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THE SUMMER EDITION

- Navigating Boundaries in Therapy
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FOREWORD

Welcome!!

We are thrilled to be introducing the second edition of Clinical Psychology Today.

The idea behind the journal is quite a simple one; we hoped to continue to create a forum where Clinical Psychologists across Ireland can exchange and discuss relevant issues which arise when undertaking this work. It is hoped that these articles will be of help in everyday practice and, in time, will create an evolving reservoir of knowledge, of value to Clinical Psychologists throughout Ireland.

One of the additional aims of the journal is to provide space for debate, a space where ideas can be shared and challenged in the spirit of true knowledge attainment.

In this edition we have some wonderfully diverse pieces and believe these will be of interest to a range of Clinical Psychologists working across these different domains. The pieces contained here both represent a significant amount of work undertaken by the various authors, and also provide valuable insights into the challenges and real value inherent in these varied forms of psychological endeavour.

This edition would not be possible without the authors who submitted their work for consideration and the considerable work of the CPT team. We wish to acknowledge the work of the steering group, the many reviewers who provided us with much appreciated feedback on the submitted articles, and Siobhan O'Neill and Olive Moloney for their work and assistance with the design and layout of this edition. A final thank you on last minute editing to Lisa Clogher and Sinead Murphy!

Lastly, don't leave without taking a few minutes and look at our "notice-board" to find out the many different ways in which you can become involved with CPT.

Thanks again,

Have a great summer.

With thanks,
Edition Editor and Deputy Editor: Sean Foy & Eoin Galavan.

MANAGING BOUNDARIES IN THE THERAPEUTIC RELATIONSHIP

RACHAEL KELLEHER

ABSTRACT

This paper will examine the ethical issues surrounding the management of boundaries in the therapeutic relationship both during therapy and outside the room. It will interpret ‘outside the room’ as the interactions with the client that occur before and after the therapy session ends. These may include insufficient closure, dual or multiple relationships, and out-of-office experiences. The paper will begin with examination of the literature and debate surrounding the definition of boundaries. It will continue with a discussion of the research and the impact of these elements on professional practice. As the paper draws on psychotherapy and psychology literature, the term therapist is used to refer to both psychologists and psychotherapists who are engaged in therapeutic work with clients. Policies and procedures which may guide best practice and the management of some of these ‘outside the room’ interactions are examined. Finally, the paper will conclude with a summary of the most salient ethical issues raised in the literature, as well as highlighting areas for future research.

DEFINING BOUNDARIES

A key framework for practicing ethical client-therapist interactions both inside and outside the therapy room is the concept of boundaries. Therapeutic boundaries are defined as "the edge of appropriate or professional behaviour, transgression of which involves the therapist stepping out of the clinical role”[1]. They play an important role in controlling the inherent power differential in the client-therapist relationship and allowing clients needs to be addressed and prioritised over the therapist’s own needs[1]. Addressing clients’ needs and maintaining professional boundaries also ties into psychologists’ ethical duty to act with integrity and responsibility towards clients[2]. The maintenance of boundaries helps preserve the integrity of the therapeutic relationship and expand the trust which the public holds towards therapists and clinicians[3]. This article attempts to explore the existing guidelines as regards common boundary queries facing therapists in practice, and to facilitate discussion around boundary-related issues which have not yet been covered by ethical guidelines or literature.

Ethical guidelines and therapeutic literature have reached a consensus that the therapeutic relationship between a therapist and the client exists with the sole purpose of enacting therapy. While the therapeutic relationship progresses and becomes more personal as the client discusses more confidential topics, there is an increased likelihood of developing strong emotional bonds[4]. A strong emotional bond in itself does not constitute a boundary issue. However, whenever the therapeutic relationship deviates from its basic goal of treatment, it becomes non-therapeutic[4]. It is this deviation that is known as a *boundary violation* as it may result non-therapeutic activity[4].

Gutheil and Simon differentiate between two types of boundary issues; *boundary violations* and *boundary crossings*[1]. Boundary issues have also been referred to as boundary transgressions[5]. *Boundary crossings* are defined as a transient deviation from classical therapeutic activity that is harmless and is non-exploitative of the client. The boundary crossing may, in some instances, support the therapy. Examples might include scheduling clients outside regular hours, helping an elderly client with their coat or offering more frequent follow-up contact than strictly necessary. A *boundary violation,* meanwhile, is harmful to and exploitative of the client, as well as damaging to the therapy[1]. Examples might include sexual misconduct with clients, dual relationships (such as therapist and friend), inappropriate self-disclosure, conflicts of interest, inappropriate behaviour arising out of transference and countertransference, and inappropriate touch. Related to these two definitions are the ‘slippery slope’ concept, which refers to the idea that what starts as one incident of boundary crossing may deteriorate into further and more frequent boundary violations[6].

Boundary transgressions may be made by clients towards therapists and may commonly include asking personal questions, attempting to socialize, and being overly affectionate or abusive. It is important that therapists maintain boundaries to minimise and manage boundary transgressions, while simultaneously respecting the client’s authentic goals and autonomy. Respect for the dignity of the client should always remain the fundamental ethical principle when therapists are approaching boundary problems[7]. However, defining what constitutes a boundary problem or transgression requires further discussion on the definition of boundaries themselves, explored below.

DIFFICULTIES IN DEFINING BOUNDARIES

Much of the ethical literature emphasises the complex and nuanced definition of boundaries. Deciding what constitutes a boundary violation or crossing is a complex issue. Bennett and colleagues’ model of the process of decision-making argues that the process is multi-factorial and complex, and that unambiguously right or wrong answers are rarely available to the decision-maker[8]. Thus, defining boundaries cannot merely be reduced to a list of approved and disapproved behaviours[9]. Neither can an informed consent document anticipate the entirety of boundary management dilemmas that a therapist may encounter[10].

Several have maintained that therapists cannot be absolutist as regards boundary guidelines[7,11]. Beauchamp's definition of therapeutic boundaries emphasises that they should not separate the client from the therapist[7]. Rather, appropriate boundaries should "define a fluctuating, reasonably neutral, safe space that enables the dynamic, psychological interaction between therapist and patient to unfold"[7]. This view is supported by Oldham and colleagues[9], who argue that the definition of a boundary is context-dependent. Equally, the importance of cultural considerations has been emphasised in explaining that role boundaries may vary in their rigidity, depending on the role and on the cultural climate[12]. The therapists' theoretical orientation may also play a role in determining the relative rigidity of boundaries, with psychodynamic tradition tending towards the view that out-of-office experiences can interfere with the transference process[5] . Ethical literature and therapeutic orientations vary on their stance as regards whether gift-giving by or to therapists constitutes a boundary crossing. There are no psychological codes of ethics which find *all* gift exchanges to be unethical, instead, there are ethically appropriate instances in which gifts may be given or received[13] . The nature of the gift may be important in interpreting this particular ethical boundary; for example, a more permanent gift (like an ornament) may be interpreted differently to a practical or perishable gift.

It has been noted that working in smaller or in rural settings can make it increasingly difficult for therapists to avoid certain boundary crossings, such as multiple relationships when they may live and work within the same community as their clients[14]. This idea is discussed in greater detail below.

MULTIPLE RELATIONSHIPS

Much research has been conducted into the process of *dual* or *multiple relationships*, whereby an individual may play both a professional role (as a therapist) and a personal role (for example, neighbour or friend) in the client's life. The APA did not prohibit psychologists engaging in sexual relationships with clients until 1977[15], lending more insight into the relatively nascent nature of the debate regarding dual relationships and professional boundary maintenance[10]. While psychological bodies' ethical stance against sexual relationships with clients is now absolutely clear, their stance on dual relationships is more complex.

The current ethical consensus reached by the American Psychological Association (APA) is that dual relationships constitute a boundary crossing but are not unethical in themselves[16]. According to article 3.05 of the APA's code of professional conduct, dual or multiple relationships should be avoided where they are likely to "impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists". This article is also consistent with ethical guidelines produced by the Psychological Society of Ireland. Principal 4: Integrity, states psychologists "shall not use the professional relationship to exploit clients, sexually or otherwise, and they shall deal actively with conflicts of interest"[2]. The PSI guidelines also make specific reference to dual relationships, advising that they be avoided where possible[2].

It has been argued that within some communities (for example, the military), avoiding multiple relationships is not always possible, and that such relationships may be enacted in such a manner that is still ethical[14, 17]. The PSI notes that where it is *not* possible to avoid such relationships, psychologists must "take active steps to safeguard the students', employees' or clients' interests"[2]. Again, Crowden notes the difficulty of defining boundaries within dual relationships, reporting that some ethical codes are unclear about when exactly an ethical crossing becomes an ethical violation[14]. Younggren and Gottlieb provide a comprehensive list of questions which the therapist should ask themselves before and during the enactment of a dual relationship, which may provide useful guidance in such situations[17]. The authors recommend that therapists ask if the relationship would be beneficial; that they obtain informed consent from the client regarding the risks; that therapists check if the decision-making process was well-documented in the client's records, and importantly, the therapist must consider if they can truly be objective in evaluating the matter[17]. While a full examination of multiple relationships is outside the scope of this paper, a related scenario, out-of-office experiences, is explored hence.

Out-of-office experiences: Meeting clients outside of therapy

Meetings or interactions with clients outside of the office have previously been placed in the category of a 'slippery slope' interaction, and have been defined as being related to dual relationships[5,18]. Experiences which occur out of the therapy room, whether part of a treatment plan or not, have been regarded as being on the "slippery slope"[5]. There are three types of out-of-office experiences, all with different function: i) as part of a well-considered and empirically based treatment plan, ii) to increase therapeutic effectiveness, and iii) unplanned, random encounters which occur as part of normal living within a community[5] (ibid). Zur argues that only the third type of out-of-office experience may be considered as a dual relationship[5]. Zur argues in favour of the utility of out-of-office experiences (where they constitute healthy dual relationships) in furthering the client-therapist alliance, and in allowing for a degree of flexibility in relation to clients' needs[5, 19]. The provision of several examples from his own professional practice demonstrates how therapy succeeded to a greater extent that it would have had Zur stuck more rigidly to boundary rules or to defensive practice strategies[19]. This seems to support the argument that engaging in these boundary crossings through practice of meeting his clients out of the office is, in this particular instance, ethically sound. Similarly, it is worth examining the ways that community-based outreach work by therapists, while outside of the frame, may provide different benefits to clients than traditional office-based therapy.

As in any ethical debate, the needs and well-being of the client must be considered in enacting a treatment boundary. Indeed, Younggren & Gottlieb[17] argue that good care is a key component of risk management; and that the two notions should not be viewed as mutually exclusive. This is supported by Lazarus' view that prioritising risk-management principles over human interventions constitutes "one of the worst professional or ethical violations" [20]. Some vicarious trauma literature suggests that when a therapist is out in public, or lives in the same locality as their clients, the community may see them as representing 'the cause' of psychology[21]. The authors note that this provides an important example of where therapists are encouraged to work on their boundaries with the community.

BOUNDARIES AND SUPERVISION

As the present article is focussed on client-therapist interactions, a discussion of boundaries within the supervisory relationship is outside the scope of the current article. Boundaries within the supervisory relationship is a topic which merits a much more in-depth discussion of countertransference processes. However, supervision could certainly provide a useful and important space in which novice and experienced therapists alike can define therapeutic boundaries in a more structured manner, as well as exploring experiences of insufficient closure.

THERAPEUTIC CLOSURE: A PSYCHOLOGICAL BOUNDARY

A discussion of therapeutic boundaries must take into account the importance of creating psychological boundaries outside of the session - that is, therapists must be able to 'switch off' from thinking about clients' issues after work. This can be challenging, as therapists and allied health professionals are frequently exposed to the traumatic experiences of their clients. While the reflective process is arguably a mark of expertise in a therapist[22], regulating the quantity and content of one's reflection on these traumatic emotions may be particularly demanding for the novice or trainee therapist. To do so requires regulating one's emotional involvement[22], and the use of a sophisticated paradigm known as the Cycle of Caring[23]. In this cycle, the therapist becomes attached emotionally to the client, works with them actively, and must then separate from them emotionally at termination of therapy. This is a complex process which may invoke several reactions in the therapist.

Rønnestad[24] hypothesizes that there are three styles of closure which occur in response to an overload of challenging or emotionally charged data. *Premature closure* and *insufficient closure* are maladaptive relational and professional boundaries that are either too rigid (*premature*) or overly loose (*insufficient*)[24]. Premature closure, as previously discussed, is a maladaptive defense mechanism whereby the therapist feels unable to meet the clients' intense experiences or emotions and is similar in concept to countertransference[25, 26]. Examples may include only working within one therapeutic modality or with a particular age group of clients. Insufficient closure is likely to occur in novice therapists and refers to the inability to disengage from thinking about the client's issues after the therapeutic session has ended[27]. The third type, *functional closure*, reflects best practice and is defined as the "*appropriate* [emphasis added] termination of the reflection process so that the practitioner can act therapeutically and not be stuck in continuous and non-progressive reflection"[27].

The ethical importance of regulating out-of-hours thinking about one's clients is underlined by the psychological and physical consequences of being overburdened by these thoughts. While some literature has noted that a certain degree of preoccupation with clients can be beneficial[28] most research finds insufficient closure to be detrimental to therapists' wellbeing and practice. When working with vulnerable populations, therapists listen to the distress experienced by the groups they are working with and may absorb some of this distress as a result[29, 30]. As they hold their clients' emotions, therapists may experience a plethora of intense emotional reactions ranging from anger or terror, to sadness or relief. Accordingly, insufficient closure, being a type of emotional boundary crossing, may be said to be linked to various negative sequelae including burnout and vicarious trauma[31] . The literature to date identifies certain types of emotional reactions as "traumatic stress"[32] which may result in Secondary Traumatic Stress (STS), Compassion Fatigue (CF), Traumatic Countertransference (TC), or Vicarious Trauma (VT)[32]. All of these reactions may have detrimental implications on therapists' professional efficacy, staff turnover and organizational health[33, 34].

The PSI ethical guidelines are clear around the importance of dealing appropriately with distress as an occupational hazard. Principle 2: Competence states that psychologists must recognise the limits to their own professional capacity, and must not exceed them[2]. Principle 4, Integrity states that psychologists must maintain their own mental health and manage their own personal stress[2]. More specifically, the PSI guidelines advise psychologists to seek emotional support and/or supervision from colleagues if they experience feelings of stress or vulnerability as a result of professional dilemmas[2].

Some literature suggests that trainee or novice therapists may struggle with insufficient closure and the associated sequelae to a greater extent than do experienced therapists[27]. One study of trainee therapists found that half the sample reported a self-sacrificing defense style, which was a risk factor for the development of vicarious trauma[35].

Ethical guidelines are less specific in advising psychologists how to deal with insufficient closure. A safe, structured, clinically supervised approach to discussing closure styles may be helpful in avoiding insufficient closure from negatively impacting the therapeutic relationship as well as the therapist's own well-being[33].

Aside from research by Skovholt, Rønnestad, and colleagues, insufficient closure does not appear to be well documented in the extant literature. Future research should seek to investigate the process and incidence of insufficient closure, and the therapeutic phenomena which may be related to it. Two such phenomena include transference and countertransference. Objective countertransference is defined by Cartwright and Read as "the therapist's feelings or responses that are evoked by the client's transference onto the therapist or the client's interpersonal patterns of relating"[36]. Again, there is some debate as to the ethical management of transference. Ellis theorizes that transference and countertransference may have both beneficial and destructive impact on the therapeutic relationship[37]. Potential links between countertransference and insufficient closure could be explored in greater detail by future studies.

DISCUSSION

This article has examined the ethical issues related to managing boundaries in the therapeutic relationship. It began with an exploration of boundaries, attempts to define them, and what happens when boundary issues arise. Insufficient closure, dual relationships, and out-of-office experiences were explored with reference to current theory and best practice guidelines. Overall, the literature seems ethically divided on many of these topics, particularly on boundary problems which appear to defy precise definition. Ongoing debate and research is valuable in contributing towards best practice and ethical education for therapists. Therapists' own ethical thinking, which takes into account the human aspect of ethical decision-making, may be of particular use in situations requiring flexibility, and also in the absence of specific guidelines[38]. In conclusion, more attention is needed specifically in researching insufficient closure. Practical, specific ethical guidelines regarding its management should ideally be provided by professional bodies governing those who work in a therapeutic role. Such guidelines could serve to continue the ethical discussion as regards this issue, and potentially help inform therapists' self-care practices.

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AUTHORS

Rachael Kelleher, Psychologist in Clinical Training, TCD/HSE.

REFERRAL PATTERNS OF PERINATAL WOMEN IN ADULT MENTAL HEALTH PSYCHOLOGY SERVICES

NIAMH DOYLE, MARIE TIERNEY

INTRODUCTION

Perinatal Mental Health

Perinatal mental health has been recognised globally as a critical public health concern[1]. Untreated maternal mental health in pregnancy and in the years following birth can have detrimental consequences for not only the mother's health[2], but also for pregnancy outcomes[3], marital relationships[4], paternal mental health[5] and the social, emotional and cognitive development of the growing infant[3,6-11]. Given that the antenatal period and first three years of life are critical for brain development, the neural connections made during this time form the foundation for good emotional health and attachment[12-14].

Mental health difficulties are common among women in pregnancy and in the postnatal period, with a 12-13% prevalence rate of depression and anxiety during pregnancy and 15-20% of women experiencing significant distress in the first year after childbirth[15]. In Ireland, between 2013 and 2015, four out of seven maternal deaths reported were due to suicide, making suicide the leading cause of direct maternal death occurring between six weeks and one year after pregnancy[16]. This corresponds to figures from the UK and other high-income countries[2,17].

International Guidelines

Worldwide, the importance of perinatal mental health has been recognised through the World Health Organisation Millennium Development Goals, post-2015 millennium development goals, and national strategy documents in Australia[12], the UK[15] and the United States[18]. Overall, guidelines have emphasised the importance of timely intervention and specialist services for perinatal mental health[15,19-21]. NICE[15] guidelines for example, have stated that women with a known or suspected mental health problem in pregnancy or the postnatal period should be assessed for treatment within two weeks of referral and psychological interventions should be offered within one month of initial assessment.

Perinatal Mental Health Services in Ireland

In the Republic of Ireland, the government has committed to enhancing maternal ante-natal and early childhood development services and strengthening pre-natal and ante-natal supports around the mother[22-23]. The Health Service Executive Mental Health Division Operational Plan 2017[24] outlined a plan to develop specialist perinatal services in Cork University and Limerick Hospitals. At the time of this audit, there were no dedicated perinatal or infant mental health services in the Republic of Ireland[25]. Moreover, outside of the large Dublin hospitals, there were no dedicated perinatal mental health staff and no perinatal psychology positions[26]. Most women with perinatal mental health difficulties in Ireland therefore receive fragmented care between maternity, general practice and mental health services, and many women have reported an emphasis on physical and biological aspects of pregnancy, to the exclusion of mental and emotional well-being[26-27]. Since this audit was completed, the Health Service Executive have launched a new Model of Care for Specialist Perinatal Mental Health in Ireland[28].

Adult Mental Health Teams

It has been acknowledged that women in the perinatal period are likely currently accessing psychological services within adult mental health teams[29]. Until specialist perinatal mental health services are achieved in Ireland, adult mental health teams have a responsibility to heed decades of research supporting the need for early intervention in this cohort of women. Psychology services have an opportunity to intervene quickly and effectively to treat the mental health needs of mothers, which may have a secondary gain of improving outcomes for pregnancy and the growing infant. Indeed, the Psychological Society of Ireland have identified psychologists as having a pivotal role to play in providing specific perinatal and infant mental health services, which involves assessment of the parent-child relationship, promotes mother and infant wellbeing and includes psychotherapeutic intervention for mothers' mental health needs.

Aims of the Current Study

In order to plan intervention and resource allocation for perinatal mental health, it is important to determine the number of women presenting to adult mental health psychology services and audit the current waiting times for this group of women. This study aimed to examine the referral patterns in five Adult Mental Health Psychology services of pregnant women and women with infants from under three years of age. It was expected that gaps in service provision would be identified, with implications for developing timely and appropriate services for pregnant women and mothers with young infants.

METHOD

Definitions used in this study

Perinatal Mental Health is defined in this study as woman's mental health during pregnancy and throughout the first three years after birth.

Procedures

This audit focused on perinatal women referred to five adult mental health psychology services between January 2013 and December 2016. Data was collected through chart reviews of psychology and multi-disciplinary (MDT) files in five secondary care services in the South of Ireland. Information collected included demographic information, referral patterns (year of referral, source of referral, waiting time between referral and first appointment with psychology, presenting difficulties) and psychological intervention delivered.

Ethical approval

Ethical approval was obtained from University College Cork Ethics Committee on 18th April 2017.

RESULTS

Demographics

In total, 26 women were referred to psychology services from 2013 to 2016, with an average of 6.5 referrals each year (see Table 1 for service user characteristics). One individual was both pregnant and with an infant under three years. Mean age was 32.27 (range 22-43).

Table 1: Service User Characteristics

	N (%)
AGE	
20-29	9 (34)
30-39	14 (54)
40-49	3 (12)
YEAR OF REFERRAL	
2013	6 (22)
2014	8 (30)
2015	5 (19)
2016	7 (26)
PERINATAL STAGE	
Pregnant	6 (23)
Infant under 3 years	19 (77)

Referral Patterns

Table 2 shows the referral patterns of service users, including number of women referred each year, presenting difficulties, the source of referral and wait times from referral to first appointment with psychology.

Table 2: Referral Patterns of Service Users

Characteristic	N (%)
SOURCE OF REFERRAL	
Psychiatry	15 (56)
Nursing	5 (19)
Illegible	4 (15)
Home-based treatment team	1 (4)
Social Work	1 (4)
PRESENTING DIFFICULTIES	
Anxiety	13 (48)
Major Depressive Symptoms	12 (44)
Postnatal Depression	7 (26)
Obsessions & Compulsions	5 (19)
Anger	4 (15)
PTSD	2 (7)
Emotion Dysregulation	1 (4)
Low Self-esteem	1 (4)
Alcohol Dependence	1 (4)
Unwanted Pregnancy	1 (4)
Chronic Pain	1 (4)
WAITING TIME BETWEEN REFERRAL AND 1^{ST} APPOINTMENT	
1-2 Weeks	6 (26)
3 Weeks – 1 Year	9 (39)
More than 1 Year	8 (35)

Waiting Times

Three women were removed from waiting lists prior to psychological assessment: one client sought private psychological help due to the long waiting lists; one moved region and a final woman was referred to another member of the multi-disciplinary team due to the long waiting list for psychology. Twenty three service users had an initial appointment with psychology services. The average waiting time of these service users from referral to initial appointment was 35.52 weeks (range 1 – 103). One quarter of individuals were seen within two weeks, while over half (52%) of service users remained on the waiting list for 34 weeks or longer.

Intervention offered

Eighteen individuals were offered a psychological intervention and information about the psychological model used was available for 16 of these clients. See Table 3 for frequencies of interventions delivered. Eleven individuals received an integrative psychological intervention, with a number of the models listed in Table 3.

Table 3: Frequencies of Psychological Intervention Delivered

Characteristic	N (%)
Cognitive-behavioural Therapy	11 (61)
Mindfulness	6 (33)
Compassion Focused Therapy	3 (17)
Schema Therapy	3 (17)
Relaxation	2 (11)
Psychodynamic Therapy	1 (6)
Diadic Psychotherapy	1 (6)

N=16

DISCUSSION

The present audit explored referral patterns of pregnant women and women with infants under three years of age, referred to psychology in five adult mental health teams in Ireland between 2013 and 2016.

Referral Patterns

Number of referrals. As expected[29], pregnant and postnatal women presented to psychology services in five adult mental health teams in Ireland. This was limited to approximately 1.3 referrals to each service each year. In the absence of specialised perinatal mental health services and the small number of women presenting to adult psychology services, it may be feasible to offer priority to this group without overwhelming services. As no data was collected on overall referral rates to individual services, the proportion of these to total referrals is unknown.

Considering the finding that perinatal status was not routinely recorded on referral information, this audit may underrepresent the number of women in the perinatal period presenting to adult psychology services. The relatively low referral rate may also be due in part to women obtaining care from alternative professionals on adult mental health teams such as psychiatry or nurse therapy; voluntary organisations such as Aware or care from their General Practitioner. It is also likely that many women receive no care for their mental health during this time, due to factors such as a lack of access to services, stigma and shame preventing women from disclosing difficulties and negative previous experiences of disclosure to mental health professionals[30].

Presenting difficulties. Anxiety and depression were the most common mental health difficulties for perinatal women, aligning with international data[15]. There may be scope for developing group-based interventions for these problems, with a focus on prevention and promotion of early intervention for existing perinatal and infant mental health problems.

Waiting times. Despite worldwide recognition of the importance of timely intervention for perinatal maternal mental health, over half of individuals in this study remained on the waiting list for 34 weeks or longer. Additionally, one individual was taken off the waiting list for psychology and offered an alternative intervention due to long waiting times. These findings represent a significant discrepancy between the services that women are receiving in adult mental health teams, and international recommendations that give priority to early intervention[15].

Until specialist perinatal mental health services are established in Ireland, adult mental health teams need to alter their service provision to ensure that all perinatal women have timely access to their psychology services. It is recommended that this group of women are fast-tracked for services and provided with intervention within one month of referral, in accordance with NICE[15] guidelines. Additionally, waiting times from referral to initial appointment should be routinely monitored.

Psychological Intervention

Perinatal women in psychology services received integrated psychological interventions, using models from cognitive behavioural therapy, mindfulness and compassion focused therapy. These interventions, when specifically adapted for the needs of perinatal women have been associated with overall improvements in mental health[31].

Lack of routinely collected data

This audit highlighted a lack of routinely collected data on women in the perinatal period in adult mental health teams. Documentation of pregnancy or maternal status was recorded in a fragmented and ad hoc manner. Given the importance of early intervention, it is recommended that data is routinely collected on waiting times for women who are pregnant or with infants under three years of age, so that this group can be provided with prioritised access to psychology services, in according with NICE[15] guidelines.

Strengths & Limitations

Small sample size. The small sample size of the present audit precluded analysis on factors associated with longer waiting times.

Infant mental health practices. This audit focused on individual psychology interventions with perinatal women. As such, data was not collected on specific infant mental health practices used in existing adult mental health psychology services (e.g. screening techniques for infant mental health; assessment of mother-infant attachment relationship). Recently, the Psychological Society of

Ireland have advocated for infant mental health practices to be incorporated into all existing services providing care to parents and families. It has also recommended psychologists in adult mental health teams to acquire appropriate knowledge of early childhood development and an understanding of screening and diagnostic techniques for this age group[25,32]. These recommendations were made in light of evidence that effective treatment for some perinatal mental health difficulties is not always sufficient to improve the developing infant-mother relationship[33]. Moreover, it has been previously documented that opportunities to promote infant mental health have traditionally been ignored or minimised within adult services in Ireland[32,34-35]. Future research could therefore audit the use of screening and diagnostic techniques for infant mental health within adult psychology services.

Focus on women and mothers. Given that women are at a higher risk for depression and anxiety[36] this study focused exclusively on pregnant and postnatal women. Evidence suggests however that fathers' mental health is also associated with child development[37,38] and is common across the perinatal period[36]. Data on pregnancy and infants is not routinely collected by adult mental health services in Ireland, which may make distinguishing men's needs within the perinatal period difficult, or impossible. It is recommended that information is clearly documented about men and women in the perinatal period in adult mental health files.

Conclusion

Untreated maternal mental health in pregnancy and in the years following birth can have detrimental consequences for not only the mother's health, but also for pregnancy outcomes, paternal health and the social, emotional and cognitive development of the growing infant. With no dedicated perinatal mental health services yet in Ireland, it is recommended that adult mental health services adhere to international guidelines, by providing perinatal women with timely access to effective interventions.

This audit showed that a small number of perinatal women are referred to adult mental health psychology services each year. Data is not routinely collected on this group of women however and many women are left on waiting lists for longer than 34 weeks. Given the importance of early intervention, mental health teams may wish to fast-track this group on psychology waiting lists to ensure they are seen within one month of referral (in accordance with NICE guidelines). The small number referred to services means that this may be feasible, even with limited resources. By intervening early with effective interventions, this will have a positive impact on mothers and their families, and contribute towards a healthy cycle of transgenerational mental health.

Since this audit was completed, the Health Service Executive launched a new Model of Care for Specialist Perinatal Mental Health in Ireland[28]. It identified six 'hub' hospitals in Ireland with the highest number of deliveries within a hospital group. The new model outlines that each hub hospital will have a dedicated specialist perinatal mental health service, consisting of a multidisciplinary team. These teams will be led by a consultant psychiatrist in perinatal psychiatry and include one whole time equivalent senior psychology role. The model also encompasses additional training for individuals working in Primary Care Psychology, such that individuals with milder mental health presentations can access appropriate support within the community.

SUMMARY OF RECOMMENDATIONS

The following recommendations are made based on findings from this audit.

1. Current pathways of referrals should be audited within adult mental health teams, to ensure that pregnant and postnatal women receive the most appropriate care for their needs.

2. It is recommended that psychological services within adult mental health teams prioritise timely interventions for pregnant and postnatal women

3. Waiting times should be routinely monitored in line with NICE (2014) guidelines

4. Where possible, pregnant women and mothers of children under three should be clearly identifiable in mental health records, so that this group can be offered prioritised access to services.

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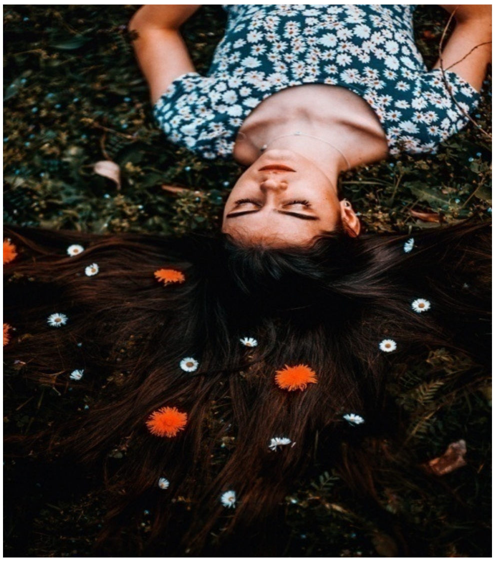
AUTHORS

1. Niamh Doyle, Psychologist in Clinical Training, UCC/HSE. Correspondence to Niamh.Doyle5@hse.ie
2. Dr Marie Tierney, Clinical Psychologist, Cork.

PSYCHOLOGICAL FACTORS OF INTRUSIVE THOUGHTS IN AN IRISH STUDENT POPULATION

Casey Donaghey, Jonathan Egan and Páraic S. O' Súilleabháin



ABSTRACT

Objectives: Intrusive thoughts are a relatively common experience in community samples. They are also commonly reported in patients who present with a range of psychiatric diagnoses, yet underlying mechanisms of effect remain unclear. As such, the overall objective of the present study was to elucidate psychological predictors of intrusive thoughts.

Methods – The sample consisted of 186 (*M* ± *SD* = 22.41 ± 6.96 years) individuals who completed a series of validated measures pertaining to hypothesized psychological factors to consider in the context of intrusive thoughts.

Results: The model emerged as significant and accounted for 32 percent of the variance in relation to current experiences of intrusive thoughts. Current depressive mood (p<0.001), high absorption (p=.01), previous experiences of trauma (p=.002), and low openness to experience (p=0.03) scores were observed as significant predictors of intrusive thoughts.

Conclusions: The findings suggest that depressive mood, high absorption, experiences of trauma, and low openness to experience are important factors to consider in the context of intrusive thoughts. These findings further suggest that clinical practice should consider these factors in the treatment of individuals with intrusive thoughts.

INTRODUCTION

Intrusive thoughts are unwanted thoughts that intrude on our consciousness. These thoughts are universal and are common in everyday life. Radomsky and colleagues[1] in a large cross-cultural sample (N = 777), found that over 94 percent of their sample of university students reported experiencing intrusive thoughts. Intrusive thoughts when distressing and affecting quality of life and engagement are also common symptoms of clinical disorders such as anxiety, PTSD, insomnia, depression, and OCD.[2,3,4] There are many contributing factors which have been highlighted to contribute to the expression of intrusive thoughts, such as: psychological trauma, anxiety, depression, personality traits (high neuroticism and low extraversion) and poor emotional regulation strategies.[5,6,7,8,9] This article will discuss these various relationship and will analyse these relationships both individually and collectively.

Cognitive theorists have suggested that the key moderating factor when considering intrusive thoughts is a person's interpretation of their initial automatic thought about an event. This interpretation can lead to or maintain a negative affect and increase levels of anxiety, or lower mood.[10] Adrian Wells's Meta-Cognitive Theory[11] examines how an appraisal of an event can positively or negatively impact peoples' stress levels. It suggests that there are two levels of fear related cognitions (fear related to specific illness or finance and then the person perceives the act of worrying as having some portentous result). This theory is supported by the cognitive behavioural theory of anxiety and obsessive-compulsive thoughts or disorder,[12,13] endorsing the interaction between cognitive processes and thoughts and behaviours.

Separately, other theorists have focused on the environmental triggers and a persons' stress responses and how they manage their emotions which may mediate the experience of intrusive thoughts.[14] Situations can elicit emotions such as fear or anger, and then these emotions can contribute to thoughts such as 'I am feeling guilty, I must have done something wrong'. Researchers note that there is a reciprocal feedback and amplification effect between cognition and affect and vice-versa.[15,16] How we react to events is idiosyncratic and can often be guided by a person's personality and life history.

As previously mentioned, personality traits such as low extraversion and high neuroticism have been identified as being related to intrusive thoughts.[17,18] In addition, agreeableness and openness to experience have also been found to be related to occurrence of intrusive thoughts. These traits have been implicated as a central component to an individual's stress responsivity, and adaptation or resilience across time.[19,20,21,22] Indeed, these traits have been linked to different coping mechanisms. Individual's reporting higher extraversion have been observed as being recharged by interacting with others, while their introverted counterparts achieve this by withdrawing to their own personal process.[23] As intrusive thoughts are a symptom of a diagnosis of Obsessive Compulsive Disorder (OCD), considerable research has focused on patients with OCD to investigate how personality traits relate to intrusive thoughts.[18,24] Extraversion and neuroticism have been observed to correlate with cognitive functioning and therefore affect the severity of intrusive thoughts.[25] In a study of patients awaiting a cancer diagnosis,[26] the personality trait of openness was related to higher intrusive thoughts and anxiety about seeking help. Neuroticism has also been highly correlated with cognitive functioning affecting event perception[16] mediating this relationship between cognition and intrusive thoughts even further.

Emotional regulation strategies have been shown to have a significant impact on the presence of intrusive thoughts.[24,27,28] There are several types of emotion regulation strategies such as appraisal, suppression, repression, depersonalisation, and dissociation. In a sample of non-clinical participants, the presence of dissociation was found to be highly correlated with the experience of traumatic events as a form of diminishing the emotional impact that these traumas had and reducing traumatic memories and intrusive thoughts.[29]

Dissociation is an involuntary way of regulating acute stress and emotions in threatening situations. Biologically it is related to the release and presence of higher levels of cortisol.[30] It results in people reporting confusion, poor memory consolidation and difficulty in tracking themselves across place and time. Following the initial fight-flight stage of the sympathetic branch of the autonomic system arousal it is associated with a deactivation of the limbic system and a hyper-arousal of the pre-frontal cortex, allowing cognition to remain intact whilst also numbing emotional reactions. [29,31,32,33,34] Recently an Irish study with a sample of 761 young adults[35] found that depersonalization mediated the relationship between insecure attachment style and depression, anxiety and stress. Depersonalization was higher in those who experience maltreatment and emotional abuse than those who experienced physical or sexual abuse. In addition, those who were in the clinical cut-off range of depersonalization were found to have higher somatic symptoms on the PHQ15 as well as almost double the levels of anxiety, depression and stress.

Dissociation measures have been found to contain three factors; (a) depersonalization/derealisation, (b) amnesia and (c) absorption. Absorption allows an individual to remove themselves in thought from a current stressor. In a study by Naring and Nijenhuis,[28] they found that absorption was the most significant factor in peoples' trauma responses. In an effort to decrease a person's reaction to a trauma, they automatically detach from the stressor, focussing their consciousness on everything else. Failure to absorb the daily moments in detail helps the individual to dissociate from what is going on around them. Brand and Stadnik[36] and Seffer-Dudek [37] found that absorption elicits obsessive ruminations and resulting compulsive behaviours. Seffer-Dudek and colleagues [38] reports absorption to have similar effects to inferential confusion on attention where individuals get too absorbed in their own imagination during their reasoning process bringing about obsessions that do not match reality.

Traumatic experiences often reduce a person's ability to cope with regular life stressors. [39] When someone experiences trauma, their body produces stress hormones causing high activity in the hypothalamus region of the brain. This often results in more frequent intrusive thoughts. For example, a study by Ironson and colleagues[40] examined survivors following Hurricane Andrew for a period of a year. The participants stress hormone levels were investigated as well as scores of intrusive thoughts and avoidant thoughts. Both the levels of cortisol and adrenaline were higher at times close to the trauma, as were the levels of intrusive thoughts. Over the year, all variables decreased, showing a strong temporal relationship between the experience of trauma and intrusive thoughts. Recent research from Northern Ireland[41] in a sample of 49 patients found a relationship between trauma, parental bonding and current diagnosis of bipolar disorder or depression.

To conclude, the studies reviewed indicate that a variety of factors are distinctly associated with intrusive thoughts, namely, personality traits, dissociation, anxiety, depression and traumatic experiences. Empirical evidence has shown low extraversion and high neuroticism personality traits, previous experiences of trauma as well as dissociative experiences to increase the presence of intrusive thoughts in clinical and non-clinical samples. The overall purpose of the current study is to determine the relationships of these factors and intrusive thoughts. In doing so, we are seeking to develop a more robust and encompassing set of indicators of potential associations which may then result in assessing the clinical impact of focusing treatments on each predictor found, with the knowledge that anxiety and depression are key moderators to control for in any analysis. Considering research hasn't investigated the interaction between all of these variables on intrusive thoughts, at once, this research aspires to increase knowledge in the clinical field about the connection between dissociation, personality traits and intrusive thoughts in the aim of aiding diagnostic models and improving quality of care. All in all, this research aims to give a broader view of the symptoms and possible treatments of intrusive thoughts/OCD.

METHOD

Participants

The current sample consisted of undergraduate university students (N = 186; females = 142, males = 43, non-binary = 1; age *M* ± *SD* = 22.41 ± 6.96 years; range = 18 – 52 years). 65% of the participants were aged from 18-21. 37% of the population reported experiencing trauma while 63% did not. The overall response rate was 96% with 186 out of 193 people answering the questionnaires. All participants were voluntary and received partial course credit for participating. Exclusion criteria excluded anyone under the age of 18 and who did not speak English as their first language.

Measures

Six questionnaires were used in this study. Firstly, there was a demographic questionnaire administered which had questions about the participants' age, gender and previous experience of trauma. In addition, there were questionnaires on dissociation, personality, presence of intrusive thoughts, depressive tendencies as well as experiences of anxiety.

The Dissociative Experiences Scale[42] (DES) is a 28 item self-report scale used to measure the presence of dissociation in a person's life. The scores were scaled from 0 to 100% comprising of 10% increments. The scores for each question were totalled and averaged to get the mean DES score. Van IJzendoorn and Schuengel[43] have shown robust discriminant and convergent validity (d=1.82; N = 5,916) in association with interviews (d = 2.05) and questionnaires (d=1.81). Cronbach's alpha for the DES when assessing students was 0.93 in Frischholz, Braun, Sachs and Hopkins[44] and was 0.94 in the present study. Often this scale is divided into the 3 subscales of depersonalisation, amnesia, and absorption.[45] The Cronbach's alpha for each scale in this study were;

depersonalisation (0.83), amnesia (0.80), and absorption (0.83).

To evaluate the participants' personality traits, the NEO – Five Factor Inventory[46] (NEO FFI-3) was used. This is a 60 item self-report scale used to measure the personality traits of extraversion, openness to experience, conscientiousness, agreeableness, and neuroticism. A five-point Likert scale was used to measure it ranging from '*strongly disagree*' to '*strongly agree*'. In Schwartz, Chapman, Duberstein, Weinstock-Guttman and Benedict,[47] the Cronbach's alpha was calculated for each subscale (extraversion = 0.80, neuroticism = 0.87, agreeableness = 0.74, openness to experience = 0.71, and conscientiousness = 0.84), showing good internal consistency in this measure. Good convergent and discriminant validity was also shown for the five key personality traits in Hopwood and colleagues.[48] The Cronbach's alpha scores in the current study were; extraversion = 0.80, neuroticism = 0.87, agreeableness = 0.74, openness to experience = 0.61, and conscientiousness = 0.86.

To check for the presence of intrusive thoughts, the participants filled out the Revised Obsessional Intrusions Inventory[48] (ROII). This was a 52 item self-report scale. A seven-point Likert scale was used to measure it from '*not at all*' to '*all of the time*'. Cronbach's alpha for the ROII ranged from 0.82-0.93 showing great internal consistency.[49] The Cronbach's alpha for this measure was 0.95 in the present study.

Depression was investigated using the Patient Health Questionnaire-9[50] (PHQ-9). This was a 9 item self-report questionnaire used to measure the presence of depression in a person's life. It was measured by frequency on a 4 point Likert scale from *'not at all'* to '*nearly every day'*. Cronbach's alpha for the PHQ-9 has been observed as 0.85 in existing research.[50] The present study Cronbach's alpha was observed as 0.86.

Anxiety was then measured using the Generalised Anxiety Disorder-7[51] (GAD-7). This was a 7 item self-report questionnaire used to measure the presence of anxiety in a person's life. It was measured by frequency on a 4-point Likert scale from *'not at all'* to *'nearly every day'*. Spitzer and colleagues[52] found that the GAD-7 had good discriminant and convergent validity. Zhong and colleagues[53] confirmed this while evaluating the Cronbach's alpha for GAD-7 to be 0.89. When analysing anxiety measures, Cameron and colleagues[54] found that the GAD-7 had greater validity and reliability when compared to the HADS-A, HRSD-17 and the William's test. For this sample, the Cronbach's alpha was 0.91.

Procedure

Prior to commencement the present study procedure received full ethical approval in accordance with the Declaration of Helsinki from the institutional Research Ethics Committee at the National University of Ireland, Galway. Following approval, all materials were made available through an online research survey medium (Survey Monkey). Participants were then invited to participate in the study through the Sona System which was linked to the online survey. Each participant received course credits for participating in the study. An information sheet and consent form were given to each participant before they completed the questionnaires. Just enough information was given to the participants to prevent any experimenter bias. They completed a battery of six questionnaires; a demographics questionnaire, the Dissociative Experiences Scale (DES), the NEO – Five Factor Inventory, the Revised Obsessional Intrusions Inventory (ROII), the PHQ-9 and the GAD-7. After completion of the questionnaires, the purpose of the study was explained in full and contact details for support services were provided to all the participants.

Data Analysis

The data was collected on www.surveymonkey.com and was transferred into a SPSS file for analysis.[55] This programme then conducted descriptive analysis, correlation matrices and hierarchical regression to investigate the relationship between the different categories of independent variables on intrusive thoughts. The inclusion of variables into steps within the multiple regression are as follows; step one (anxiety and depression); step two (trauma); step three, (neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness); and finally step four (the three subscales of dissociation; depersonalisation, amnesia & absorption).

RESULTS

Data Screening

Scale reliability was assessed using Cronbach's alpha and there was a range from 0.61 - 0.95. The data distributions were then examined. Intrusive thought measures were positively skewed and required a log transformation. As the remaining data was normal, further analysis was conducted using SPSS.

Preliminary Analysis

Descriptive statistics for intrusive thoughts, the two emotional regulation strategies, the five personality traits, demographic variables (see Table 1.) and control variables (depression, anxiety and experience of trauma) are presented in Table 2. below. This shows the variety in the participants' scores. A table for the ROII scores is included in Table 3.

Table 1: Demographics of Participants

	Frequency (%)
Gender	
Male	23%
Female	76%
Non-binary	1%
Trauma	
Yes	37%
No	63%
Age	
18-21	65%
22-25	15%
26-29	5%
30+	15%

Table 2: Descriptive Statistics for Predictor and Criterion Variables

	Range	Mean	SD
Neuroticism	12-58	31.99	(8.70)
Extraversion	12-49	32.44	6.72
Openness to experience	24-47	35.22	4.89
Agreeableness	15-49	28.13	6.02
Conscientiousness	16-54	33.42	7.58
Depression	0-27	8.79	5.81
Anxiety	7-28	13.65	5.55
Depersonalisation	0-14	2.16	3.16
Amnesia	0-2	2.49	2.92
Absorption	10-27	8.18	4.46
Intrusive Thoughts	51-217	82.03	30.55

Main Analysis

A correlation matrix was conducted to evaluate the relationships between all the variables and to check for any multicollinearity. Trauma, neuroticism, openness, agreeableness, conscientiousness, depression, anxiety, depersonalisation, amnesia and absorption all correlated significantly with intrusive thoughts ($p<0.05$). Table 4. below shows the inter-correlations between variables.

Table 3: Percentages Scored on the ROII

	Never	Rarely	Seldom	Sometimes	Often	Usually	Always
Driving into a window	91.9	2.7	1.6	2.7	.5	.5	0
Running a car off the road	69.4	12.4	7	7.5	2.7	.5	.5
Hitting animals or people with car	82.8	8.6	1.1	3.8	2.2	1.1	.5
Swerving into traffic	72.6	11.8	5.4	5.4	3.2	.5	1.1
Smashing into objects	66.1	14	7	7	5.4	.5	0
Slitting wrist/throat	81.2	8.1	3.2	4.3	1.1	1.6	.5
Cutting off finger	91.4	5.9	1.1	1.6	0	0	0
Jumping off a high place	62.4	14	9.1	8.6	2.7	1.1	2.2
Fatally pushing a stranger	82.3	7.5	4.8	3.2	1.6	0	.5
Fatally pushing friend	84.9	7.5	4.3	2.2	.5	0	.5
Jumping in front of train/car	71	8.6	7	5.9	4.8	2.7	0
Pushing stranger in front of train/car	89.2	6.5	2.2	1.6	.5	0	0
Pushing family in front of train/car	94.1	2.2	3.2	0	0	.5	0
Hurting strangers	81.2	9.7	4.8	3.2	.5	.5	0
Insulting strangers	58.1	19.4	9.1	9.1	2.7	1.1	.5
Bumping into people	57	16.7	9.1	8.6	6.5	1.6	.5
Insulting authority figure	53.8	17.7	9.1	11.8	4.8	2.7	0
Insulting family	44.6	30.1	8.6	8.6	4.8	2.2	1.1
Hurting family	78	12.4	4.8	3.2	1.6	0	0
Choking family member	94.6	3.8	1.1	.5	0	0	0
Stabbing family member	94.1	3.8	1.1	0	.5	.5	0
Accidentally leaving heat/stove on	56.5	14.5	14	7.5	4.3	2.2	1.1
Home unlocked, intruder there	55.4	14.5	11.8	10.2	4.8	1.6	1.6
Taps left on, home flooded	84.4	5.9	5.4	1.1	2.2	.5	.5
Swearing in public	28.5	18.3	15.6	16.1	11.8	4.8	4.8
Breaking wind in public	54.8	22	7	9.7	3.2	2.7	.5
Throwing something	32.8	24.2	12.9	17.2	7	4.8	1.1
Causing a public scene	69.4	17.2	5.9	4.8	1.6	0	1.1
Scratching car paint	88.3	3.8	1.6	3.2	2.2	.5	.5
Breaking window	83.3	5.4	4.3	3.8	1.1	1.1	1.1

Wrecking something	57.5	16.7	8.1	10.8	3.2	3.2	.5
Shoplifting	75.3	10.8	5.4	3.8	4.3	.5	0
Grabbing money	82.8	8.6	2.7	2.7	1.6	1.6	0
Holding up bank	91.4	3.2	1.1	2.2	1.6	.5	0
Sex with unacceptable person	64	14.5	6.5	5.4	5.4	2.7	1.6
Sex with authority figure	64.5	12.9	4.8	9.1	4.3	3.2	1.1
Fly/blouse undone	63.4	18.3	8.1	5.9	2.7	1.1	.5
Kissing authority figure	61.3	16.7	5.4	9.1	2.7	3.8	1.1
Exposing myself	93	4.8	1.1	.5	0	.5	0
Acts against sexual preference	78	11.8	3.2	3.2	2.2	.5	1.1
Authority figures naked	76.9	12.4	3.8	2.2	2.7	1.6	.5
Strangers naked	70.4	11.3	9.1	3.8	2.2	2.7	.5
Sex in public	65.1	13.4	8.6	5.9	3.2	2.7	1.1
Disgusting sex act	81.7	8.1	5.9	2.2	1.6	.5	0
Catching sexually transmitted disease	76.3	15.1	4.3	3.2	1.1	0	0
Contamination from doors	69.9	12.4	6.5	4.8	2.7	2.7	1.1
Contamination from phones	68.8	15.6	7.5	4.8	1.6	1.1	.5
Getting fatal disease from strangers	82.3	8.1	5.4	2.2	1.1	.5	.5
Giving fatal disease to strangers	91.9	4.8	.5	1.6	1.1	0	0
Giving everything away	75.3	11.8	3.8	4.3	3.8	.5	.5
Removing all dust from the floor	64	9.7	7.5	8.6	5.9	3.8	.5
Removing dust from unseen places	69.9	9.1	8.1	5.9	2.7	3.8	.5

Table 4: Summary of Pearson's Product Correlations for Predictor and Criterion Variables

	1	2	3	4	5	6	7	8	9	10	11	12
(1) Trauma	1											
(2) Neuroticism	-.010	1										
(3) Extraversion	-.014	-.389*	1									
(4) Openness	-.260*	-.011	-.102	1								
(5) Agreeableness	0.10	-.076	.248*	-.128	1							
(6) Conscientiousness	-.023	-.289*	.152*	.162	.177	1						
(7) Depression	.118	-.583*	.239*	-.044	.117	.241*	1					
(8) Anxiety	.062	-.623*	.210*	-.010	.029	.037	.727*	1				
(9) Depersonalisation	.068	-.237*	.012	.002	.124	.099	.441*	.428*	1			
(10) Amnesia	-.064	-.190	-.005	.082	.070	.171	.259*	.271*	.586*	1		
(11) Absorption	.059	-.270*	.018	-.098	.137	.119	.403*	.393*	.694*	.738*	1	
(12) Intrusive Thoughts	.242*	-.279*	.014	-.231*	.121	.147	.375*	.287*	.356*	.353*	.514*	1

Note: **p*<.01,

Further analysis involving a single multiple hierarchical regression was conducted to investigate the impact that these variables had on intrusive thoughts separately and as a whole. For the hierarchical regression, the overall model was significant, contributing to 32% of the variance accounting to the presence of intrusive thoughts (see Table 5). Within this model, step one, both depression and anxiety were entered. This step accounted for 14% of the variance (F(2, 161 =14.72), p<0.00, R2 =.16, Adj R2=0.14). Depression was the sole contributor and had a significant beta weight (β=.38, p<0.001). Introducing prior trauma within step two further contributed to the model (F(1,160)=9.48, p=.002, R2 =.20 Adj R2=0.19). This added 5% of variance to the model (β=.22, p=.002). Evaluation of personality traits within step three further contributed to the model (F(2,158)=2.38, p = 0.04, R2 = .22 Adj R2 =0.21). Openness to experience was the only trait that emerged to be significant (β=-.16, p=0.03), contributing to a further 2% of variance to the model. Finally, in step four, depersonalization, absorption, and amnesia were added and they significantly contributed to the overall model (F(3,155)=9.75, p<0.01, R2=.35 Adj

R2=.0.32), resulting in an additional 11% of variance leading to a total of 32% of variance explained in the occurrence of intrusive thoughts. An examination of the separate contributions revealed that absorption (β=.30, p=.01) was the significant contributor.

Table 5: Hierarchical Regression of the predictor variables

Step	Variable	B	R²	Adj R²	F Change
1	Depression Anxiety	.38** .02	.16	.14	14.72***
2	Experience of Trauma	.22**	.20	.19	9.48**
3	Neuroticism Openness to Experience	-.02 -.16*	.23	.21	2.83
4	Amnesia Absorption Depersonalisation	.10 .30** .00	.35	.32	9.75**

Total R2= 0.35, Total Adj R2= 0.32

*Significance level: *p<0.05, **p<0.01,*

DISCUSSION

This study aimed to investigate the different variables that have an impact on the presence of intrusive thoughts in a non-clinical sample. Intrusive thoughts are a common experience and it was important to investigate the impact that personality traits, personal trauma history and mood states could have on the presence of intrusive thoughts. The findings of this research can help to both normalise these thoughts and also to guide treatment protocols. It seems timely to explore the importance of personal trauma and the tendency to use absorption as a defence while also inviting clients to be open to explore the connection between these and their intrusive thoughts. The connection between trauma and absorption has been shown in previous research[29] but research has not investigated the impact of absorption alone on intrusive thoughts.

Findings

In this study, the aim was to investigate what variables would influence the presence of intrusive thoughts. It was hypothesised that five NEO FFI-3 personality traits, depression, anxiety, trauma and dissociation would predict intrusive thoughts.[56,57,58,59,60] The correlation matrix showed most personality traits were significantly (with the exception of extraversion) correlated with the occurrence of intrusive thoughts. The hierarchical regression found that depression, experience of prior trauma, openness to experience, and absorption had a significant impact on presence of intrusive thoughts. Significant positive relationships between depression, prior experience of trauma, dissociation and intrusive thoughts were found. A negative correlation between openness to experience and intrusive thoughts meant that a lower openness to experience led to a higher presence of intrusive thoughts. These findings that openness to experience supports previous literature which suggested that there is a significant relationship between low openness to experience scores and intrusive thoughts. The personality trait of openness to experience refers to an individual's propensity to be open to a variety of experiences, with a need to enlarge and examine experience.[40,61] As with all personality traits, it is an adaptive mechanism that has been naturally selected. While much research has historically overlooked the relevance of openness to experience more generally, the present findings have implicated lower openness to experience as particularly relevant within the context of intrusive thoughts. This may relate to the cognitive functioning and flexibility which underpins the trait. Considerable literature exists which highlights the positive association between openness to experience and cognitive functioning.[62] Indeed, further research suggests a decreased ability for cognitive restructuring in persons lower in openness to experience.[63] Taken together, possessing a decreased tendency for cognitive flexibility may infer a risk for intrusive thoughts with those lower in openness to experience.

A previous experience of trauma was related to an increased presence of intrusive thoughts. This finding reflects Pujol and colleagues[64] research where intrusive thoughts were a key symptom for patients with PTSD. Childhood trauma was shown to result in an increase an individual's chance of having PTSD and or OCD at a younger age.[65] This research emphasised the relationship between trauma and the presence of intrusive thoughts.

Depression has been shown to affect a person's cognitive processing which results in higher intrusive thoughts.[66,67] On the other hand, anxiety was proposed to alter a person's cognitive processes, like in Robinson, Vytal, Cornwell and Grillon[68] where anxiety was found to affect perception and attention among other cognitive processes. The findings demonstrated a correlation between the two variables, albeit non-significant, in the hierarchical regression, which suggests that there is a connection between anxiety and intrusive thoughts but anxiety does not significantly influence the presence of intrusive thoughts.

These findings on absorption highlight its impact on cognitive processes and intrusive thoughts. A person who practices absorption as a coping strategy will be unable to absorb their daily moments effectively and often live in a tranced state. A lot of past literature has focused on dissociation as a whole and its impact on intrusive thoughts.[69] These findings build on pieces of literature showing absorption, as a part of dissociation, to have a strong influence on emotional regulation and intrusive thoughts.[29]

Limitations

There were many strengths to this study such as a large sample size with a high response rate of 96% but limitations still arose. This sample was an undergraduate student sample meaning that the data may not generalizable to the whole population. As students often want to appear 'normal' answering the correct answer [70] they may submit incorrect answers causing bias to the scores, a manifestation of the 'good subject effect'. This may explain the correlation between low neuroticism and high intrusive thoughts, the opposite of what has been observed in previous research.[17, 18] Another limitation is that it was a self-report study which may not be as accurate as using experimental design. Unfortunately, those participants who scored highly in dissociation may not remember aspects about themselves that could give the researchers a different score. As the minimum score for anxiety was 7, this study had no participants who were not anxious and therefore the study could not investigate the levels of intrusive thoughts for people with no anxiety. In a study on university students, anxiety was the most prevalent psychopathology[71] suggesting that this may need to be accounted for in future research.

Suggestions for future research.

With this study supporting results from past research as well as showing new findings on the relationship between the presence of intrusive thoughts and other variables, further research in this area is possible. This could involve experimental designs where different measures can be used to confirm these findings in a more sophisticated way. Researchers could also perform the same procedure on a larger more generalizable sample as well as with a clinical sample who have a psychopathology with obsessive thoughts as a symptom such as OCD. Future research could also involve comparing resiliency of intrusive thoughts in a general population versus a clinical population. This would hopefully confirm the hypotheses and then these findings could be used to add to knowledge of dissociation that is used in therapy worldwide.

Summary and Conclusions

From this research, one can conclude that the sub-component of dissociation, absorption has a strong influence on the frequency of intrusive thoughts, as well as prior to experience of trauma and openness to experience. Those who experienced intrusive thoughts were more likely to be prone to dissociation, have experienced a personal trauma, and may have low openness to experience.

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AUTHORS

Casey Donaghey, BA, NUI Galway. caseydonaghey@hotmail.com

Dr. Jonathan Egan, Director of Clinical Practice, NUI Galway.

Dr. Páraic S. O'Súilleabháin, Post Doctoral Researcher, NUI Galway.

AN EVALUATION OF A GROUP PSYCHOSOCIAL INTERVENTION FOR CLIENTS WITH SCHIZOPHRENIA

E. HENNESSY, M. CAROLAN, B. MULCAHY, M. MURPHY AND A. CORCORAN

SUMMARY

This study aimed to explore service users' initial experiences of Cognitive Behavioural Social Skills Training (CBSST), aimed at improving psychosocial functioning in clients with schizophrenia. To date, CBSST has been delivered in the USA and Canada, as well as parts of Europe, but not yet in an Irish setting. The main focus of this study was to assess how service users received the programme, if it was acceptable to them, as well as to explore their overall experiences of being in the group to this point.

INTRODUCTION AND RATIONALE

Historically, the majority of people with severe and enduring mental health difficulties, such as schizophrenia, resided in psychiatric hospitals and had poor long term outcomes which meant that they were often given little optimism for their future[1]. As a result, a movement toward a more holistic view of recovery, and recovery-orientated mental health services for this population group, has taken place internationally over the last thirty years[2-4]. This concept has been growing in Ireland over the last 10 years since the publication of the Government mental health policy document 'A Vision for Change – The Report of the Expert Group on Mental Health Policy'[5] which advocated for recovery as a 'facilitative process that enables disadvantaged individuals to access as independent a life as possible in social, cultural and economic terms'(p104). Consequently, the formation of rehabilitation and recovery community mental health teams has taken place in order to provide specialised care for people with severe mental health difficulties, which could not be adequately met by the general adult Community Mental Health Teams.

It was further advocated in 'A Vision for Change' that service users and their families should be at the centre of all service provision and development, and service users should be viewed as 'active participants in their own recovery rather than passive recipients of 'expert' care'[5(p13)]. It was emphasised that services needed to be evaluated in terms of the benefit and value they were having for service users directly with the hope that their responses would lead to improved service provision for future client groups. So, what do people with severe and enduring mental health difficulties want from mental health services?

Recent national research from the UK surveyed 20,000 mental health service users on their views of the same and found that “too often, care was ‘done to’ them rather than shaped with them and that health professionals did not systematically listen to them or take their concerns seriously”[6(p10)]. In the same vein, Rethink Mental Illness in the UK conveyed in their report entitled ‘The Abandoned Illness: A report by the Schizophrenia Commission’[7] that service users wanted to have their experiences validated, to be viewed as an individual outside of their diagnosis and symptoms and to be given hope for the future. Furthermore, research by Byrne and Morrison[8], which investigated service users with psychosis’ preferences for services, found that a desire for more information, choice and collaboration in treatment decision-making were the most highly valued. The researchers also noted that services which appreciated people’s individual differences as well as their own identified goals were seen as more acceptable to service users and therefore more effective.

These findings are in harmony with those from Pitt and colleagues[1] who looked at service-user defined recovery. Their research illustrated that reconstructing lives; hope for the future and reclaiming a sense of self were highly valued by people with psychosis. Leamy et al.[9] created a framework for operationalising recovery after conducting a systematic review of 97 research papers that explored theories of personal recovery from mental health difficulties. Their findings highlighted five main themes, namely: connectedness, hope, identity, meaning and empowerment/choice (CHIME). What is more, Romme[10] noted several aspects of standard psychiatric service delivery to be detrimental in their study of 50 people who had recovered from voice hearing experiences. These included the negative impact of hospitalisation, medication and diagnosis; negation of staff to participate with the voice hearing experience; being treated as a “passive victim of pathology”[(p27)]; and a symptom focus over a focus on psychosocial difficulties.

One model of intervention, Cognitive Behavioural Social Skills Training (CBSST), developed by Granholm, Holden, McClure, Link, Perivolitotis and colleagues[11] incorporates the training of social, problem-solving, and cognitive skills with clients desire to achieve personally relevant goals in one programme. This is achieved by targeting the negative symptoms of schizophrenia, which in opposition to popular acceptance, are the greatest barriers to recovery[12] and are often an unmet need of service users[13].

The programme comprises of three modules: Cognitive Skills (used to challenge beliefs that interfere with communication skills, performance and goal-directed actions in the real world); Social Skills (to improve communication skills capacity); and Problem Solving Skills (to address neurocognitive impairment related to solving problems and developing goal-directed action plans). It is a simplified practical learning programme to facilitate recovery goal achievement[12].

Results of three randomized control trials[11,12,14,15] showed that CBSST is an effective psychosocial intervention to improve functioning and reduce negative symptoms in people with schizophrenia (aged 18-65 across all trials). Improving dissemination of evidence-based-practice such as CBSST into real-world clinical practice is a public health goal as research indicates that the psychosocial needs of 90% of clients with schizophrenia are consistently underserved[17].

To date, CBSST has been delivered in the USA and Canada, as well as parts of Europe, but not yet in an Irish setting. The current study aims to evaluate service user's initial experience of a CBSST intervention programme in clients with schizophrenia. This is in line with the need for continued dialogue with service users and their families about their experiences of the mental health services they are receiving[18]. Although the group is run over a total of 18 sessions, the current evaluation, conducted through a focus group, took place at the end of the first six sessions. The evaluation aimed to assess; how the programme was being received and if it was acceptable to service users, and to explore their overall experiences of being in the group to this point, so as to inform the group going forward.

In order to address the above aims, the following objectives were used to shape the interview schedule and elicit information from participants:

- Clients' experiences of being in the group so far.
- What they find helpful and what they find less helpful.
- If the group is meeting clients' needs thus far.
- Could delivery of the group be improved?
- Impact of integrating goals and skills into their lives

These objectives were obtained from best practice guidelines for service user-centric model of care.

SERVICE CONTENT

The service in question works with service users, aged between 18 and 65, with severe and enduring mental health diagnoses, who represent a cross section of society, including both gender and all socio-economic groups. This population of people have been found to suffer significant disablements in their psychosocial adjustment, particularly in the area of refractory symptoms as well as personal care, social skills, vocational and recreational skills. In many cases they may also be unable to maintain independent living skills and so their needs cannot be adequately met at the level of the Sector Service.

METHOD

Design

In order to ensure the experience and views of the group participants were captured, a qualitative methodology was employed for this study. This involved the use of a focus group at the end of the first module (six sessions) to gather the data and subsequent thematic analysis. A doctoral researcher who was not involved in the facilitation of the CBSST group, and did not have any therapeutic contact with the participants carried out the focus group. This was intended to reduce any ensuing research biases from such involvement.

Participants

Participants (*n*=5) were attending a rehabilitation mental health service in Community Health Organisation Four (CHO-4), Ireland, had a diagnosis of Schizophrenia and had identified functional rehabilitation needs. Participants originally included five males and two females of which just the five males completed all six sessions and attended for the focus group.

Procedure

Participants were invited to partake in the current study and were informed that should they decline involvement, it would not affect their involvement in the CBSST group. They were given an information leaflet which was explained individually to each participant by the researcher and which outlined the parameters of confidentiality, anonymity and also highlighted the right to withdraw from the study at any time. Following this, if they wished to continue with the study, participants were asked to sign a consent form. The consent forms were then stored in accordance with the service's Data Protection and Safe Storage Policy.

The focus group was carried out once the first six sessions of the programme were completed and took approximately one hour from start to finish. A semi-structured interview schedule was used, which was informed by the study objectives previously outlined. The full focus group schedule is available on request. Group interaction was stimulated and facilitated by the researcher by encouraging participants to add their perspectives to other member's responses and also to offer different viewpoints. At the conclusion of the focus group participants were invited to ask any questions that they had about the research study.

Following the focus group, participants were made aware that they had the option to speak privately to the team's Senior Clinical Psychologist should they wish to discuss any issues that came up for them during the focus group.

The focus group was recorded using the voice recorder function of an encrypted Lenovo 'ThinkPad' laptop and transcribed verbatim by the researcher.

Ethical Considerations

The Ethics Committee at the School of Applied Psychology, University College Cork granted ethical approval prior to data collection. Data was only collected following fully informed consent. Specific consideration was taken to ensure that all data was anonymised and names assigned a pseudonym for reference. The data was kept confidential for the duration of the study and was available only to the research team. All data collected was stored securely and safely in accordance with the service's Data Protection and Safe Storage Policy. Data will be retained for a further ten years and then destroyed.

Analysis

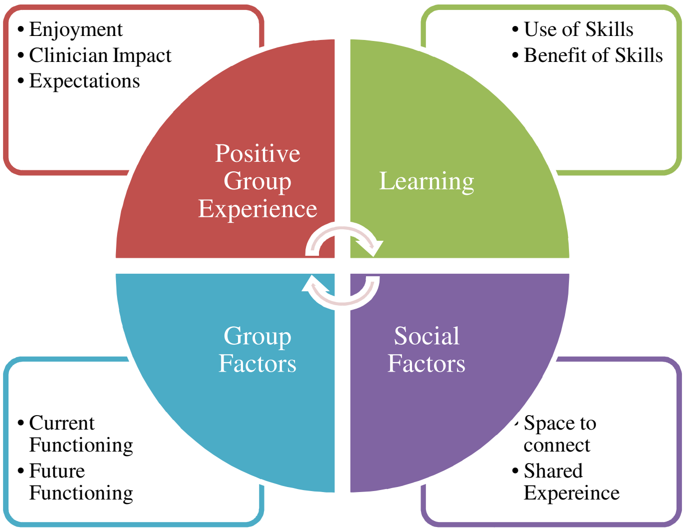
Data were analysed using thematic analysis in accordance with Braun and Clarke's[19] six-stage approach.

RESULTS

Participant's narratives encapsulated several aspects about their experience of being in the CBSST group. An overall sense of positivity and enthusiasm for the group was evident throughout the focus group and indeed in the analysis. Four main themes, each further explained by sub-themes, were realised from the data set:

- Positive experience of the group
- Learning
- Group factors
- Social factors

Diagram 1: Thematic Map



Theme 1: Positive Group Experience

The first main theme provides rich information of how the group was experienced by participants in a clinical context. In order to capture the essence of this experience, it has been divided into three sub-themes: 'enjoyment', 'clinician impact' and 'expectations'.

Enjoyment. All participants reported enjoying the group, describing it as 'interesting'.

'It's good yeah, very interesting, it's very good'

'...I was happy once I knew there was something that could help'

Participants also reported that they were enjoying all aspects of the group so far, with one participant naming 'learning' as part of what he enjoys and another naming 'goal setting'.

'I'd be into all of it'

'It is interesting to learn something like'

'It's the goals I like'

Clinician Impact. Input from the clinicians involved in running the group was noted to contribute to participants overall positive experience. Support from the clinicians was particularly noted as helpful to participants.

'They are there to help everybody...if you're having hassle writing down your notes or thinking of goals, they will give you a hand'

'Ah they try hard to make it good like'

'I can honestly say...[Clinician], [Clinician] and [Clinician] are great'

Expectations. Participants discussed their expectations of what they had thought the group would be like before commencing. The majority agreed that they were unsure of what to expect.

'I wasn't exactly sure but when I started the first day, I got to know what it was about'

'I thought it would be more like the walking group we did last year, but then we came in on the first day and they showed goal setting and I was like yeah, yeah, but I got into it then'

One participant stated that he feared the group would rely heavily on literacy skills.

'Be writing and spelling and things like that...hard words and small words...'

He stated that this was not the case on beginning the group, when asked in the focus group.

Theme 2: Learning

The second theme encapsulates participants perceived learning from the programme so far. Participants spoke about using the 'Three C's' as a method of learning how to challenge their thoughts as one of the skills taught. They also spoke about learning how to break tasks and goals down into small steps in order to help them achieve these. The skills taught were viewed as positive overall for participants. This theme is discussed under the subthemes 'use of skills' and 'benefits of skills'.

Use of skills. Participants discussed their use of the skills they have acquired thus far in the group.

'I get anxious travelling, so I am using them with that'

'I've tried to give up smoking and it was like: why? What are you waiting for? Why haven't you started yet? So I said what I had to do...'

'The three c's was great and I'm trying to enact them in my life constantly now'

'(learning) if you don't want to do something, then you don't have to do it'

They described learning to break tasks down into small steps in helping them to achieve their goals as beneficial.

'I'll try and do it in the same way again...kind of figure out what I must do and break it down'

'They are in small steps so if you do one, two, three and then fail on four, you just start again from where you left off'

*'The whole thing is breaking it down into small steps...instead of looking at one big goal and thinking I'll never f***ing achieve that!'*

Participants conveyed that the skills learned have been valuable to them in helping their thinking styles. Although one participant noted that changing their thinking style was one of the most difficult parts he has learned.

'It gives you a proper way of thinking about things'

'Changing your thoughts is the worst part...the most difficult'

Benefit of skills. The group discussed some benefits of learning new skills in the group and how they are beginning to effect change in their lives.

'You get smarter with it like...and you get interested in things'

'It's helping me with my anxiety and how to control it'

Participants portrayed a sense of empowerment gained from the group.

'...to learn how to build yourself up, to feel like it and actually want to do it'

Learning new skills in the group was noted to be an alternative to taking medication and described as a more favourable option.

'If you are on tablets and you want to do something, the tablets would tire you down'

Theme 3: Group Factors

The third theme discusses factors relating to the functioning of the group and is divided into two subthemes: 'current functioning' and 'future functioning'. On the whole it was acknowledged that the group is very much still in its early stages and the remainder of the group is positively anticipated by participants.

Current Functioning. When speaking about the current functioning of the group participants described the teaching element and how this impacts on them. They noted that the way the group is run, in that it is required that a person completes tasks at home before the following group is a motivating factor.

'Knowing you have to come in and state what you did and didn't do...it gives you a push'

'You can't come in every week and say you didn't do anything'

They also expressed that having three clinicians facilitating the group has been helpful for them in accessing the teaching materials.

'...everybody nearly has somebody sitting beside them to give a hand with the paper stuff'

'The teacher explains it to us and goes through it with us on the sheets'

Participants reported satisfaction with the composition of the group in that there was an appropriate amount of members without being overcrowded and that it meant that they were not one-to-one with a professional.

'I think it's kind of cosy'

'Yeah you wouldn't want too many and you wouldn't want to just be in here yourself with another person'

It was not reported to be of importance if the group was composed of males and females or just males.

The frequency of sessions and overall duration of the group programme was an important topic during the focus group and was given much attention by the participants. As the group had been running twice per week participants were eager to know if this format would continue going forward. This topic was revisited several times during the focus group.

'So it's going to be one class a week from now on is it?'

'Is it only once a week from now on?'

'Is it going to be for how many months did you say?'

Participants stated they were happy with the timing of the group, which was 12pm-2pm. Equally the location of the group was acceptable to participants, with transport noted not to be an issue for them.

'It's not eight or nine so it's good'

'I'm just up the road'

'I'm from (town) but I have a van so I can drive here'

Future Functioning. On the whole the group did not have very many recommendations for the future functioning of the group. They stated they were happy with how it was going so far and in some cases felt they felt it was too early to know what they would like to change.

'Ehhh...no, not really' (any recommendations for the future)

'To improve it? Ah no, I like it the way it is'

'We will know more when the sessions start back - we will have to let you know'

'There will be more weeks of it, so I'll know more in the next week or so'

Following from this, a view of positive anticipation was portrayed by the group when looking to the future functioning. Moreover, participants reported a sense of motivation in being able to achieve their goals in the future of the group.

'Yeah I'll be looking to get into it again once it starts'

'By the end of it I'll be able to do it'

'...I'm going to try again when the group starts back'

The group reported that they enjoyed the break they had been getting in the middle of the session to go for a walk. They stated they felt this would be finishing as it was part of another 'walking group' they had been involved in, and had since achieved their goals from that group. Being allowed to keep the walking break was referred to as a recommendation for the future running of the group.

'The walk would refresh you like, it would clear your head'

'It's good because when you are up early in the morning you would be tired and the walk helps'

'Oh yeah we won't be walking now because we've finished'

One participant stated that he would like the group to run for a little longer.

'I don't know really, maybe stay on a bit longer? Maybe an extra 20 minutes'

When asked more about this he stated *'I think it is because we finish a bit earlier or something usually'* and did not elaborate further.

Participants reported that they would recommend the group for future participants and urged them to be open to giving it a try.

'Just stick with it'

'Yeah give it a shot'

Theme 4: Social Factors

The fourth and final main theme looks at the social factors participants outlined as being associated with the group. These are discussed under two subthemes: 'space to connect' and 'shared experience'

Space to Connect. All participants described the group in terms of social benefits. They reported that it is a place where they meet other people and commented that without the group, they may not have had another opportunity that week to connect with others.

'I could be at home all week and meet nobody except the family'

'I'm getting out more'

'Yeah it's good to meet people'

'I get to come here and see the lads and we have a bit of a chat like'

One participant noted that the group offered him something more than what he receives in his shared housing.

'Well I am in (supported accommodation) so there is people around there all the time but really it is in the courses where you meet people'

Shared Experience. During the focus group the participants spoke about knowing each other for a long time. They also noted that they were open to meeting new people through the groups.

'Well we have known each other a while now'

'I know him about seven or eight years'

'I only met (name) during the sessions'

They referenced this with regard to somewhat of a shared experience of being in the service and having attended groups and outings together in the past. Of note, the group became quite animated when discussing this and appeared to be an important point for them to get across.

'There was a group before, a young person's group, and we used to go to the cinema together'

'It was with the national learning network for three years'...'I was up there too...'

'...and we went to tayto park together last year'

DISCUSSION

This section will discuss the overall findings from the study with reference to existing empirical literature and potential implications for the service.

The first main theme identified in the findings, 'Positive Group Experience' suggests that participants are enjoying the group and are finding the content interesting. This positive atmosphere is important to maintain so that participants continue to attend all sessions and get the most they can from the programme. It was also found that participants value the support they receive from clinicians during the group which should be kept in mind by the facilitators as they continue the programme, particularly as some of the participants highlighted that they struggle with literacy. It is also important to note as it is in contrast with research from service users in the NHS[6] which found that too often they felt health professionals were not listening to them and thus contributed to a negative service experience.

The second theme, 'Learning', discusses the skills that participants have obtained and used from the group and also the benefit they have been to them. Participants spoke about feeling as though the skills have given them hope that they will be able to achieve their goals as they offered them a way of breaking tasks down into manageable chunks. Moreover, they spoke about failure, and how this makes them feel, but that by using the small steps approach this feeling is lessened as they can start again from where they left off. This is significant as information gathered by Rethink Mental Illness[7] and by Pitt et al.[1] noted that service users wanted to be given hope for the future when asked what it was they needed from the mental health services. In addition, it was acknowledged by one participant that the group offers a positive alternative to taking medication. This links with findings from Romme et al.[10] who highlighted medication as one potentially harmful aspect of psychiatric care.

The third theme describes participant's perceptions of the current functioning of the group and also their thoughts on the future of the group. Overall participants are happy with how the group is being facilitated currently. Clinicians should continue with the same format going forward but ensure to inform participants in advance how many days per week the group will run and for how long, as this topic was discussed on several occasions during the focus group. This endorses Byrne and Morrison's[8] research which found that service users with psychosis had a desire for more information and choice in their treatment.

With regard to the future functioning of the group participants, reiterated that they are happy with how the group currently runs and did not have any suggestions for improvement as such. One participant did recommend a longer session however. Participants were clear in their thoughts that they enjoyed the 'walking group' element at break times in the group and that it had a positive impact on how they functioned in the group. This should be noted going forward and incorporated if possible. On the whole, participants are looking forward to starting with the group again.

The final theme, 'Social Factors', illustrates important information about what participants get from the group outside of direct programme learning. Participants conveyed that the group offered them a space to connect with other people and in some cases was noted to be the only opportunity for social experiences in the week. This social gain could easily be overlooked when planning a therapeutic group but is important to remember when thinking about what attendance at groups such as this offers people, and how it adds to their everyday lives. This corroborates with Leamy and colleagues[9] who found that the theme of connectedness was linked to personal recovery from mental health difficulties. Of note, they also highlighted themes of hope, meaning and empowerment in relation to recovery which are also attended to in the current study. Finally, it must be recognised from the findings that participants valued the experiences they have shared with the other group members over the years and how important it appeared to be for them to have a space to share these memories.

Limitations

As the focus group was carried out after six of the 18 sessions, it highlights participant's initial experiences of being in the group and cannot as such be generalised to how they will experience the entire programme, although the service has made plans to address this in future research. Furthermore due to the small sample size, the themes identified should be considered suggestive rather than representative, as a different group of participants may favour different issues, especially female service users as they are not represented in this study. It is also possible that some participants may find it difficult to express their views in a focus group setting, particularly if they are new to the group who stated they know each other for some years. In this instance individual interviews may be more appropriate and will be addressed by the end of programme research.

Future Research

Future research has already been planned by the service and will include individual interviews to assess participants overall experience of the full CBSST programme using similar questions to the current study. This research will also look at clinical psychometric measures taken routinely by the service before and after the intervention so as to assess the therapeutic effectiveness. Measures will include:

- Independent Living Skills Survey (ILSS)[20]
- Goal Attainment Scaling (GAS)[21]
- Scale for the Assessment of Negative Symptoms (SANS)[22]
- Comprehensive Modules Test (CMT)[11,12,14,15]
- The Defeatist Performance Attitude Scale (DPAS)[23]

CONCLUSION

This study aimed to explore service user's initial experience of a CBSST intervention programme aimed at improving psycho-social functioning in clients with schizophrenia. Findings from a focus group carried out with participants at the end of the first six sessions of the programme illustrate that it is well received by service users, they are learning helpful skills to support them in their day-to-day living and they are looking forward to continuing with the programme. Additionally participants reported that they find a great social element to the group which is of importance to them. These findings are the first to be realised for this programme in an Irish context and can be looked at positively going forward with the group. At this point it does not seem that changes need to be made to the delivery of the programme as participants reported that it is being well received. There are a number of limitations to the study as outlined earlier, some of which will be addressed by future research planned by the service. This future research which is to be carried out at the end of the completed CBSST programme will provide a more detailed picture of participants experience of the group in its entirety and may lend itself to amendments if required at this time.

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AUTHORS

Emma Hennessy, Clinical Psychologist in Training, HSE/UCC.
emma.hennessy@hse.ie

Mairead Carolan, Senior Clinical Psychologist.

Breda Murphy, Mental Health Nurse.

Maeve Murphy, Occupational Therapist.

Dr Alan Corcoran, Consultant Psychiatrist.

"I CAN BE GIVEN SUPPORT BY PEOPLE WHO UNDERSTAND MY PROBLEMS…"

YOUNG PEOPLES' VIEWS AND EXPERIENCES OF THEIR HELP-SEEKING JOURNEY THROUGH A CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS) – A PILOT STUDY ON THE PRACTICAL IMPLEMENTATION OF SERVICE USER RESEARCH IN SECONDARY CARE MENTAL HEALTH SERVICES

EMMA HICKEY, RUTH MELIA, ARAN TOMAC AND BARRY COUGHLAN

ABSTRACT

The participation of children and young people in informing the delivery of high quality care is integral to a child-centred and rights-based approach to mental healthcare provision. It was the aim of this research to describe the process through which the views and experiences of service-users were captured in one CAMHS setting. **Method:** Young people were invited to participate in a focus group which aimed to explore their journey through CAMHS. Young people were asked to give feedback on how satisfied they were with the service, via a questionnaire, to inform future service provision. **Results:** Quantitative survey data indicated high satisfaction levels with professionals' ability to listen and understand the difficulties discussed and the support provided to manage and deal with presenting issues. Areas with lower satisfaction levels were noted in developing relationships between the young person and family or carers and improving family and carers' knowledge of the young person's difficulty. Four key themes emerged from focus group and qualitative survey data: (i) The Help-Seeking Journey (ii) The Therapeutic Alliance (iii) Discovery (iv) Future Directions. **Conclusion:** Implications for clinical practice include dealing with stigma and shame as a therapeutic theme and treatment goal, separate consultations for parents and young person to encourage open communication and information sharing with Health Care Professionals (HCPs), and facilitation of parent psycho-education groups to better support parents in their roles. As recruitment for the focus group was a considerable challenge faced in this study, clinicians may find it useful to employ a triangulated approach to data collection and combine semi-structured interviews with participatory research methods such as focus groups to facilitate service-user

preferences for different methods of exploration.

INTRODUCTION

Person-centred care (PCC) is defined by the Health Foundation as a system of care that helps people make informed decisions to successfully manage their own health and delivers care with respect for individual abilities, preferences, and goals.[1] Tusla, Child and Family Agency, have adopted the Lundy model of child participation [2] to facilitate the implementation of PCC. This model highlights the importance of giving children space to express their views, facilitating the expression of these views, ensuring these views are communicated to someone with responsibility, and ensuring these views are acted upon, as appropriate.[3]

Community CAMHS teams are at the forefront of specialist mental health services, with adolescents reported as the most frequent service users.[4] Previous research into adolescents' experiences of CAMHS in Ireland indicated that their right to assent to treatment and participation in decisions were often not maintained.[5] Service user research conducted in Northern Ireland reported participants' frustration with poor service accessibility, long waiting times, incomplete services, fear of stigma and lack information provision[6]. Research conducted in CAMHS in 2015 in Ireland reported a strong negative correlation between reduction in impairment and levels of satisfaction.[7] It was reported in another Irish study on CAMHS satisfaction that the presence of parents during the session contributed to self-censorship, where both service users and carers felt *'inhibited to speak in front of each other'.* [8]A CAMHS report developed by the HSE in 2012 [4] found significant disparity between the distribution and resourcing of CAMHS across regions, highlighting a major barrier to effective and efficient implementation of PCC across secondary care services. The limited research into service user experiences of and satisfaction with CAMHS in Ireland highlights the discrepancy between policy and legislative focus on PCC and service user involvement and the implementation of this on a practical level in local services.

Within CAMHS in the UK, the adoption of Routine Outcome Measures (ROM) or Patient Reported Experience Measures (PREMs) to assist in service user involvement has been promoted by both national and local initiatives such as NHS Outcomes Framework policy[9] and the National Service Framework (NSF)[10]. Research which compared the use of ROM in CAMHS from an audit conducted in 2011 with a re-audit conducted in 2012/2013 indicated a greater use of combined measures in comparison to ROM usage in the original audit[11] highlighting the effective implementation of policy to practice. Common barriers reported in this study for the lack of completion of outcome measures in clinical practice included constraints on both time and resources[12]. The restricted provision of prompt feedback from completed ROMs has been reported to decrease clinicians' motivation and likelihood to use these measures, rendering them a 'tick box' exercise used to meet service targets but with restricted clinical utility[12]. Other barriers to the uptake of ROM included apprehension about how the feedback will be used by managers and commissioners.[13]It has been reported that training in outcome measures and administrative support allocated to ROM implementation facilitated the increase in ROM usage[11]. It is necessary that initiatives continue to increase clinicians' awareness around the importance of measuring outcomes within CAMHS, and it was the aim of this pilot study to begin to test out ROM/PREM usage for general service satisfaction in an Irish CAMHS setting.

It was the aim of this study to foster an environment that aims to engage young people in an honest and innovative conversation about their perspectives on their journey through a mental health service and the facilitators and barriers experienced along the journey. As very little research has been conducted in this area in Ireland to date, it is the main aim of this study to begin to describe the process of integrating service-user research into CAMHS services practically. This will inform clinicians who wish to implement similar practices in other CAMHS settings and may inform their practise in terms of previous research, measures, resources and possible recruitment issues.

The process of seeking service-user views and experiences to guide future care planning was operationalised using the following methods.

1. Conducted a focus group with CAMHS service users to encourage creative discussion on mental health service provision in Ireland using the Lundy Model of child participation, as recommended by Tusla, Child and Family Agency[5].
2. Administered a CAMHS Satisfaction Survey – Young Person Rated (Routine Outcome Measure) to receive quantitative and qualitative feedback from young people on current satisfaction levels with the service.

METHOD

Design

A mixed methods design was employed for this study to capture subjective experience of engagement with a mental health service and general satisfaction levels respectively. A focus group method was chosen to explore service users' experiences of accessing and using CAMHS. Focus groups aim to encourage open communication and disclosure between participants.[14] The group was moderated by a senior clinical psychologist and a psychologist in clinical training and lasted approximately 1.5 hours.

Two members of the research team drafted the moderator's guide which was guided by Tusla's Child and Youth Participation Toolkit[3]. Topics were also drawn from clinical practise, research and theory. The CAMHS team in this area were due to move to another building therefore perspectives on environment were important to explore from a clinical perspective. The importance of technology and well-being is supported by ReachOut's policy on mental health and technology, which highlights the need for technology to be safe, supportive and creative as well as user driven and empowered.[15] This may inform any future e-mental health strategies in Ireland and therefore was deemed important to include in the focus group discussion.

The CAMHS Satisfaction Survey – Young Person Rated questionnaire was chosen as an appropriate measure as its main dimensions have been demonstrated to have a high level of internal consistency.[16]

Study Setting and Recruitment

The study took place in a CAMHS clinic, staffed by a multidisciplinary team led by a consultant child and adolescent psychiatrist. Participants were selected by reviewing the active client list of CAMHS with the senior clinical psychologist in the service to access names, addresses, and phone numbers in order to post out a formal request to participate. Consent and assent forms to participate, information packs on the study, and satisfaction questionnaires were included in the request to participate package. Follow-up phone calls were conducted 1-2 weeks after postage. Inclusion criteria for the focus group were adolescents aged between 12-18 years old and those who felt able to participate in a group setting at the time. Satisfaction surveys were also placed in the CAMHS clinic waiting area in order to facilitate those who did not wish to participate in a focus group but wished to provide written feedback on their experience.

Participants

The aim was to recruit 6 participants for a focus group, as per focus group guidelines outlined by Tusla's Child and Youth Participation Toolkit[3]. The final sample included 3 participants currently accessing CAMHS treatment. A total of 17 surveys were collected via post and the clinic waiting room. Demographic information for survey data was not requested to protect anonymity, as per the QNIC, Royal College of Psychiatrists, UK guidelines[17].

Data analysis

Data analysis of the focus group and written qualitative survey feedback was guided by principles of Thematic Analysis.[18] Descriptive statistics were conducted on quantitative survey data received using IBM SPSS Statistics Version 24 software package.

Ethical Considerations

Ethical approval was obtained from the relevant local research committee and the participants gave written, informed consent to participate in the study. Confidentiality was discussed with the participants when the group began. Participants in the focus group were debriefed and follow up phone calls to parents of participants were conducted 3 days after the group. Data from focus group sessions and questionnaires were stored in the CAMHS administrative office.

RESULTS

Summary of Quantitative Results

A number of strengths were noted when satisfaction levels with the CAMHS facility were analysed. 58.8% of the sample were either very happy or happy with the effectiveness of the service in helping them deal with their problems. 82.3% of the sample were very happy or happy with how the professionals in the service understood their problems and 88.3% were very happy or happy with levels of confidentiality and respect for their rights. 82.3% of participants were very happy or happy with how effective the service was in helping improve knowledge and understanding of their problems, with no participants reporting that they were very unhappy or unhappy with this. 82.3% of young people in this sample reported being very happy or happy with their wait time before receiving a service.

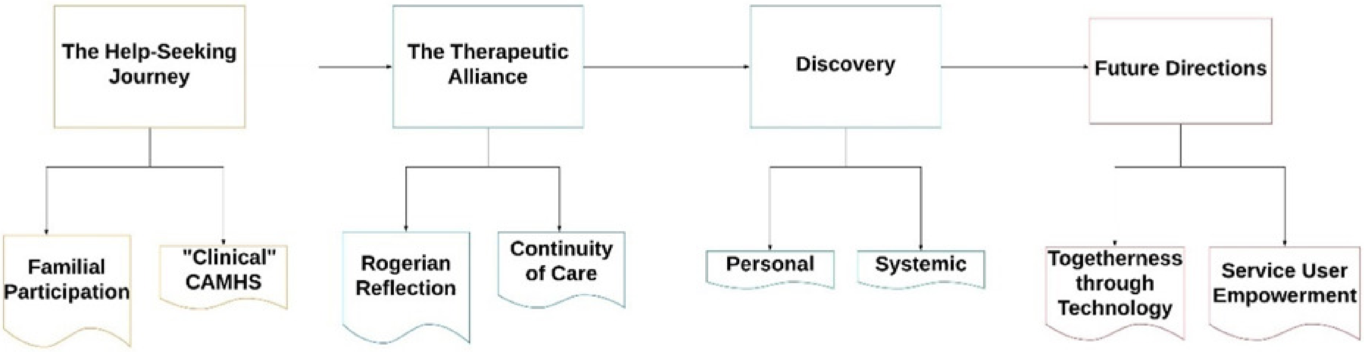
53% of participants were mixed/unhappy/very unhappy with how effective the service was in helping the relationship between the young person and their family or carers and with how effective the service was in helping their family or carers understand their problem. 35.3% were prescribed medication. Of this, 50% of participants were happy with this, 33.3% mixed and 16.7% reported being very unhappy. When those who were not prescribed medication were asked if it may have been helpful, 63.6% said no, 36.4% said yes.

41.2% engaged in family therapy. Of this sample, 42.9% were happy and 28.6% very happy. Out of those who didn’t receive it, 40% said it would have been helpful. 17.5% of participants reported that their parents had the opportunity to attend a parents group. All who did, reported being very happy about this. Out of those who reported their parents had no engagement with a parents group, 57.1% reported it would have been helpful.

Summary of Qualitative Results

Thematic analysis of focus group and qualitative survey data resulted in 4 main themes and categories (see Figure 1).

Figure 1: Results of Thematic Analysis



Theme 1: The Help-Seeking

This theme explores participants' journey to a mental health service, noting some facilitators and barriers experienced along the way.

Familial Participation. Participants discussed the impact their family had on the journey to CAMHS. Familial attitudes and opinions were noted as one of the first steps on the help-seeking journey. Family opinions, and the possible presence of stigma or shame, emerged as an important facilitator or barrier to seeking help in the first instance.

"Stigma – you don't want people knowing"

Participants were generally referred through their General Practitioners (GPs) which they attended with family or carers. The majority reported that their waiting time was ok – approximately 1 month, a notable facilitator of accessing any mental health service.

Participants reported that they did not do any research into CAMHS before attending initial intake.

"Knew where I was going, didn't know what it was"

Participants highlighted that they believe parents can do too much research into different services at times, and develop expectations that may not be realistic.

Lack of concrete information about CAMHS tended to increase participants' anxiety on the day of the first appointment; participants remembered their first day visiting CAMHS very well and reported that it was a *'nerve wracking and scary'* experience. An important barrier to engaging with CAMHS discussed by participants was feeling inhibited by the presence of their parents at intake. Participants reported that they did not want to speak or open up in front of their parents.

"I hated – despised - the assessment. Was made answer personal questions in front of my parents – if I wanted to say it in front of my parents, I'd be opening up to them, rather than being in therapy!"

"Clinical" CAMHS. Participants reported that the CAMHS waiting room can be *'empty and quiet.'* It was reported that the addition of resources for older clients in the waiting room would be beneficial. Other suggestions included access to Wi-Fi in reception whilst waiting; this may buffer against any anxiety experienced while waiting for parents.

The physical environment, layout and design of clinic rooms were reported to be clinical; participants emphasised the need for more inviting and welcoming therapeutic rooms.

'The room are often quite bland and not inviting or not supplied with tissues, but I also understand that it is a HSE service.'

Other barriers reported included loud doors and buzzers in the building and a lack of privacy and fear of other professionals or service users looking into their therapeutic space. All participants reported being very aware and sensitive to their surroundings while in CAMHS.

Theme 2: The Therapeutic Alliance

This theme looks at participants' perception of the role of the therapist in their journey through a mental health service.

Rogerian Reflection. All participants discussed the positive relationships formed with CAMHS therapists and the power this positive relationship can create for positive treatment outcomes. Qualities endorsed by participants included showing an interest in hobbies, being empathetic, encouraging, a good listener, informative, open-minded, friendly and dedicated.

"…to be themselves"

'I liked to be able to talk to people who will actually listen …'

Participants discussed the importance of creating a welcoming and comfortable environment which is *'not clinical.'* An adjunct to the non-clinical approach included participants' preference for therapists to be themselves and begin to break tradition with the expert-patient approach. An important element of nurturing a sound therapeutic alliance included allowing the client to lead the narrative,

"They remind you of the progress you have made"

'Not pushing you when you don't want to say something'

Participants reported an appreciation for the core tenets of the reflective model of practice, including reflective listening, paraphrasing, reframing and summarising. Unhelpful or negative qualities reported included always being very serious and asking the same questions repeatedly.

Continuity of Care. Continuity of care i.e. meeting regularly with the same therapist was reported as an important prerequisite for developing a solid therapeutic alliance.

'I enjoyed the regularity of my appointments. I always met the same person which I think is why it worked so well. I enjoyed every meeting. Therapist always upbeat and I always looked forward to my appointments.'

Conversely, a number of participants reported that the lack of consistent engagement with the same therapist was *'stressful and scary.'*

"Switching therapists didn't help"

'I was changing therapists too much. I had too many to even remember, maybe more than 10.'

Theme 3: Discovery

This theme explores some of the participants' personal and systemic outcomes through using CAMHS.

Personal. Participants reported a number of positive personal outcomes as a result of attending CAMHS, including a better understanding of how they feel, integrating different perspectives into their personal narrative and understanding when they may be thinking negatively.

'For an hour every week, I get to escape from a stressful environment…I can be given support by people who understand my problems and the effect that they have on me and my everyday life'

Other personal outcomes included learning new techniques, learning how to cope with panic attacks and learning more about themselves.

'I really enjoyed the ability to be able to share my thoughts in a confidential and safe space.

Some participants noted that *'lots of things didn't work.'* Participants were interested in learning more about how to deal with stigma outside of a CAMHS setting e.g. one participant discussed friends knowing about CAMHS involvement and not feeling comfortable enough to talk to them about it.

Systemic. Some participants noted that engaging with CAMHS produced positive effects within the family system.

'Coming to CAMHS made parents aware of what was going on'

However, the majority of participants reported that developing and improving family relationships was not a main goal of treatment.

"My parents need to understand that it's ok to not feel ok"

'I would have liked if I had gotten a session with my family so they could have understood what was going on…'

Participants reported that lack of understanding by family members can inhibit treatment progress and hinder a young person's pathway to well-being. One participant noted the burden it can place on the system, highlighting the importance of a holistic approach to care provision.

'More groups, I liked the idea of a parents' group. It could be beneficial.'

Theme 4: Future Directions

This theme explores participants' ideas on the evolvement of CAMHS and mental health services in Ireland.

Togetherness through Technology. The use of mobile technology was discussed as a possible adjunct to CAMHS treatment. Participants noted that while technology can be used as a positive tool to promote the discussion of mental health, there can be a considerable amount of misinformation and mislabelling when using the Internet or online forums to explore mental health difficulties.

'…can shine a light on mental health issues but can go too far too'

Some participants reported engaging in online tests for depression and/or anxiety and reported that this was not a positive experience as they were given inaccurate information.

'[Online] can be toxic…'

Discussion about the use of mobile technology with participants highlighted their desire to hear from those who are experts by experience – shared experience was found to be integral to enhance connectedness amongst individuals, which could potentially be facilitated by an online forum. Participants were open to engaging with app and website suggestions put forward by CAMHS professionals.

Service User Empowerment. The use of ROMs measuring satisfaction with the service was deemed to be an important element to maintaining consistent service user involvement in service provision. Participants in the focus group reported that the establishment of a Youth Advisory Panel (YAP) may be a productive way of beginning to incorporate young peoples' voice into the long-term improvement of service provision.

'It's a more youthful, modern approach.'

Similar to reports on the therapeutic alliance, participants agreed a non-clinical approach would be an important facilitator to encouraging young people to get involved in an advisory role. Table 1 provides a list of action points developed by participants at the end of the focus group in order to structure their main suggestions covered in the group.

Table 1: Action Points from Focus Group

Theme	Action Points
The Help-Seeking Journey	• More local accessible community based talks e.g. in schools, on well-being and resilience for young people • More information about CAMHS and assessment procedure prior to intake - Websites/information packs on CAMHS • Separate meetings for parents and child at intake
The Therapeutic Alliance	Core skills of a therapist appreciated included: • Getting involved in the service user's interests • Rephrasing issues in a different light • Empathy and putting the person at ease
Discovery	• More information for parents on how to respond to difficulties at home • Parent psycho-education group • How to deal with stigma outside of CAMHS
Future Directions	• Create online supports which focus on shared experience to increase connectedness • Create CAMHS forums which allow service users to share their experiences online in an anonymised way • CAMHS recommendations of useful websites and apps. • Satisfaction surveys as a permanent Routine Outcome Measure in waiting room • Development of CAMHS Youth Advisory Panel • More opportunity for participatory groups with a relaxed, genuine approach to service user involvement. Emphasis on 'non-clinical' approach

DISCUSSION AND IMPLICATIONS FOR PRACTICE

Quantitative results from the pilot study suggest that this service had particular strengths in HCPs therapeutic skills and behaviour e.g. high satisfaction levels with HCPs ability to listen and understand the young persons' problems and helping them deal effectively with these difficulties were reported. Lower satisfaction rates were reported by young people in relation to the provision of a parents group and the majority of the sample who did not receive this service reported the experience may have been helpful. This is consistent with Coyne et al.'s study[8] on CAMHS satisfaction in Ireland which reported that parental psycho-education groups were requested by parents or caregivers of young people attending CAMHS. This pilot study adds to this finding by highlighting young people's desire for this to be part of the treatment plan too.

Ambivalence towards prescription of medication was also a notable finding, with half the sample who were prescribed medication reporting they were happy with this, and half reporting they had mixed feelings or were very unhappy with a medical intervention. The majority who were not prescribed medication reported they were happy about this. This finding raises questions regarding a medicalised approach to mental health problems and person-centred decisions around this choice. Young people and parents/carers need to be well-informed by the HCP on the potential effects of medication usage as a long term coping strategy as there is a considerable body of research highlighting poorer long-term outcomes.[19]

Qualitative findings from this pilot study suggest a number of facilitators and barriers to engaging with and benefitting from CAMHS treatment. Facilitators included positive therapeutic relationships, learning new coping strategies, developing a better understanding of negative feelings and young people integrating different perspectives into their personal narrative. In this sample, waiting time for a service was not reported to be a barrier to accessing services, in contrast with Coyne et al.[8] Barriers discussed included a lack of information about CAMHS services and procedures, fear of stigma, and a lack of a systemic approach to CAMHS treatment. Similar barriers have been reported in other research conducted in Ireland and England.[20] The heterogeneity of service users' CAMHS experience, and reports of empowerment or disempowerment as a result of attending CAMHS, was evident from both qualitative and quantitative accounts, which is reflective of significant variation in the distribution and resourcing of CAMHS across different regions[21] and the number of HCPs available at any given time in a service may vary depending on availability, leave, funding etc.

As this was a pilot study with limited recruitment time, it may be beneficial to include parental experiences of using CAMHS to investigate differing priorities of the family system. Small uptake for the focus group was a particular difficulty in this pilot study and highlighted the difficulty in recruiting service users to openly discuss engagement with mental health services in a group setting. An opportunity for a longer recruitment period may help to address this issue. Qualitative research often has small numbers due to the amount of data collected from each individual and it is possible to construct themes with a sample of six participants.[22] The current study had a sample of three participants for the focus group and 17 written qualitative satisfaction reports, which whilst small, employed the research method of triangulation which resulted in a large amount of data from which the themes were constructed. While facilitators were members of the CAMHS team, focus group attendees were accessing treatment from a different team, and surveys were completed anonymously and placed in the waiting room.

Implications for Practice

The main implications which emerged from the data included dealing with stigma and shame as a therapeutic theme and treatment goal, separate consultations for parents and young person to encourage accurate and detailed information sharing, parent psycho-education groups for managing difficulties at home, the permanent use of ROMs and development of YAP to begin to develop solid roots in service user participation in service provision. Lack of resourcing in CAMHS is likely to hinder this preference for separate treatment sessions for families which directly contradicts the Strategy for the Rights of the Child[23] (Council of Europe, 2012-2015).

Further practical action points which emerged from the focus group discussion which may inform clinical practice included a community based approach to mental health e.g. more local, accessible talks in schools on well-being and resilience for young people. The provision of information packs about CAMHS and the assessment and intervention procedure prior to intake was reported as potentially being useful and may reduce anxiety around attending a mental health service. This may take the form of online or hard copy access to information packs on CAMHS professionals, assessment, and treatment goals. Recent videos launched by the HSE and Spunout provide information on CAMHS and the professionals service users are likely to meet; This may be a useful signposting resource for clinicians before clients attend the initial appointment in the service. As an adjunct to CAMHS treatment, the creation of HSE approved online supports which focus on shared experience to increase connectedness may be useful.

Implications for Future Use of Service User Research in CAMHS

A multi-site CAMHS study to assess variability in experience may be useful to cater for potential heterogeneity in resource distribution. It may prove useful to include therapeutic outcome measures (suggested on QNIC Royal College of Psychiatrist Website)[17] to monitor therapeutic outcomes as well as satisfaction levels. Future studies may look to include larger samples of adolescents and parents, and combine semi-structured interviews with participatory research methods such as focus groups and monitor satisfaction and outcome levels over time, using a longitudinal study design and a triangulated approach to data collection.

Further investigation into psychiatric versus non-psychiatric approaches to care in CAMHS would be useful to determine differences in therapeutic outcomes and satisfaction levels with these two varying approaches to treatment. A comparison study with primary care services may also prove useful to gain an overall depiction of current mental health services in Ireland. Regular evaluative and audit research in CAMHS looking at the practical implementation of the Irish iCAMHS National Quality Guidelines which emphasise appropriate care for children in vulnerable situations[21] is integral to establishing service user research as a core tenet of successful service provision.

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AUTHORS

Emma Hickey, Psychologist in Clinical Training, UL/HSE.
0227544@studentmail.ul.ie.

Dr Ruth Melia, Senior Clinical Psychologist, East Clare.

Dr Aran Tomac, Consultant Child and Adolescent Psychiatrist, East Clare.

Dr Barry Coughlan, Assistant Director of the Doctoral Programme in Clinical Psychology, University of Limerick.

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