successfully integrate one's life experiences is viewed as contributing to despair and depression (Erikson, Erikson, & Kinvick, 1986). RT entails a progressive return to an awareness of past experiences, both successful and unsuccessful, so that salient life experiences may be reexamined and reintegrated. The life review process gives older people opportunities to place their accomplishments in perspective, to resolve lingering conflicts, and to find new significance and meaning in their lives, thereby relieving the despair and depression that often accompany aging (Butler et al., 1991). Support for the effectiveness of RT as a treatment for depression in older people has been found in several studies (Goldwasser et al., 1987 ; Rattenberg & Stones, 1989).

Evaluation of Effective Treatment Strategies

Arean et al (1993) evaluated the comparative rates of effectiveness between RT and PST. The comparative efficacy of the two psychotherapeutic approaches for the treatment of depression in older adults was examined in a randomized, prospective investigation. This study not only compared the effects of treatment between the two psychotherapy groups but also compared both groups against a wait listed control group.

Subjects in both groups were assessed on the comprehensive battery of depression, life events, and problem solving skills scales, as well as semi-structured clinical interviews. All

subjects who were included in the study met the criteria for Research Diagnostic Criteria (RDC; Spitzer, Endicott, & Robins, 1978). The 75 patients were randomly assigned to one of the three study conditions. Each treatment was implemented over 12 weekly sessions; each session lasting approximately 1.5 hours.

Results showed significant improvements in depressive symptoms compared with those who received no treatment. In addition, 64 percent of the study patients who completed treatment showed substantial improvement in their condition. These patients had improved to the point where their symptoms could now be classified as sub-clinical presentations and no longer depressed.

Contrary to previous findings of differences in treatment response to cognitive, behavioural, or psychodynamic approaches, this study found significant differences between the skills oriented, cognitive approach of the PST model and the more introspective RT approach. The effectiveness of the PST approach in relieving depression may be attributed to improvements in the participants ability to cope with the major and minor stressors in their lives. Over the course of the study PST subjects made significant improvements in three of the five component skills of the problem solving measures. The RT subjects did not show such robust improvements on these measures. Such finding support the position that ineffective coping with problem in living may contribute to the experience of depression in older adults.

Conclusions

Once patients are clearly identified as suffering from depression, the question of whether they can respond to treatment and whether or not they should receive treatment becomes moot. Elderly patients who suffer from depression and poor life integration skills clearly benefit from various psychosocial interventions. This appears to be independent of the presence of pseudodementia or dementia. Older adults who suffer from depression respond to treatment the tend to minimize the impact of a lifetime of accumulated stressors, and/or provide the patient with more adaptive coping mechanisms to relieve their distress. Though we may debate which interventions are most appropriate and effective, psychosocial treatment clearly relieves a wide range of depressive symptoms and increases coping skills. Treatment also has a positive impact on the symptoms associated with pseudodementia as well.

As noted throughout this essay, depression in older adults is associated with and is closely related to the aging process. A lifetime of depressing events, (bereavement, painful illness, etc, coupled with the effects of physical illness, decreasing mental, and deminished physical energy) reduces the ability of many older adults to cope with not only the impact of past events, but to solve problems in the present. This leads to greater dysfunction, poorer coping with stress, and greater levels of depression. The fact that these causal and contributing factors are so common among older adults that they appear to normative and a part of the normal aging process, may delude some clinicians into the false belief that treatment for this population is neither effective, nor desirable.

On the contrary, the research base and demographic trends make it clear that treatment for depression among older adults is both effective and beneficial not only for the individual but society as a whole. As medical treatment and improvement in preventative health continues into the 21st century, life spans continue to increase. This trend also has an impact on the

vitality and creative contributions of the elderly as well. As life spans increase, people remain productive for more years and contribute to not only their own development but to their social circles and to society as well. Improving their ability to cope with multiple stressors and continue to solve problems in the face of failing health or long term debilitating medical conditions, not only serves their interest by reducing their depression, but serves society as well.

Though the older adult depressive patient has special needs and conditions that require specialized psychosocial care, they are no different than any other special needs population. A lifetime of stress, specific catastrophic events, and failing physical conditions contribute to reduced coping, but are all conducive to treatment. Thus, accepting a normative view of older adult depression and considering it a normal function in the life cycle, is categorically flawed and thus, unethical as well. Instead, clinicians should be concentrating their efforts on expanding systems and techniques/models that have proven efficacy for these patients.

In addition to direct treatment for depression, improved housing and social conditions that contribute to isolation, withdrawal and depression should be addressed and efforts made to provide the resources that will improve the quality of life for this group. Based on the evidence, it is clear that instead of finding rationale for limiting services, we should continue the struggle to determine what works, for depressed elderly patients, under a variety of circumstances to improve their connection with their community and reduce their distress to the greatest extent possible.

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A Review of the Current Evidence for the use of Psychological Interventions in Psychosis

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Abstract:

This article reviews current evidence for the use of psychological interventions in psychosis. Evidence based research for individual therapy for schizophrenia, cognitive behavioural treatment, interventions for unremitting psychotic symptoms, and interventions for acute psychosis are compared and contrasted. The studies reviewed here are consistent in demonstrating the benefits of well-developed cognitive interventions for sufferers of schizophrenia. Less evident are the benefits of non-specific, supportive counselling, although this also appears to offer some advantages over routine care. Effects tend to be specific to the domain of positive symptoms, such as delusions and hallucinations, though other psychosocial gains are noted as well.

Introduction

Following the introduction of phenothiazines in the 1960's, psychiatry became increasingly divided into adherents of the psychodynamic and biological approaches (Fenton, 2000). Discordant ideological and scientific debates formed around the value of intensive psychotherapy versus medication. However, the past decade has seen a shift away from these ideological disputes towards an understanding that no single treatment can improve the symptoms of schizophrenia. Today, evidenced-based treatment is considered the standard for psychiatry. Hence, the scientific documentation of efficacy forms the basis upon which treatments are either considered viable or rejected (Carpenter, 2001).

Although neuroleptic medication remains the principal treatment for psychosis, between 25-50% of sufferers will continue to experience persistent and distressing symptoms (Garety et al, 2000). Patients may be subject to periodic relapse, despite ongoing adherence to medication regimes (Hogarty & Ulrich, 1998). Furthermore, patients are often reluctant to take long-term medication due to its unpleasant and even disabling side effects. As a result, many clinicians have seen the need to develop complementary treatments. The main areas investigated are those that involve some form of psychotherapy. However, compared to the many hundreds of studies evaluating pharmacological agents in schizophrenia, few controlled clinical trials of individual psychotherapy have taken place.

Individual psychotherapy for schizophrenia.

Fenton (ibid) provides both a comprehensive, historical account of the theory of individual psychotherapy for schizophrenia and a literature review of studies evaluating its efficacy. He warns against the search for a single common component to effective psychotherapy, believing that it could lead to a return of acrimonious ideological debate, thus obscuring further research. Such dogmatic adherence to a single technique applied to all patients is considered damaging and unhelpful (Fenton & McGlashan, 2000).

Malmberg and Fenton (2002) find no evidence to support any positive effect of psychodynamic, insight-orientated therapy for schizophrenia and comment that the possibility of negative effects seems never to have been considered. Similarly, Fenton (2000) finds little evidence to indicate a clear advantage of psychodynamic therapy over medication. Out of the six trials reviewed during the psychotherapy versus biology debate, the most promising approach proved to be the least analytical. Overall, groups treated with medication always demonstrated superior outcomes, whether or not psychotherapy was offered. However, positive outcomes were found for an approach that focused on the specific and current problems adversely affecting the patient's functioning. Here began a move away from treatments founded upon psychogenic aetiology, towards problem solving, cognitive-behavioural interventions.

Current research

In this review, the current evidence for psychological interventions is critically appraised. Studies differ in both the techniques employed in therapy and the specific goals of treatment. Targeted outcomes include measures of overall symptomatology, social functioning and relapse rates. Whilst some researchers have focused on dysfunctional schemas, interventions range from an emphasis on problem solving and coping strategies, to the rational exploration of delusional beliefs and the use of reality testing. In short, there are broad variations in what is being tested and for whom.

The review reflects the results of a literature search using the keywords "psychological", "psychosocial", "psychotherapy" and "schizophrenia." Reference lists of retrieved papers were also examined for further relevant material. Lack of space permits a detailed examination of CBT alone, although an additional, closely related intervention is given consideration. Studies are divided into those focusing on unremitting, medication-resistant symptoms and those focusing on acute episodes of psychosis.

Cognitive-behavioural therapy

Cognitive-behavioural therapy was developed for the treatment of neurotic disorders, such as anxiety and depression. As its efficacy in this area has grown (Haddock et al, 1998), so has the interest in its application to psychosis. Eells (2000) tells how the largely disappointing efforts of the psychodynamic approach in the past have tempered today's treatment methods, which are more modest and pragmatic in their aims. These methods are viewed as part of a comprehensive package of psychosocial interventions that assume a diathesis-stress model, in which pharmacology performs an important function. Furthermore, in addition to being more empirically based and often shorter-term in focus, CBT views psychotic phenomena as a highly convoluted expression of normal experiences (Beck & Rector, 2000). Finding a growing body of favourable evidence for psychotherapeutic interventions, Thornicroft and Susser (2001) suggest CBT is of proven benefit and thus ready for wider assessment in non-

experimental settings.

Interventions for unremitting psychotic symptoms

An investigation into whether intensive CBT results in significant improvements in psychotic symptoms and relapse rates was conducted by TARRIER et al (1998a). Their study compared both cognitive therapy and supportive counselling to routine care. Intervention involved 20 hours of CBT delivered by experienced therapists over a 10-week period. The control group received the same intensity and duration of supportive counselling, centred on unconditional positive regard and the development of rapport. Both groups had experienced persistent symptoms for at least six months. Assessors were independent and blind to treatment assignments. Finding that the CBT group were more likely to experience a 50% reduction in symptoms and a reduced number of days spent in hospital, the authors conclude that CBT provides a significant advantage and is thus a potentially useful adjunct treatment for patients with chronic schizophrenia. Echoing the ideological disagreements of the past, CURTIS (1999) comments that the supportive counselling group did not differ significantly in terms of outcomes to those patients who received CBT.

However, in a subsequent paper, describing a 12-month follow-up study (TARRIER et al, 1999), the advantages of CBT over supportive counselling appear to hold. The researchers found significant improvements in respect to a reduction in positive symptoms, whereas supportive counselling performed similarly to routine care. In terms of relapse rates, no differences were found between CBT, supportive counselling and routine care. Similarly, both CBT and supportive counselling proved equally as effective in producing small, non-significant improvements in negative symptoms. Patients who failed to complete treatment were more likely to be male, single, unemployed and have a lower I.Q. (TARRIER et al, 1998b).

A long-term trial of CBT is reported by WIERSMA et al (2001). In a quantitative study, the effects of CBT with coping skills training on persistent auditory hallucinations and social functioning were explored. The study of 40 patients was conducted over four years and found durable effects on hallucinations and their burden to the individual sufferer. The majority of patients had over five years of contact with psychiatric services. A number of robust assessment tools were used, such as the Auditory Hallucinations Rating Scale (Haddock, 1994) and the Positive and Negative Syndrome Scale (Key et al, 1987). However, the study has several limitations. No control group was employed and the assessors were not independent. Furthermore, baseline measures for frequency and subjective burden of voices were obtained retrospectively, some two years after the start of treatment. Similarly, no baseline assessments of social functioning or psychopathology of schizophrenia were performed.

Complete disappearance of hallucinations occurred for 18% of patients, whilst 60% sustained improvement with regard to anxiety, loss of control and disturbance of thought. These effects generalised to daily functioning, with 67% showing sustained improvement in this area. However, the authors found that in a few cases, "booster sessions" were needed to strengthen these skills and enhance coping abilities in specific social situations.

In a 60-patient trial over nine months comparing CBT and standard care to standard care alone, no such generalisation into daily functioning was found (KUIPERS et al, 1997, 1998). Patients had distressing symptoms that were resistant to medication and unremitting for at least six months. Treatment methods differ from those of WIERSMA et al (2001) and TARRIER et al

(1998). A more investigative, schema-focused approach is described, which involved eliciting the detail of the client's own interpretation of their problems, with particular attention paid to the development of delusional ideas and hallucinations from their first emergence and over time. The aims of therapy were extensive, in that they included a reduction in both frequency and severity of psychotic symptoms, a reduction in depression, anxiety and hopelessness, an increase in social functioning, an increase in self-regulation of relapse and the modification of dysfunctional schema. This contrasts with the approach adopted by Tarrier et al and Wiersma et al, where intervention focused on the development of coping strategies, training in problem solving and relapse prevention.

Although encouraging results were reported, the authors found that the therapeutic aims were achieved in part only. At the end of intervention, 64% of the treatment group compared to 47% of the control group achieved clinically significant improvements, produced mainly by changes in delusional distress and frequency of hallucinations (Kuipers et al, 1997). At follow-up, nine months after intervention, these improvements were marginally amplified for the CBT group, compared to a mere 17% improvement from baseline for patients who received standard care (Kuipers et al, 1998). However, these gains did not generalise into other areas. Although negative cognitions, depression and social functioning were specifically targeted, no benefits were found for the intervention group. In an accompanying paper, Garety et al (1997) details the mechanisms of therapeutic change and concludes that specific effects on delusional thinking were of primary significance. For the CBT group at baseline, a degree of cognitive flexibility in delusional conviction proved a statistically significant predictor of good outcome. Other factors were greater insight and a higher number of admissions in the last five years. However, no correlation between I.Q. and better outcome was found.

The study suffers a number of methodological problems and limitations. Whilst independent of the trial, assessors were not blind to treatment allocation. Furthermore, no control intervention was offered. Thus in comparing CBT to standard care, any non-specific factors inherent in the therapeutic relationship remain uncontrolled. The authors indicate a "proactive outreach" approach was employed to follow-up non-attenders. Although additional therapy costs were offset by a reduction in service utilisation, no robust data is given to demonstrate the degree to which this approach was utilised, hence only limited conclusions can be drawn regarding its value to the clinical setting. Similarly, a specialised therapeutic style was adopted by highly experienced clinical psychologists, further questioning the duplication of the study's findings. Finally, the control group demonstrated higher baseline levels of self-esteem.

In a study designed to overcome many of these limitations, Sensky et al (2000) compared CBT with a non-specific befriending control intervention for clients in the post-acute phase of illness. Ninety patients received treatment over a nine-month period with follow-up at 18 months. Assessors were independent of the trial and blind to randomisation, to treatment allocation at baseline, at end of intervention and at follow-up. Both intervention and control group received routine care. Robust data is given to support the validity of assessment tools and the randomisation process. Furthermore, the paper provides a detailed account of the steps taken to exclude any possibility that improvements were attributable to medication changes. Quality control measures were employed to ensure that a blind assessor monitored therapy sessions.

The aims of therapy for the CBT group focused on reducing distress and disability and treating coexisting depression. As detailed in the authors' chosen treatment manual (Kingdon &

Turkington, 1994), for those patients with systematised delusions this was achieved by working at the schema level, beneath the resistant psychotic symptoms. Both duration and frequency of sessions were flexible to accommodate individual patient's needs, however therapists aimed for at least 45 minutes per week for the first two months, at which point session frequency was reduced. The control group received an equal amount of therapist contact, with therapists aiming to provide empathic, nondirective support.

The authors found that both CBT and the supportive intervention led to clinically significant improvements in positive and negative symptoms at the end of treatment. However, in accordance with Tarrier et al (1999) and Kuipers et al (1998), differences between the groups emerged at the nine-month follow-up period. Patients who had received cognitive therapy continued to improve, whilst those in the befriending group did not, thus adding weight to the argument that the specific treatment benefits of CBT are effective, rather than non-specific factors. Furthermore, in contrast to Kuipers et al (1997, 1998) significant gains were also reported in the reduction of depression severity.

A strength of this study is that these outcomes appear replicable outside the research setting. Experienced psychiatric nurses with recognised CBT qualifications, rather than psychiatrists administered treatment, suggesting the need for generalised training amongst health care professionals. Furthermore, therapy sessions were not overly intensive and thus may be achievable in community mental health teams or the ward environment. However, as the authors admit, patients were selected to "represent the group most likely to benefit from direct effects of CBT", hence those with evidence of poor medication compliance were excluded. Given that non-compliance has been estimated at between 35-80% and is associated with 43% of admissions to psychiatric wards (Perkins & Repper, 1999), this limits the application of the study.

Interventions for acute psychosis

Despite the predominance of research in the area of post-acute, drug-refractory schizophrenia, there is evidence that psychological interventions may also facilitate recovery from an acute episode. In a five-year study, Drury et al (1996a, 1996b, 2000) tested the effectiveness of CBT in acute psychosis. Of clinical significance is the fact that 35% of these patients were experiencing their first episode of psychosis. This reflects a view gaining ground that the early phase of a psychotic illness has major influence on its long-term outcome (Birchwood et al, 1998; Garety & Jolley, 2000; Lenior et al, 2001). It is considered a "critical period" which impacts on future impairments and disabilities. This period is associated with the risk of negative effects on cognitive and social functioning occurring from changes in mental state and behaviour.

In the initial trial (Drury et al, 1996a), 40 patients were randomly allocated and compared to a control group. The treatment group received intensive CBT, consisting of individual, group and family sessions and a structured activities programme. Therapy targeted the modification of delusional beliefs and associated distress, negative symptoms and relapse prevention. The control group received a structured activities programme and non-specific counselling. Overall, for both groups mean therapist contact time was eight hours per week for six months. A limitation of the study is that assessors were neither independent nor blind to treatment allocation. Since the CBT intervention consisted of a number of different elements, the essential ingredients of therapeutic change were obscured. Furthermore, it is questionable

whether any results generated by the study could be achieved outside the control trial setting, given the degree of intensive therapeutic contact.

Initially, the study produced promising results. CBT resulted in a significantly faster and more complete recovery from the psychotic episode. At nine-month follow-up, 95% of clients in the intervention group showed significant improvements in positive symptoms. This compared to 44% of the control group. Both groups showed similar improvements in negative symptoms. A marked reduction in delusional conviction was found but no corresponding reduction in preoccupation with delusional beliefs. Furthermore, depending on the definition of recovery from the acute phase of illness, a 25-50% reduction in recovery time was achieved (Drury et al, 1996b). However, at five-year follow-up the CBT group had lost most of these initial gains, performing similarly to the control group in terms of positive and negative symptoms (Drury et al, 2000). No significant differences in delusional conviction were found in either group. Furthermore, both groups showed a similar pattern of relapse. However, patients who had at most one relapse in the intervening years showed some marginal improvements in terms of positive symptoms and belief conviction.

Encouraging results in relapse prevention were found by Kemp et al (1996, 1998). Their randomised controlled trial focused on compliance therapy, a psychological intervention that has adapted techniques from cognitive therapy and motivational interviewing. It is described as a brief, pragmatic treatment, aimed at improving attitude to medication, promoting post-discharge compliance and developing insight. The treatment is intended to be widely applicable in the clinical setting (Surguladze et al, 2002).

The study population was drawn from consecutive admissions to a ward of the Maudsley Hospital over a 14-month period. Seventy-four clients with acute psychosis received a total of 4-6 sessions of CT twice weekly or the control treatment of non-specific counselling. The importance of treatment alliance and client participation in care is well recognised (Olfson, 2000), hence the study is clinically meaningful. Whilst reliable assessment instruments were used and robust baseline data obtained, limitations of the study include an overall 35% drop-out rate during the 18-month follow-up period. Furthermore, a researcher who was not blind to treatment status made initial and three-month follow-up ratings. At subsequent 12 and 18-month ratings, however, researchers were blind to treatment status. Compliance was measured by corroborating evidence from a number of independent sources such as relatives, family practitioner and CPN's. However, no direct compliance measures, such as urine or blood analysis, were employed, as these were either unavailable for all medication types or were considered excessively invasive.

The authors found that the goals of compliance therapy were achieved. For the treatment group, significant improvements in insight, compliance and attitudes to treatment were found. Similarly, advantages in social functioning and an increased number of days before readmission were reported. However, both intervention and control groups performed similarly in terms of significant improvements in positive and negative psychotic symptoms. Whilst having no difference in baseline psychiatric symptoms, the patients who dropped-out had lower baseline insight ratings and more severe extra-pyramidal side effects. Despite the high drop-out rate, the researchers comment that CT was generally acceptable to patients and proved adaptable to the busy clinical environment. Predictors of good outcome were voluntary status

on admission, fewer side effects and, in contrast to Garety et al's (1997) study, higher I.Q.

Conclusion

Overall, the studies reviewed here are consistent in demonstrating the benefits of well-developed cognitive interventions for sufferers of schizophrenia. Less evident are the benefits of non-specific, supportive counselling, although this also appears to offer some advantages over routine care. Effects tend to be specific to the domain of positive symptoms, such as delusions and hallucinations. In this area, problem-solving, symptom-focused approaches appear effective, as do those based on the modification of dysfunctional schemas. Fewer trials demonstrate benefits in terms of negative symptoms. The debilitating effects on social functioning caused by schizophrenia appear more resilient and impervious to therapeutic change. However, conflicting results in this area suggest the means by which these interventions achieve therapeutic change is not well understood.

Evidence that cognitive interventions achieve a high satisfaction rate with clients (Kuipers, 1997; Kemp et al, 1996, 1998) is encouraging. However, a recent Cochrane review (Cormac et al, 2002) highlights how the efficacy of these procedures remains largely untested when applied by practitioners who are less experienced than those involved in clinical trials. This indicates that further pragmatic and methodically robust studies are needed to explore what treatment works best for whom and under which conditions. In conducting these studies, researchers need to agree a template by which to determine the most crucial outcomes measures. Furthermore, whilst not aiming to limit the scope of further research, studies should reflect the realities of caring for people with schizophrenia. Finally, research findings should be incorporated into a theoretical model of psychosis, which in turn, could inform both further research and current practice, thus facilitating the titration of therapeutic interventions according to clinical need.

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Case Management: A Critical Analysis of the Literature

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Abstract:

This article reviews a variety of case management models that have been developed over the past two decades. The clinical case management model is a response to the problems inherent in identifying these resources. It thus recognises that case managers may need to provide services directly and hence act as clinicians. Assertive community treatment models are characterised by more frequent client contact and is provided by a multi-disciplinary team with services delivered in the community rather than by and individual in the clinician's office. The differences between ACT and intensive case management are reviewed. The ACT model of case management in the United Kingdom takes a historical perspective and is discussed in terms of the wider social context. The UK700 group study found substantial improvements in hospitalisation rates only when the team had medical control over the discharge of clients. However, no significant gains in social functioning or mental state were discovered. They conclude that "the policy of advocating intensive case management for patients with severe psychosis is not supported. In contrast, Marshall and Lockwood (1998) find that ACT results in reductions in both frequency and duration of admissions and proves superior to standard case management in maintaining contact with service users. In reviewing the literature on case management in the UK, broad differences in models become apparent. However, these differences may be more due to social and political factors than clinical outcomes between the models.

Introduction

Throughout the 1980's and early 1990's, psychiatric hospitals in Britain underwent a period of closure and reduction in bed numbers. Seen as "warehouses for human beings who have been discarded by society" (Stein, 1991 cited in Sandford and Gournay, 1996) these large institutions were the subject of a social policy that reflected the fears of many health care professionals. Institutionalisation was seen as greatly disadvantaging the individual sufferer of serious mental illness and was thought to be responsible, in part, for compounding many of the negative symptoms of schizophrenia (Brennan et al, 2000). Currently, the number of psychiatric beds in Britain is some seventy four percent less than at its peak in 1954 (Lamb, 1997). Emerging from the United States in the 1960's, during a period of similar de-institutionalisation, case management evolved as an alternative to hospitalisation.

King et al (2000) detail the problems inherent in attempting to arrive at a working definition of case management and describe how little is known about its service organisation and process. Many sources highlight the fact that case management is not a cohesive philosophy or disciplined set of ideas (Chan et al, 2000). A significant influence of national culture is evident in both approaches to research and definitions of case management (Burns et al, 2001). Gournay (2000) observes how terms such as assertive community treatment, case management and home treatment are used interchangeably. It appears that even among researchers, some confusion regarding these terms exists and is thus reflected in the literature. However, Sledge et al (1995) attempt to arrive at a lexicon definition and in so doing reveal that implicit in the term "management" is the "definition of authority over the conduct of work and the control of resources." They refer to the fragmentation of services and the absence of a general linkage between hospitalisation and community care. Hence, despite this apparent lack of clarity in definition, the object of case management can be regarded as the coordination of services in a way that ensures their integration and continuity for individual sufferers.

A variety of case management models have been developed over the past two decades and are detailed by Mueser et al (1998). The Broker model, one of the first to emerge, places emphasis on assessing the needs of clients, treatment planning and referring on to other agencies. This model, also known as standard case management, views the manager as the client's advocate who is responsible for coordinating between various services and for the ongoing monitoring of care. There is an assumption that in acting as a "broker" the case manager does not require any specific clinical skills, but rather the ability to match available resources with needs.

The clinical case management model is a response to the problems inherent in identifying these resources. It thus recognises that case managers may need to provide services directly and hence act as clinicians. The model identifies four broad areas; an initial phase of engagement, assessment and planning; environmental interventions involving the use of community resources, maintenance of support networks, family work and advocacy; patient interventions such as counselling, development of independent living skills and education; and finally patient-environmental interventions such as monitoring and crisis intervention.

Designed as a package of care for sufferers of more severe mental disorders, assertive community treatment is characterised by more frequent client contact. It is provided by the multi-disciplinary team with services delivered in the community rather than the clinician's office. Caseloads are low (about 10-15 clients), shared across clinicians and are not "brokered out" to other agencies. Twenty-four hour provision of care and assertive outreach is characteristic of this approach and services are generally regarded as time limited. However, Freeman (2000) finds that evidence from the United States indicates how ACT is most successful in reducing hospitalisation rates when a comprehensive and enduring approach is adopted. Similarly, Marks et al (1994) find that many clients require an assertive outreach approach indefinitely.

The differences between ACT and intensive case management are detailed by Gournay (2000) and are given greater emphasis than Mueser et al's account. Other than the sharing of caseloads that occurs in ACT and not intensive case management, Mueser et al make little distinction between the two models. However, Gournay considers ACT to involve community

work exclusively, whereas ICM includes working with other parts of the psychiatric service and the provision of care in a wider range of settings.

The development of case management in Britain can be traced to the publication of the Griffiths Report in 1988. Commissioned by the government following the killing of a social worker by a former client, the report recommended the transfer of all community care to local authorities. In response, the government published the White Paper *Caring for People* (Department of Health, 1989). It marked the development of the distinction between purchaser and provider and set out a framework for changes to community care, which included case management. The legal changes necessary for the implementation of the White Paper were established by the NHS and Community Care Act 1990. In Wales, the development of multidisciplinary community mental health teams was driven by the All Wales Mental Illness Strategy (Welsh Office, 1989).

The Care Programme Approach (CPA) was introduced as an attempt to standardise the delivery of community care services and provide guidance on how health authorities in England should meet the requirements of the NHS and Community Care Act 1990. Case management is widely used in the United Kingdom in response to the CPA guidance (Bowers, 1998). Anyone in contact with "specialist psychiatric services", including in-patients as well as those living in the community, should fall under the remit of the CPA. These services include psychiatrists, psychiatric nurses, counsellors, psychologists and mental health social workers. A systematic assessment of health and social care needs, detailed written care plans, a regular review system and the appointment of a key-worker are fundamental to the approach. Highly critical of the CPA, Marshall (1996) describes case management as a "dubious practice ... underevaluated and ineffective" and asserts that its "astounding ability to flourish" against sparse favourable evidence and hence its apparent "immunity to scientific analysis", is indicative of the protection it receives as government policy.

In comparing case management to standard community care, Marshall et al (1997) draw a number of unfavourable conclusions. Although criticised for their exclusive study of the brokerage model (Shepherd, 1998), they find that whilst case management facilitates increased contact with psychiatric services, there are increases in rates of admission to hospital with a possible corresponding increase in the duration of stay. Similarly, despite the fact that improved compliance is reported, there is an absence of evidence to support improvements in mental state, social functioning and quality of life. They conclude that case management is "an intervention of questionable value, to the extent that it is doubtful whether it should be offered by community psychiatric services." These findings are supported by a randomised controlled study in London over an eighteen-month period. The study found that whilst a higher level of supervision lead to a reduction in loss of contact, the approach lead to an increased use of psychiatric beds (Tyrrer et al, 1995).

Nonetheless, the Department of Health has emphasised the government's commitment to the further development and on-going implementation of case management. The NHS Plan outlines the government's agenda and pledges the establishment of 220 assertive outreach teams across the country by 2003 (Department of Health, 2000). However, many sources warn that this approach may be "no panacea" (Brimblecombe, 2001; Sainsbury Centre for Mental Health, 1999; Shepherd, 1998). Areas with the most comprehensive community

services continue to depend upon the inpatient facilities of psychiatric hospitals to provide a secure and supportive environment for a minority of individuals.

Freeman's account of the ACT model of case management in the United Kingdom takes a historical perspective and considers the wider social context. The Ritchie Inquiry (cited in Freeman, 2000) concluded that public support in the government's community care project was diminishing due to the inability of the psychiatric services to meet the needs of severely disturbed and chaotic individuals. This resulted in another tragic killing of a member of the public. The inquiry called for highly intensive care, risk assessment and the training of key workers. Seen by some as a response that was both unconsidered and lacking in awareness (Marshall, 1999), the government published *Modernising Mental Health Services: Safe, Sound and Supportive*, a document containing the controversial statement "community care has failed" (Department of Health, 1998). Commenting that the document sets out "an extensive – and possibly unrealistic – wish list for improvement", the Sainsbury Centre for Mental Health (1999) warn against the potentially demoralising effects on both community staff and service users and stress that "it is vital to distinguish between political 'spin' and the substance of the strategy". Allot (1999) is critical of the government's strategy for its lack of evidenced based recommendations. The Sainsbury Centre for Mental Health (1999) refer to a steady three percent decline in statistics relating to homicides committed by people with a mental disorder. Furthermore, a recent study in the United States suggests the sufferer of serious mental illness is fourteen times more likely to be the victim, rather than the perpetrator of a violent crime (Brekke, 2001). The study concludes "the risk associated with being in the community was higher than the risk these individuals posed to the community". Differences between the two cultures notwithstanding, it would seem that Brekke's comments are pertinent to the UK.

In a major review, the Sainsbury Centre for Mental Health (1998) focused on the needs and aspirations of the seriously mentally ill, estimated at between 14-200 per hundred thousand of the adult population. Attempting to address this client group's failure to engage with services, the review found a number of interrelated factors at play. For some individuals this failure to engage was due to the inappropriate nature of services, for others their individual experiences such as negative staff attitude. The report places attitude and style of working at the centre of an effective service. In accordance with research conducted in the United States (Williams et al, 1994) it stresses the ability of staff to empathise with some of the most alienated and dispossessed members of society. The Review concludes that it is impossible for community mental health teams to meet the needs of this group without the employment of an assertive outreach approach. However, the work of the UK700 group appears to stand in contrast with these conclusions.

McGrew and Bond (1995), cited in Dodd (2001), found a maximum caseload size of one staff member to ten clients allowed for the high level of contacts required to ensure meaningful interventions. However, in exploring the clinical effectiveness of ACT, the UK700 group discovered no correlation to caseload size, thus shedding doubt on one of its main principles (Burns et al, 1999). In a two year study the group found that teams working with small caseloads of around fifteen clients did not produce significantly different outcomes to those with caseloads of thirty and thus comment that "energy and investment should aim at the specific content of care ... rather than its form and delivery." However, King et al (2000) comment that caseload size has a significant impact on the health care professional's "self-

perceived role performance". Acknowledging the controversies around this area, the Welsh Office (2001) use this evidence to assert a difference in approach from the assertive outreach practices outlined in governmental policy. They advise the "careful management" of caseloads in order to allow an "assertive approach" to occur. Furthermore, as confirmed by an inner London study conducted over a twenty-month period (Marks et al, 1994), the UK700 group found substantial improvements in hospitalisation rates only when the team had medical control over the discharge of clients. No significant gains in social functioning or mental state were discovered. They conclude that "the policy of advocating intensive case management for patients with severe psychosis is not supported" (Byford et al, 2000).

Supporting this argument is the work of the PRISM Psychosis Study. Here, Thornicroft et al (1998) whilst finding some improvement in social functioning and mental state, note that these differences are not significant when compared to less intensive models of case management. They conclude "there is little difference between the community mental health team models." In addition, unacceptable delays for community services effect thirty percent of inpatient beds, resulting in delayed discharge, and staff responsible for the delivery of community care have high sickness rates and low morale (Thornicroft and Goldberg, 1998).

In contrast, Marshall and Lockwood (1998) find that ACT results in reductions in both frequency and duration of admissions and proves superior to standard case management in maintaining contact with service users. When compared to traditional hospital based rehabilitation they find that it has no effect on mental state or social functioning. However, they conclude that for sufferers of serious mental illness ACT offers an effective alternative to both standard case management and hospital based rehabilitation. Their findings are questioned by Wasylenki (1998) since they do not address issues of homelessness or substance abuse problems. Lehman et al (1997) demonstrate how ACT can result in more stable housing and increased contact with psychiatric services by homeless people. Marshall and Lockwood do not indicate to what extent these factors influence their findings. Furthermore, whilst the reduction in admissions results in a reduction in hospital expenditure, this saving is offset by the additional cost of providing ACT. This is confirmed by Harrison-Read's (1998) two-year study in an outer London Borough. Here, ACT failed to produce a significant saving in the cost of hospital bed use, yet doubled the spending on community care.

Many researchers appear preoccupied with the monetary savings made possible by the various models of case management (Byford et al, 2000; Harrison-Read, 1998; Latimer, 1999; Lehman et al, 1999; Llorca et al, 2001; McCrone et al, 1999; Rosenheck and Neale, 1998). Few question the assumption that mental health care and cost improvement plans are compatible. Hence, the notion that practitioners should strive towards an evidence based approach, not for the promotion of that which is scientifically valued in meeting the client's needs, but rather to compete for seemingly scarce resources is left unchallenged.

User satisfaction with the principles of ACT and how they translate into practice is well documented (Gerber and Prince, 1999; Brimblecombe, 2001; Lloyd et al, 2000). The assumption that clinical practice and the criteria for judging clinical effectiveness emerge from social, political and economic interests underlies the work of Rohde (1997). He details how clinical intervention should centre around empowerment of the service user with priority given to the user's right to voice opinions regarding the access to and delivery of mental health

services. However, with some concern, Smith et al (1999) cite evidence from the United States that assertive outreach does not emphasise the importance of a therapeutic relationship, but rather the recording of contact with individual sufferers. In their opinion the wishes and rights of clients are ignored in favour of risk management and assessment. Threats of detention or punishment, infringement of privacy and the use of public toilets to administer depot medication are given as some of the worst examples of assertive outreach in the US. In examining the development of case management over the past thirty years, Rohde finds that the various models have evolved to accommodate the growth of the community mental health system following de-institutionalisation, at the abandonment of clients' interests to improve their quality of life.

Inadvertently, authorities on assertive outreach in the United Kingdom offer descriptions of its accepted practices that may indicate the growth of a parallel system of coercion. "Housing departments, police stations, social security offices and inpatient units" are listed as examples of the client's "own environment" and accepted as settings "where they feel most comfortable" (Sainsbury Centre for Mental Health, 2001).

Recognition of growing social inequality is increasingly commonplace, yet remains largely unacknowledged in the literature. Both the World Health Organisation (2001) and The Financial Times (Le Grand, 1999) refer to a gap between rich and poor that is greater than at any time since records began some 100 years ago. Brimblecombe (2001) comments that "few pioneers of home treatment ... have appeared to take a clear philosophical stance on its meaning or ideals." Whilst undoubtedly true, it is hard to see how the absence of such an approach can be justified, given that the provision of case management is set against a backdrop of such a fundamentally unequal society.

In reviewing the literature on case management, broad differences in models become apparent. Low intensity models such as the brokerage system stand opposed to high intensity models such as ACT and ICM. Reasons for these differences are largely historical, yet interweave with both theoretical differences and differences in nuance and approach. The content of care, style of working and importance of staff training have emerged as recent themes in the literature (Sainsbury Centre for Mental Health, 1998; Burns et al, 1999). Whilst research into clinical effectiveness has proven somewhat contradictory, the evidence would appear to suggest that, with a degree of caution, assertive treatments may prove the way forward in caring for sufferers of severe mental illness in the community. However, it seems clear that the practice of case management may reduce, but will not remove the need for inpatient beds.

UK policy governs the development and application of case management and has been the subject of much criticism. This policy may be viewed in the context of specific political and social factors. Rather than evidence based considerations, governmental concern relating to a wide spread loss of faith in its ability to protect the public appears to drive case management policy. It could be said that in hiding its motivation to transfer the financial burden of care from the state to the community, the establishment has exploited the fear of institutionalisation held by many health care professionals.

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The Influence of Collateral Informants on Psychiatric Emergency Service Disposition Decisions and Access to Inpatient Psychiatric Care

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Abstract

Objective: Psychiatric Emergency Services (PES) are the entry point to the mental health system for many and the presentations frequently involve coercion. In these cases, the societal value of access to appropriate care may conflict with the value attached to confidentiality and procedural justice. Many influences on these decisions have been studied previously but financial pressures affecting access and public policy changes affecting patients' rights have significantly altered the context in which PES assessment and disposition decisions occur. This necessitates a re-examination of the factors which influence both voluntary and involuntary hospitalization. This paper addresses the important role of collateral sources of information on the admission process. **Methods:** A retrospective chart review of 287 people presenting at the Bellevue Comprehensive Psychiatric Emergency Program was conducted. Medico-legal and socio-demographic data were collected on each visit and multiple outcomes, primarily involuntary hospitalization and hospitalization of any type were examined. Step-wise logistic regression models were used to test the importance of multiple influences on these outcomes. **Results:** The presence of additional sources of information provided by collaterals increases the likelihood of both involuntary and voluntary hospitalization even when diagnosis, level of dangerousness and other socio-demographic variables are controlled. **Conclusion:** Additional information appears to facilitate access to inpatient care. In the current climate within which psychiatrists must make admission decisions, information from collateral sources takes on increased importance.

The Influence of Collateral Informants on Psychiatric Emergency Service Disposition Decisions and Access to Inpatient Psychiatric Care

Access to inpatient psychiatric care, and particularly the role of involuntary hospitalization in accessing care, is a topic of new importance. Historically the study of psychiatric emergency service (PES) decision making has focused on the array of medical/ legal and social factors that influence involuntary hospitalization. This approach has often assumed that involuntary

hospitalization is undesirable and searched for inappropriate influences, such as race, on the involuntary hospitalization process. However, recent changes related to reimbursement have created a situation in which inpatient hospitalization, even through civil commitment, may be a desired resource for some people, their families and communities. If this is the case, the influences on PES decision making must be re-examined using new models.

Medical and legal characteristics such as diagnosis, symptoms and a person's potential for dangerous behavior (1,2,3,4) as well as social factors such as race (2,3,5,6,7), gender (2,3,8), and source to the emergency room (2,3,5,9) have all been examined previously for their impact on PES decisions. As expected, diagnosis, symptoms and level of dangerousness all predict involuntary hospitalization (1,2,3,4).

Social factors have been examined primarily from within a social control framework. According to this model, people who are marginalized and powerless will be more likely to receive undesired and coercive treatment (10). Support for the social control perspective has been found in the disproportionately high rate of involuntary commitment among black patients or patients brought to the PES by police officers (5,11).

However, the current setting in which involuntary hospitalization occurs is dramatically different from that of a decade ago. The numbers of inpatient beds have been greatly restricted while the number of visits to PESs has increased (12, 13). Reforms in civil commitment law beginning with the Lanterman Petris Short Act in California [Lanterman-Petris-Short Act (Cal Welf & Inst Code, div 5 pt 1) have improved procedural justice in the area of involuntary hospitalization by requiring evidence of mental illness and danger. Some have argued that the dangerousness standard permits patients to "die with their rights". Some states allow civil commitment on the basis of grave disability but even the more paternalistic grave disability standard may link disability to evidence of associated danger. Thus, in New York State, an individual in the same mental state may be detained in the winter due to the risk of freezing but released in the summer. Management of hospital utilization has simultaneously resulted in near universal application of a similar dangerousness standard for reimbursement. Under these conditions, clinicians must show evidence that most hospitalized patients satisfy involuntary hospitalization criteria to withstand utilization review if not judicial review. Evidence concerning the presence of mental illness and dangerousness have hence become *the sine qua non* of hospitalization.

Attention has recently broadened to a number of other factors influencing the quality of PES assessment such as staffing (15) and interrater reliability (16). Collateral information is another factor that has an important bearing on outcome

Collateral sources of information include family members, other medical providers, police officers, friends or prior records. Collateral informants may supply objective data and improve assessment or advocate a particular outcome and add to bias.

Developing collateral information also requires additional time and effort of patients, staff and others; training including cultural competency; and resources such as phones and computers. Consumers may view the additional time as delay and contacting third parties as intrusive. On the other hand, if associated with a poor outcome, failure to take the necessary time and gather additional data may be viewed by some as malpractice.

In this study, we report on the influence of sources of information other than the patient on the decision to admit patients to the hospital from the Bellevue Comprehensive Psychiatric Emergency Program (CPEP).

Methods

The study was conducted in one of the busiest urban, public, teaching hospitals in the country. The CPEP receives over 6000 visits per year and, at that time, served as the admission service for 350 inpatient beds. These beds were at 100%+ capacity throughout the entire course of this study. Cases were identified from the CPEP logbook from January, March and June of 1995. There were a total of 1546 visits during these months. Stratified sampling was used in order to guarantee adequate data on police involved cases. Every fifth non-police case (N=228) and every police case (N=315) was included in the sample. This included both Emotionally Disturbed Persons (EDPs) for whom no criminal charges were pending and pre-arraignment cases. EDPs are said to be "aided" by the police in presenting to the hospital and are not charged with a crime. Prearrest cases are in the process of arrest and will be formally charged with a crime. Prearrest cases have been excluded from this analysis as the assessment in these cases is limited in scope in an effort to avoid delays in the due process protections afforded by arraignment in the criminal justice system. Such individuals may return to a hospital subsequently either voluntarily or at the direction of the arraignment judge for a more typical examination. Therefore the process of evaluation and disposition of these cases is not similar to those of the rest of the sample. Medical records were available for 362 of the sampled visits. This represented 67% of the non-police involved cases and 66% of the police involved visits. This provides evidence that differential loss to follow-up related to police involvement did not bias these results. The possibility that other characteristics related to missing charts (ie. admitted vs. not admitted) could not be ruled out.

For each sampled visit the patient's socio-demographic characteristics and medical and legal characteristics were collected from the medical records. Dummy variables for diagnosis were: affective disorders including bipolar disorder, major depression or depressive episode and dysthymia; psychotic disorders including schizophrenia, psychosis nos, brief reactive psychosis, and schizoaffective disorder; substance use disorders; personality disorders; and anxiety disorders. In addition variables were created reflecting the comorbidity among diagnoses. The inclusion of the comorbidity variables in the logistic regression models did not change the results so in order to create parsimonious models only the individual diagnostic variables were included in the final models.

The 'level of dangerousness' variable, was created from data collected on the precipitating events from the patient's chart. Four levels of dangerousness were created based on the person's most acute level of dangerousness. A person was coded as 'dangerous' if they had attacked someone or something with or without a weapon or made a suicide attempt. A person was coded as 'potentially dangerous' if they were described as being potentially dangerous to themselves or others. The third

level of dangerousness included people with noted suicidal ideation and the final level of dangerousness includes people with bizarre behavior who do not fall into any of the above categories. Multiple informant reports of the precipitating events were used whenever available to try to address potential bias in the recording of the precipitating events in the chart.

To check coding reliability of the descriptions of the precipitating events, a random sub-sample of forty cases were coded by three independent coders. All gender and race language as well as any references to police involvement were removed. Cohen's Kappas for the various combinations of the three raters ranged from .34 for bizarre behavior which was a very subjective rating to 1 for suicide attempt.

Data on patient race/ethnicity, sex, age, insurance status and education level were obtained from the CPEP visit sheet. Unfortunately education and insurance data were frequently missing and could not be used in these analyses. Employment data were assessed from the CPEP visit sheet as well as the social work report when available. Homelessness was determined from physician notes in the CPEP visit sheet and variables were created for where the person lived (apartment/house, shelter, SRO, street etc) and with whom (parents, spouse/partner, alone, other family member). This served as a cross-check of the person's actual living situation.

Data on individuals who arrived at the CPEP with the identified patient were collected from the medical record, and confirmed with police reports. Data on the sources of information about the patient available to the clinician in the CPEP were collected from the medical chart and the police reports. Possible dispositions for cases at the CPEP include emergency hold, involuntary commitment, voluntary admissions, transfer to other hospitals, transfer to state hospital or long term care, and treated and released or discharged.

The stratified sampling used in this study necessitates the use of SUDAAN in the final analyses. SUDAAN uses Taylor Series methods to calculate appropriate standard errors when such complex sampling designs are used. Throughout the paper all frequencies are unweighted (N) and all proportions have been computed using the weighted data.

Results

Table 1 contains data describing the sample characteristics. The sample is predominantly male (77%) and the mean age is 38. Thirty-two percent (N=96) of the sample is white, 43% Black (N=115), 20% Hispanic (N=54) and 5% of other ethnic origin (N=22). In addition the hospitalization outcomes were found to be as follows: Forty-six percent of the sample was hospitalized: 10% percent voluntarily, 36% involuntarily. Police reports were present for 12.5% (N=105) of the sample. In 13% (N=31) of the visits prior records were available, family members provided information in 22% (N=74) of the visits, a medical professional outside of the CPEP provided information for 30% (68) of the cases, 6% (n=14) of the sample was noted to be known to the staff, and for 8 cases friends provided information. Nine percent of the sample was ultimately transferred to long-term care, most frequently the state hospital.

Table 1: Frequency Table for the Medico-legal and Socio-demographic Variables

	Weighted Proportion (%)	Unweighted N
Psychotic Diagnosis	53.6	156
Affective diagnosis	34	94
Substance abuse disorder	55.2	155
Personality disorder	4.4	12
Anxiety disorder	5.3	12
Speech irregularity	21.9	73
Suicidal/homicidal ideation	30.4	83
Thought content irregularity	45.5	134
Thought process irregularity	39.8	126
Attacks on people or objects	5.2	31
Threats of attacks on people or objects	17.1	60
Potentially threatening behavior to others or self	24.1	83
Suicidal ideation	29.4	68
Suicide attempt	5.9	22
Bizarre behavior	42.4	122
Seeking social services	7.6	17
Seeking medication	29.8	60
Sex Male	76.9	209
Female	23.1	78
Race		
White	32.1	96
Black	42.5	115
Hispanic	20.4	54
Other race/ethnicity	5.1	22
Living arrangement		
Apartment/house	37.2	115
SRO	3.3	10
Shelter	17.2	40
Street	26.8	76
Other	15	45
No family involvement	61.7	117
Living alone	64.7	174
Unemployed	77.4	217
Source to the CPEP-Along		
Family	65.1	122
Police	7.2	14
Other	17.6	131
	10	20

Initial univariate analyses were conducted on all source of information variables and several were significant univariate predictors of involuntary hospitalization and total hospitalization, ie, either voluntary or involuntary. A police report, information provided by a family member and information provided by a medical professional outside of CPEP all significantly predicted hospitalization outcomes. The source of information variables were then collapsed, due to small numbers in some cells, into one variable indicating the availability of any outside source of information to the clinician in the CPEP.

Step-wise logistic regression models were developed for the role of any outside source of information on the two primary outcomes: involuntary hospitalization (Model 1) and total hospitalization (Model 2). In Model 1, the presence of any outside source of information significantly predicts involuntary hospitalization with diagnoses, age, level of dangerousness, sex, source to CPEP and race controlled. People for whom collateral information was available were 2.9 times more likely to be involuntarily hospitalized than those for whom no collateral information was available. In addition in Model 2 a similar relationship is seen. Controlling for the same medical and social variables, people for whom collateral information was available were 2.5 times more likely to be hospitalized than people for whom no collateral information was available. Parallel analyses were conducted among the subsample of cases without police involvement and the same relationships were found.

Table 2: Univariate Analyses of Source of Information and Hospitalization

	Frequency % (N)	Odds Ratio	(95% C.I.)
Source of Information			
Police Report	12.5 (105)	1.98*	(1.07, 3.61)
Medical Chart	13.1 (31)	1.54	(.68, 3.50)
Family Member	22.2 (74)	2.06*	(1.04, 4.22)
Friend	2.1 (8)	.38	(.04, 3.39)
Known to Staff	6.3 (14)	.70	(.22, 2.34)
Medical Professional	30 (68)	2.94**	(1.55, 5.61)

Table 3: Final Logistic Regression Models on Involuntary Hospitalization and Hospitalization

	MODEL 1 Exp B (Odds Ratio)	MODEL 2 Exp B (odds ratio)
	Involuntarily Hospitalized	Hospitalized
Informed	2.891**	2.469 *
Danger 1 (dangerous)	3.471	2.961 *
Danger 2 (potentially dangerous to self or other)	7.865	4.336 *
Danger 3 (suicidal ideation)	1.069	2.226 *
Danger 4 (bizarre behavior)	.047 **	.655
Age	1.052	1.042 **
Dxad (anxiety)	1.448	.816
Dxaff	9.119 **	10.976**
Dxpd (personality)	.957	.4
Dxpsych	23.927 **	8.843 **
Dxsubs	4.425 **	1.880
Sex (1=male)	.133 **	.647
Source= Alone		
Source1 (family)	7.195 **	2.090
Source2 (police)	3.163	5.233 *
Source3 (transfer from other hosp)	2.556	3.262
Source4 (other)	185 **	19.478 **
Black	.349 *	1.081
Hispanic	2.965 *	3.847 **
Other race/eth	4.055	5.004

* p<.10 ** p<.05

Other significant predictors of both involuntary hospitalization and total hospitalization include a diagnosis of an affective, psychotic or substance use disorder. Further analyses conducted on the influence of diagnoses found that substance abuse not comorbid with psychotic disorder did not significantly predict hospitalization by any mechanism but in fact decreased the likelihood of inpatient admission (15).

Regarding race and gender, Hispanic patients were more likely than white patients to be admitted. Black patients were a third as likely as white patients to be admitted involuntarily but there was no overall admission difference. Finally female patients were more likely than male patients to be involuntarily hospitalized.

Discussion

It is fairly common for family or community providers to arrange for a patient to go to an emergency room with the expectation that the patient will be admitted to hospital only to have the patient return to them often with no direct communication from the ER. This is a source of great concern and frustration to the community.

This results of this study seems to suggest that, as admission decisions are increasingly constrained by formal legal and utilization criteria, data from multiple sources improve the chances of clearing the legal and financial barriers to hospital care. If that is the desired outcome, then communication by concerned parties with responsible PES personnel is advisable. This is understood among physicians and is the subject of continuity of care agreements, EMTALA regulations, etc. It may be less well understood by nonmedical providers, police, families and advocates. While confidentiality may limit the extent to which hospital personnel may contact others regarding the patient, those limits do not apply to individuals contacting the hospital to provide data. The credibility of informants and the potential for abuse must be considered in weighing the resulting data but in civil commitment decisions, such reports may be legitimately considered and need not be treated as "hearsay" as they might in criminal proceedings. This study can also be viewed as lending support to the practice of providing a structured means of qualifying informants and communicating relevant data such as a form that may then be entered into the medical record. This is a common practice with police informants.

Segal et al (15) have pointed out this association of informants with admission may reflect bias in favor of third party advocates for admission. However, those authors reported that data from advocates contributed to the assessment of dangerousness and hence facilitated application of civil commitment criteria rather than social bias. In that study, conducted under California law, psychosis and dangerousness were the main contributors to coercive retention modified by availability of alternatives and information from other sources. Our findings are consistent with those of Segal et al. In the authors experience, PES clinicians are receptive to data but less so to opinions or directions. Data may include evidence of the failure of alternatives to hospitalization including the inability of community providers to render care under the circumstances. Alternatively, sending the patient to the ER with a request for admission but little data to support that recommendation may be viewed as "dumping".

Our findings with regard to diagnosis are also consistent with those previously reported. In a different sample in the same facility, one of the authors has reported that cocaine use was inversely correlated with admission (18).

Our finding of a strong relationship between admission and Hispanic origin is interesting. More work is needed to better understand this relationship which has also been reported by others (5). It may be that family were more involved and influential in Hispanic cases. Specific attention needs to be focused on the role of language and culturally specific understandings of family and family involvement in help seeking and admission decision making. Additionally the influence of black race on involuntary admissions must be further explored since our study clearly does not find black patients more likely than white patients to be involuntarily hospitalized but does suggest equal access to hospital care overall. The impact of race and ethnicity will be the subject of a subsequent report.

This study has the limitations inherent in retrospective reviews of routine data collection instruments. However, the design of this study avoids the observer effect that may have been present in the prospective studies by Segal et al.

This study was not able to ascertain the reliability or validity of assessments and decisions. We did not attempt to determine whether the disposition was "correct" in light of subsequent examinations or outcomes such as future contacts with ERs, criminal justice system or, in the case of suicides, the coroner or medical examiner. As suggested by the low level of agreement about factors such as bizarre behavior in this study and impulse control in a related study, there is a need to improve the reliability of key constructs in PES decision making(16).

As hospitalization rates decline, Lamb and Weinberger have reviewed evidence suggesting that a stable number of individuals will be confined in either hospitals or jails and prisons and that the trend in the US has been toward the latter, incarceration of the mentally ill in jails and prisons (14). Hence the question may not be if but where and under what conditions incarceration will occur: deprivation of liberty with or without deprivation of care. We must continue to weigh the importance of respecting confidentiality, third-party bias and potential abuse with this question. Increasing the information available to decision makers concerning an individuals behavior in the community may contribute to improving these critical decisions.

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