# THE WINTER EDITION

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# FOREWORD

Welcome and happy holidays!! We are excited to introduce this third edition of Clinical Psychology Today.

Part of the vision and intention of this journal is to provide a space in which Clinical Psychologists can connect, exchange and discuss relevant issues which arise when undertaking this work. Of equal importance is the forum the journal can provide for debate, for sharing and challenging each other with the intention of better serving our respective client groups.

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 diversity seen here reflects the multi-faceted role that Clinical Psychologists play today at the level of the individual, the family, the community and broader society. The articles speak to the unique ways in which Clinical Psychology contributes to basic science and interdisciplinary collaborations, and to the ways in which our work can inform and lead at a policy and a political level. We are particularly pleased, for example, to include an insightful piece on social justice and inequality. A piece on the experience of Assistant Psychologists points to the central role of reflective practice, and to the supports and structures needed to nurture and maintain this capacity at all stages of a Clinical Psychologist's career.  The articles provide valuable insights into the challenges and value inherent in different aspects of the work. It is hoped these articles will be of use in everyday practice and will add to an evolving reservoir of knowledge, of value to Clinical Psychologists throughout Ireland.

Many of you will be members of the PSI Division of Clinical Psychology, the BPS or the new ACP-UK. Among the many issues that concern Clinical Psychologists regarding training, registration, and therapeutic modalities, you might share a sense that we could provide a stronger advocacy voice for the people with whom we work. We would welcome pieces co-authored with clients, for example.

This edition would not be possible without the authors who submitted their work for review, and the considerable work of the reviewers who volunteer their time to support their peers, and develop their own critical faculties. We wish to acknowledge the work of the CPT steering group, and Pádraig Collins in particular, who has been at the forefront of this endeavour from the beginning. Special thanks must also go to Siobhán O'Neill for her creative and impressive work on the journal design.

Lastly, please don't leave without taking a few minutes to read the whole way through to the notices, and the many different ways in which you can become involved with CPT. We are especially interested in people putting themselves forward for the reviewer panel, an opportunity to develop reviewing, critical analysis and feedback skills.

Wishing you all a warm and connected season!

With thanks,
*Edition Co-Editors:* Olive Moloney, Ruth Melia

# THE LIVED EXPERIENCE OF ASSISTANT PSYCHOLOGISTS IN CLINICAL SETTINGS

## EMMA RYAN AND GERALYNN WALSH



## ABSTRACT

The Psychological Society of Ireland references the development of reflective practice as a pivotal skill in clinical psychology[1]. The authors found themselves in a novel position, as two Assistant Psychologists (APs) whose roles have moved from voluntary to a newly developed paid grade within a clinical setting in the Health Service Executive. With approximately 18 months voluntary and paid AP experience each, the authors completed this reflective article. We aim to give a personal perspective of our lived experience working as APs by reflecting on the following roles and responsibilities; 1) Training and Research, 2) Client Work and 3) Supervision. Within this, we identified similarities within our experiences such as supervision structure, and differences, including client contact experience gained across various clinical settings. We consider how these may have impacted our clinical learning and our sense of self as early career psychologists. We do this while also reflecting on the impact of the AP role in enhancing service provision.

## INTRODUCTION

Reflective practice is a necessary part of clinical psychology highlighted by the Psychological Society of Ireland (PSI) who request training courses to follow a reflective scientist/practitioner model[1]. While the scientist-practitioner model roots clinical psychology in an evidence base, the reflective model allows focus on the process of practice[2]. Reflective practice in clinical psychology is described as; reflection in action (e.g. when interacting with a client), reflection on action (e.g. when engaging in clinical supervision), reflection about your impact on others and reflection on the relationship between the work and the self[3]. Both authors are early career

psychologists and noted an opportunity to develop these reflective practice skills highlighted by the PSI. We are currently working within the same Child and Family Psychology Service in the newly developed paid Assistant Psychologist (AP) grade in the Health Service Executive (HSE). We have previously worked under this title in a voluntary capacity across different departments. This move lent us the opportunity to engage in reflective practice on our experience in the AP role and across this transition.

To successfully attain our positions as paid APs in the HSE, candidates are required to have at least an undergraduate degree in psychology. APs then work under the supervision of a professionally qualified Clinical Psychologist. This experience is typical for gaining admission to the professional training programmes to become a qualified Clinical Psychologist. 71% of successful applicants to these professional training courses in Ireland measured over a 10 year period have previously worked in either a paid or voluntary AP role in various public and private services[4]. It is the role of the AP within the HSE to provide support to enhance the service provision and research capacity of the qualified Clinical Psychologists. Following induction and training, we undertake prescribed tasks of assessment and intervention relevant to our competence under supervision of Clinical Psychologists who hold clinical and professional responsibility.

This article is presented following numerous discussions between the authors on their approximate 18 months experience each in both voluntary and paid capacity. These discussions were shaped by Gibb's reflective cycle[5]. While working as voluntary APs, authors gained experience across services including the Child and Adolescent Mental Health Service, the Community Adult Mental Health Service, the Inpatient Psychiatric Unit, Early Intervention Team and Liaison Psychiatry. We reflected on similarities and differences within the experiences we gained across different clinical settings. While working in a voluntary capacity, the focus was often on gaining experience and developing skills for entry to the clinical training programme. This contrasts to the paid AP grade that was developed to meet a specific need within Child and Family Psychology Departments. The focus of the AP role is now on the service needs and how our skillset and competence level can enhance service provision. We feel this shift has increased our sense of self as early career psychologists and in this article, consider what elements of our role have led to this.

Previous research has typically been conducted in the United Kingdom and less so in Ireland, where it has focused on quantitative profiling of APs as opposed to their lived experience. In this article, we aim to give a personal perspective of our lived experience working as an AP and how we feel this role enhances service provision. We do this by reflecting on our representation of our experience and

discussing how it has been influenced by our perception of the following roles and responsibilities[6]; 1) Training and Research, 2) Client Work and 3) Supervision.

## TRAINING AND RESEARCH

Induction and continued professional development was outlined as a strategy in improving the service user experience within the National Strategy for Service User Involvement in the Irish Health Service (2008-2013)[7]. When starting work as volunteer Assistant Psychologists, no formal induction training was completed. Both authors had completed undergraduate and postgraduate academic degrees but had no clinical experience in the HSE. Instead, induction happened over time by observing the work of the Clinical Psychologist, and through questions and support in supervision. This differs to our experience in the current paid roles where observation and support in supervision is still provided but in conjunction with induction packs and further scheduled induction training days. On reflection, we identified that the formal induction training facilitated a greater understanding of our role within the service structure. We feel that having this named and facilitated at the initial stage of employment impacted positively on our professional sense of self by clearly outlining the roles and responsibilities expected of us in the post, for example,

clinical assessment skills, how to use supervision effectively and professional ethics of an AP. We wonder if this has impacted the client's experience of the service as we feel capable in communicating, engaging and supporting clients at our level of competence.

In addition to the initial induction training, further training has been facilitated for APs in clinical intervention programmes including computerised Cognitive Behaviour Therapy (CBT) (e.g. Pesky gNATs) and parenting programs (e.g. 'Triple P' Positive Parenting Program). There is also scope for APs to attend conferences and talks relevant to their working day. We feel these opportunities fit the defined role of the AP, using our level of skills under supervision to engage in prescribed intervention with clients to enhance service provision. This differs from our experiences as volunteers. As voluntary APs, we found at times that funding for relevant training to suit the capabilities of the AP and the service needs were difficult to match. Despite this, we took part in excellent trainings while volunteering including Mindfulness Based Cognitive Therapy (MBCT) and Compassion Focused Therapy (CFT) and adapted skills from these trainings to our clinical practice. For example, after completing MBCT, one of the authors utilised these skills and implemented mindfulness within one-to-one and group work. However, the author trained in CFT holds that although she utilised aspects of the training, it was pitched to a level not appropriate to her role. Attending these

trainings was facilitated as it came up compared to the paid AP role, where it is currently occurring in a planned manner. We feel the intervention training we have received in our paid AP roles have impacted on our daily practice, thus directly enhancing service provision.

In terms of research, as volunteer APs we both had positive experiences with opportunity to develop our skills in this area and enhance the service provided. These opportunities included conducting literature reviews and service evaluation to support the work of the qualified Clinical Psychologist. Our understanding of these tasks was supported in supervision with teaching around evidence-based clinical formulation. We note that the same applies in our current posts and consistently observe how AP skills and time allocation to research allows the enhancement of service provision. However, we recognised that as volunteer APs the research element consumed a denser part of our workload. We wondered why this element was emphasised more than other responsibilities while working in a voluntary capacity and perhaps the following was relevant; 1) Working across services under a number of supervisors who may each assign a research task 2) APs previous experience 3) The supervisor's understanding of the AP role, and 4) APs clinical competence relevant to the clients presenting needs. We compared this to our current paid AP role, where time is allocated as per the job

description across defined roles and responsibilities, for example, 11.4 hours of research and 13.2 hours of service user contact per week. This allocation of time across responsibilities has afforded the opportunity to work with clients in direct and non-direct work through referral to discharge. In this process, we have learned experientially the necessity of working from a reflective scientist-practitioner model. The literature searches we have conducted in our paid roles are relevant to the clients we are currently working with. Conversely, in our voluntary AP roles, literature searches were often conducted for our supervisors, without any direct client contact. Through lived experience of both processes, we recognise the benefits of being engaged with the client in learning the requisite of evidence-based practice[8]. We feel this learning is pivotal to bring forward throughout our careers in clinical psychology.

## CLIENT WORK

As paid APs, it is expected that we observe and engage in direct and indirect client work under the supervision of the qualified Clinical Psychologists. These tasks include observing and co-facilitating intake assessments, interventions and groups, liaising with clients and other services and drafting referrals and reports. For us, in our voluntary and paid AP roles, CBT was the most frequently used

therapeutic approach, followed by mindfulness and a behavioural approach when working with clients. This experience corresponds with Hughes[9] who identified CBT and mindfulness as the most frequently used therapeutic approaches in a study completed in Ireland and UK with 136 APs.

In our experience as volunteer APs, the level of direct client work often depended on the opportunities available within the service. For example, volunteering in a hospital based environment offered opportunities in delivering psycho-educational talks to both staff and patients and facilitating group sessions within a psychiatric unit. This contrasts with volunteering with an early intervention team, where there were more opportunities in the assessment process. We found that client work was often reactive rather than planned in these volunteer roles, for example, completing a discrete piece of psycho-educational work with a client who was otherwise engaged in therapy with the qualified Clinical Psychologist. This experience was invaluable when it came up but availability of appropriate direct client work could be sparse. At those times, we developed our clinical skills through observation and indirect client work. In our current positions, our client contact experience runs from referral through to discharge. We feel this has enhanced our understanding of the therapeutic relationship, our sense of the utility of our role and the client's accessibility to the service.

When reflecting on our experience of client work, we both feel a level of 'Imposter Syndrome'. This term is used to describe feelings of fraudulence and a lack of confidence in ability. Gravois[10] estimates that 70% of people will experience at least one episode of in their lives. We commented on experiencing higher levels of this phenomenon while in our voluntary roles and considered if the uncertainty of the role, our responsibilities, and lack of consistency in client work impacted on this. In our current paid role, we notice a decreased feeling of imposter syndrome. Perhaps experience over time has impacted; however, we feel that it is the stepped, consistent approach with a clearly defined job description that has made most difference to our experience.

## SUPERVISION

The Psychological Society of Ireland states that supervision has three main functions; to be 1) supportive, 2) developmental and 3) provide quality assurance[1]. As paid Assistant Psychologists, we receive at least one hour of formal supervision with a qualified Clinical Psychologist weekly that includes management of work load as well as personal and professional development.

Both authors have had positive supervision experiences in their volunteer and paid AP roles, where formal weekly supervision has occurred. This has been

and currently is prioritised and allocated a consistent time slot. It was noted that we have both been encouraged to take the lead on aspects of each session, for example, agenda setting and case discussion, but also provided with structured material and direction when appropriate. Formal supervision provides space for reflective practice, for example, the recognition of the importance of acknowledging and managing what we bring to a therapeutic relationship. We have learned experientially to normalise and discuss the issues that have made us feel uncomfortable, identify our own biases, think about how they could impact how we engage with clients, and what strategies we would use when it arises. Furthermore, we work under direct observation of our supervisors, which allows for the active process of supervision within sessions. We hold that this style of supervision lends to our learning by receiving constructive feedback on directly observed skills and competencies. As early career psychologists, we are grateful for this experience. We endeavour to continue engaging in reflection in supervision, with the aim of continuously challenging our understanding of the process of practice.

Certain differences were identified in the supervisory experience during our time spent as voluntary APs. For example, one author had been introduced to the supervision contract, the other had not. Although the structure of supervision had been similar, we noted the positive element the supervision contract

provides, allowing clear understanding of expectations of the supervisor and supervisee. Both authors did not experience AP peer supervision in their voluntary roles. This differs to our current paid role in that AP peer supervision meetings take place every 8 weeks. This experience has impacted our work by encouraging reciprocal learning through the sharing of experiences, increased our skills in providing feedback and has developed a peer support network within the AP group in our area[11].

## CONCLUSION

In this article, we noted the PSI identifies reflective practice as a pivotal skill in clinical psychology. As our roles moved from a voluntary to paid grade within the HSE, we took an opportunity to engage in reflective practice on our learnings to date from approximately 18 months experience each as Assistant Psychologists. In writing this piece, we give a personal perspective of the lived experience working as APs and how it has been influenced by our perception of the following roles and responsibilities; 1) Training and Research, 2) Client Work and 3) Supervision. Through engaging in reflective practice, we feel our experience as APs to date has offered us invaluable learning in terms of; clinical learning, our sense of self as early career psychologists, experience of how a psychological service runs in the HSE, and our understanding of

how the AP role can enhance service provision.

This article captures our lived experience and learnings as APs. We feel it important to acknowledge there may be differences in other APs' experiences in this role and future research could explore this. We acknowledge that our reflective practice is an accumulation of our clinical experience, and as early career psychologists we recognise the limitation of this. Perhaps future research would consider the perspective of qualified Clinical Psychologists on the role of the AP, both in terms of career development and service provision.

We feel our experience in the newly established AP grade within the HSE has increased our sense of self as early career psychologists, and in turn enhanced the client's experience of service provision. We anticipate that others would consider the structure of this grade and the wider implications of applying it appropriately across other HSE clinical psychology settings.

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# ETHICAL PRACTICE? THE ROLE OF PSYCHOLOGY IN THE SOCIO-POLITICAL CONTEXT

SINÉAD NÍ CHAOLÁIN



## ABSTRACT

This paper examines how a logical positivist paradigm has been central to the scientist-practitioner role in Clinical Psychology and its understanding and treatment of human distress. It outlines the potential limitations of such a paradigm and explores how professional ethics can be crucial in expanding an awareness of the importance of broader socio-political and cultural factors in human distress. At the same time, it notes how specific codes of ethics themselves can be rooted in western, individualistic values. It further explores how a narrow ethno-centric perspective has negatively influenced Psychology's historical understanding of gender identity and sexuality, and its relationship to social issues such as poverty. It concludes by acknowledging the different perspectives in this area and calling for a more politically aware and engaged stance in Clinical Psychology, highlighting a need to explore this more clearly in Irish psychological research.

## THE ORIGIN AND CRITIQUES OF THE LOGICAL POSITIVIST PARADIGM IN PSYCHOLOGY

The application of the scientific method to efforts to understand human behaviour and cognition[1] in the late 19th century gave rise to the development of logical positivist scientist-practitioner models of training and practice. These have been criticised as over-concerned with scientific objectivity, removed from socio-political awareness and contribution, and as emphasising "individualistic, internal states and objective, value-free empirical research methods seeking universalist truths"[2] (p. 258).

In his address as president of the American Psychological Association (APA), Zimbardo[3] spoke to this, highlighting that the field of psychology had overvalued the pursuit of scientific study of individual behaviour. In noting George Miller's (1969) APA presidential call to action for the profession to "give psychology away to the public" (p. 340), he identified four primary reasons he believed this had not occurred. He described an 'excessive modesty' held by the profession regarding what it could contribute to society, an ignorance as to who this public represented and how the study and practice of psychology could be 'given away'. Finally, he described a lack of concern regarding the level of accountability to which the discipline should be publicly held. He asserted that "it is imperative that we convey the sense to the citizens of our states and nation that we are responsive to society's needs, and, further, that we feel responsible for finding solutions to some of its problems"[3] (p.341).

Rappaport[4] highlights desperation on the part of psychology as a discipline to force itself into scientific models. He attributes this to a desire to be perceived as scientist practitioners, benefitting from the social advantages of this status, including financial gain, power, and perceived credibility or legitimacy. He indicates that these have little to do with knowledge and valuable contribution, and may, in fact be inappropriate and interfering. He advocates the use of social critique and a qualitative, interpretative approach as legitimate and, perhaps, more appropriate

in developing an understanding and contributing towards the alleviation of concerning social issues. Parker[5] highlights that, although improvement may be acknowledged, there has been "recognition by many psychologists over the years that there is something deeply wrong with the way that the discipline conceptualises its objects of study and the way it treats people" (p. 720). He argues that the application of objective psychological 'knowledge' to problems and social issues adds to these difficulties, and that, in this manner, psychology functions as a political entity governed and driven by its own value and disciplinary community, as opposed to challenging political discourse on such issues[5].

## THE ROLE OF ETHICS IN HIGHLIGHTING AND OBSCURING SOCIO-POLITICAL INFLUENCES ON DISTRESS

*The emergence of codes of ethics*

Akhurst & Elwell[6] highlight the importance of developing an understanding of the depth of historical, contextual and conceptual underpinnings of current ethical practice. They indicate that current ethical codes and regulatory structures were established in light of ethical breaches, challenges, and in response to events and changing normative values at a macro or societal level[6]. The APA, the largest representative organisation of psychologists internationally[7], did not

publish their first code of ethics until 1953[8]. The British Psychological Society (BPS), founded in 1901, established a division concerned with professional conduct in 1948 and began to compile a first draft of an ethical code of professional conduct in 1954, by which time membership of the society had reached 2208[9]. A 'Standing Ethical Committee' was established in 1957 to revise this code. The Psychological Society of Ireland (PSI) endorsed its first code of ethics at a General Meeting in 1978, with a revised and expanded edition not being published until 1991. This was not revised again until November 2010[10], a 19-20 year period of significant change within the Irish sociocultural context.

*Absolutist codes of ethics and their limitations*

Leach and Harbin cite Berry, Poortinga, Segall and Dasen[7] as delineating three overarching perspectives in ethical guiding frameworks; relativism, absolutism and universalism. The APA Ethical Principles and Code of Conduct are generally grounded in an absolutist framework, that is, standards and values are applied across the discipline and societally irrespective of cultural context[7]. Pettifor[11] highlights that this creates challenges cross-culturally, in terms, for example, of societies and cultures that value collectivism over individualism, or secular, as opposed to theocratic, values. He highlights various developments within psychological organisations to address multicultural challenges, such as the inclusion of the Guidelines on Multicultural Education, Training, Research, Practice, and Organisational Change for Psychologists by the APA in 2002. However, he argues that international guidelines remain dominated by western values. He argued this may therefore ill-equip practitioners working within systems that are not represented by such value systems. He argued it has yet to be demonstrated that these guiding codes do not, albeit perhaps unintentionally, enshrine ignorance and trivialisation of racism and cultural difference[11].

In documenting the contribution of Kobi K. K. Kambon to African-centred psychology, DeReef Jamison indicates that Kambon rejected the universality of Euro-American cultural values and psychology[12]. Kambon argued that definitional systems, representing worldviews (or the "peculiar philosophical orientation to the world"[13]), are central to understanding the psychology of a cultural group. He referred to the application of a Euro-American worldview to the understanding of African culture as psychological oppression, as imposing a system that values individualism and materialism over collectivism and spiritualism. He further stated that this represents a system of social pathology that uses assessments of personality which represent "only measures of the degree to which other racial-cultural groups conform to norms that are defined and thus preferenced by European (Euro-American) culture"[12]. He

argued that a repositioning of an African definitional and worldview system as central to African psychology is essential to correctively counter this oppressive framework. He highlighted a need for African psychologists to question and challenge cultural and philosophical underpinnings of their training[12]. Jamison and Keita Carroll, highlight the potentially highly influential role of psychology in the production of African-centred knowledge and frameworks for authentic and culturally-relevant understanding and interpretation of human experience and as key to cultural reclamation[13].

## ETHNOCENTRIC VALUES AND THEIR IMPACT ON PSYCHOLOGY

The oppressive influence of ethno-centric, predominately white, heterosexual middle-class male ethical and moral codified values has traditionally contributed to the pathologisation and oppression of non-heteronormative gender identity and sexual orientation. This is further reflected in individualistic normative understanding and approaches to treatment that do not take full consideration of the impact of systemic social disadvantage. The following section will explore the role of ethics in clinical psychology in relation to gender, sexuality and poverty.

*Gender, sexuality and Psychology*

The British Psychological Society acknowledged in 2012 that psychiatry, psychology and psychotherapy had played a fundamental role in "contributing to a long history of pathologising sexual and gender identities"[14]. Homosexuality was classified as a diagnosable and treatable mental disorder within the Diagnostic and Statistical Manual (DSM) until 1974, when it was de-classified by the American Psychiatric Association. This was followed by the APA in 1975, and the WHO in 1990[15]. Same-sex sexual activity was only decriminalised in Ireland in 1993. This was following judgement by the European Court of Human Rights in Norris vs. Ireland (1988), which was later ratified by the Criminal Law (Sexual Offences) Act 1993. Following a referendum in May 2015, Ireland became the first state to approve same sex marriage by popular vote. The PSI, who have not, historically, frequently issued statements in relation to contemporary political issues, on this occasion contributed to social and political debate. They publicly expressed concern regarding the improper use and misrepresentation of psychological research within the debate; "Historically, psychological research has been used to justify the unjust treatment of minorities, and the PSI is committed to ensuring that psychological research is not used, inadvertently or otherwise, to repeat such injustices. The Psychological Society of Ireland is calling for those engaged in the ongoing public debate to do so with respect for the psychological and emotional impact on young people and families at the heart of the issue"[16].

Tosh[17] highlighted the continued reinforcement of binary views of gender, a pathological framework of understanding non-conforming gender identity and the encouragement of social exclusion of those who seek to challenge these "hegemonic and normative constructions of gender"[17]. Tosh[17] highlights the significant criticism that treatment approaches that centre on prevention of homosexuality and transexuality have received, such as by Burke (1996), Lev (2005), Bryant (2008), Burleton (2008), Choe (2008), Queerty (2009) and Hegarty (2009)[18]. Aversion (conversion) therapy was deemed by the APA in 2009 as representing both inappropriate and unethical practice. The PSI Sexual Diversity and Gender Issues Special Interest Group in 2015, chaired by Dr Geraldine Moane, published 'Guidelines for Good Practice with Lesbian, Gay and Bisexual Clients'[19]. This stated that aversion therapy represents "an approach based primarily on a religious ideology that all people should be heterosexual" and that extensive empirical research has demonstrated that it is "damaging to the mental health of LGB people who undergo it"[19]. They instead advocate the use of gay affirmative therapy, which draws upon an understanding of heterosexism, the institutional privilege of heterosexuality, and, through the development of a greater awareness of internalized homophobia, place integration with self as central[20]. Pyne highlights a shift in understanding of childhood gender non-conformity from pathological to being considered part of human diversity[21]. He maintains that this

has manifested in a shift in the use of language by professionals, families and the general public, and a shift in focus of intervention from the individual child and the treatment of their sexuality or identity to examination of the social environment within which the child is embedded and developing. He highlights the implications of this paradigm shift for sexual health education, research, clinicians and availability of social support resources[21].

*Psychology and poverty*

An individualistic and objective psychology, in research and practice, and the resulting lack of recognition of underpinning psychosocial and socio-political factors may also be traced in relation to poverty. The impact of this has traditionally been framed and addressed at an individual level. Pérez-Munoz and Martínez Arias describe poverty as a social issue, perpetuated, justified and even promoted by individual and normative attitudes and social structures, and as representative of a denial of basic human rights[22]. They advocate the need for the development of an expanded and systemic definition of poverty, and the acceptance of a shared social responsibility to address it, in terms of its impact but also in its prevention. Ross, O'Gorman, MacLeod, Bauer, MacKay and Robinson highlight that poverty has been associated with onset of mental health difficulties and is disproportionately experienced by marginalised groups, such as among sexual minorities, the elderly and among ethnic minorities, such as the

Aboriginal community[23]. In highlighting the impact of poverty, in relation to inequities in access to health care, increased experience of physical and mental ill-health and psychosocial difficulties, Ramirez-Garcia, Balcazar and de Freitas describe inequality as one of the most complex and increasingly pervasive challenges to be faced in the 21st century[24]. Worton et al highlight a lack of acknowledgement in research and intervention afforded to the impact of economic disadvantage, family influence and community contexts on child development[25]. They highlight Prilleltensky's assertion that wellness be equated with fairness, and advocate the use of community-based, primary prevention and mental health promotion to support the development of children and families in economically disadvantaged communities[25]. They further highlight the UNESCO 'Better Beginnings' model as exemplary[25]. Garbarino and Briggs stress that the UN Convention on the Rights of the Child represents a legally binding mandate, one of the fundamental principles of which is that quality of life outcomes for children not be determined by parental income or functioning[26]. However, they highlight that poverty is associated with poorer IQ, health, education and overall quality of life due to the detrimental impact on psychological development and access to educational opportunities[26]. This negatively impacts on the child's access to 'pathways to success' and ability to attain better quality of life outcomes in adulthood. Additionally,

experience of early psychological distress has been associated with poorer socioeconomic outcomes, such as lower family income, educational attainment and earnings in adulthood[27, 28]. McAra and McVie, in examining the impact of gender, poverty and vulnerability in youth violence, advocate that in order to address violence, poverty and the disempowerment experienced by those living in deprivation and disadvantage needs to be addressed at individual, community and policy levels[29].

## ALTERNATIVE PERSPECTIVES

It should be noted that not all schools of psychology have been neglectful of these issues. The critical and community school of psychology has long highlighted the importance of broader social influence on the understanding and engagement with mental distress, such as David Smail[30], whose work is described as having 'exposed the damaging psychological effects of an increasingly competitive and unequal society'[31]. Paul Moloney stated in his 2013 book 'The Therapy Industry' that 'the therapeutic outlook allows the more prosperous sections of society to put the yoke of responsibility for social problems (like impoverishment) straight upon the necks of the poor'[32]. In her review of 'The Therapy Industry', Dr Joanna Moncrief highlighted that, within this perspective, traditional individualistic talk therapy, may represent a diversion from the underlying social causes of discontent[33]. Of further note are organised movements within the

UK, such as 'Psychologists for Social Change', who indicate an interest in applying psychology to policy and political action, and 'Psychologists against Austerity'[34], which may serve as templates for such mobilisations within psychology in Ireland.

It should also be noted that certain authors contest that attending to social influences, such as poverty, is of greater value than providing more psychological treatment. Flèche and Layard, for example, argue in their analysis of international data on 'life satisfaction' and socioeconomic variables that misery is caused more by the presence of 'mental illness' than poverty[35]. It is, however, beyond the scope of this paper to explore these alternative perspectives in more detail.

## THE IMPORTANCE OF AN ENGAGED SOCIALLY AND POLITICALLY AWARE PROFESSION

Haeny highlights that, although the APA codes of ethics do not seek to place restriction on the private lives and values of psychologists, the public expression of opinion or positions within social and political spheres, particularly in relation to controversial or potentially divisive issues, may impact the individual's professional relationships, and, potentially, the profession or discipline[36]. However, this effective neutralisation of the role and potential contribution of psychology to public discourse and social change has been challenged. This is particularly pertinent in relation to countering traditional structures or frameworks of power, in the promotion of social justice and empowerment of marginalised groups, and most particularly within critical community psychology. [2, 4, 24, 25, 30, 37]

Prilleltensky (as cited by Fisher, Sonn & Evans) referred to 'psychopolitical validity', which advocated drawing into balance psychological and political factors, in both research and practice. This requires drawing focus to the negative impact of inequality within the multiple levels of power in societal structures, and the political forces of oppression, exploitation and discrimination they exert on vulnerable and marginalised groups within society[2]. Fisher, Sonn and Evans argue that to maintain an objective and neutral position renders psychology as disconnected from the influence of power in society and the issues of concern that warranted research and intervention in the first place[2]. This has traditionally been conceptualised, and interventions designed, at the individual or micro level, but power may be mediated through historical, social, cultural, economic and political meaning systems and contexts[2]. Ramirez-Garcia, Balcazar and de Freitas advocate a more in-depth understanding of the role of power, determined by social and historical circumstances, structural, such as gender, ethnicity and socioeconomic status, and personal factors, such as education, in the

exacerbation and perpetuation of social and health inequality[24].

## CONCLUSION

This paper has examined the limitations of a narrow logical positivist perspective underpinned by individualistic western values in meeting the diverse needs of those in need of psychological support. It notes alternative perspectives on this issue, but highlights the vital importance of Psychology attending to broader social, political and cultural issues in its work.

The frame of reference and understanding underpinning this paper is best encapsulated by Fisher, Sonn and Evan's concluding remarks, whereby they advocate for the contribution of psychology to the alleviation of social issues, in research and practice, through engagement with socio-political inequality, such as in relation to ethnicity, sexual orientation, gender identity, and poverty, as summarily addressed in this essay, assuming a proactive rather than reactive position within social change;

"*While these may have been desirable states* [objectivity and apoliticism] *for some, the realities of the world in which we live—personally and professionally—do not match these ideas. The world is governed by power—access to resources, professional power, power differentials, power to name and prescribe, power to oppress (malignantly or benignly). If we try to ignore this power in the name of objectivity and professional scientist standing, we compromise our abilities to deal with the root causes of so many social issues. We become complicit in the maintenance of problematic social relationships and the reinforcement of imbalances that exacerbate negative processes and outcomes*" (p. 265)[2].

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# FOETAL ALCOHOL SPECTRUM DISORDERS: A HIDDEN DISABILITY

ALISON GARVEY



## ABSTRACT

Foetal alcohol spectrum disorder (FASD) is a lifelong, persistent condition caused by prenatal exposure to alcohol. Research suggests a deficit in health-care professional's knowledge surrounding the symptomatology and treatment of FASD, which can result in misdiagnosis or missed-diagnosis of the condition. Psychologists can play a key role in the identification and treatment of FASD. Thus, in order to create awareness of FASD among psychologists, this article will provide general information on FASD, including existing diagnostic challenges, an overview of primary and secondary disabilities associated with the condition, and will conclude by summarising recommended strategies for supporting clients impacted by FASD.

## INTRODUCTION

Alcohol is a potent physical and behavioural teratogenic agent that plays a complex role in Irish society[1,2]. There are a myriad of health implications associated with the consumption of alcohol, including devastating long-term effects on the normal developmental progression of the foetus[2]. Consequently, national guidelines for the USA, UK, New Zealand and Australia recommend complete abstinence from alcohol during the gestational period, and the HSE in Ireland is advising pregnant women that there is no amount of alcohol that is considered safe during pregnancy[3].

Alcohol has been identified as a direct cause of Foetal Alcohol Spectrum Disorders (FASD)[4], which is a term used to describe a continuum of life-long persistent conditions caused by prenatal exposure to alcohol and is internationally recognised as the leading preventable cause of birth defects[5]. In 2012, the National Substance Misuse Strategy Steering Group launched a report addressing the future direction of policies to deal with the use and misuse of alcohol in Ireland. The report contained a number of recommendations, including promoting greater awareness of FASD among

healthcare professionals in order to improve the diagnosis and management of alcohol related disorders[1]. While there has been a gradual progress in this regard, international research has revealed that there remains a significant lack of awareness and knowledge regarding FASD among health professionals[6, 7], including psychologists[8]. Psychologists can play a crucial role in recognising, diagnosing and treating individuals with FASD to ensure that those affected receive prompt and comprehensive treatment[8]. Thus, this article aims to create awareness of FASD among psychologists in Ireland by providing general information on common symptoms, diagnostic challenges and treatment strategies associated with the condition.

## FOETAL ALCOHOL SPECTRUM DISORDERS

Foetal alcohol spectrum disorders (FASD) is an umbrella term that encompasses the range of consequences following prenatal exposure to alcohol[2]. The two main conditions subsumed under the spectrum include Foetal Alcohol Syndrome (FAS) and Alcohol Related Birth Defects (ARBD)[9]. FAS is the most severe and identifiable form of FASD and is associated with a range of mental and physical defects including dysmorphic facial features, brain damage, congenital anomalies, stunted foetal growth, along with cognitive, behavioural, emotional and adaptive functioning impairments[2,4,10]. International diagnostic guidelines define the cardinal facial features associated with FAS, including short palpebral fissures (small eye openings), smooth philtrum (vertical groove between nose and upper lip) and a thin upper vermillion border[2] (upper lip). However, while FAS requires the presence of facial dysmorphology[11], there are also a wide range of cognitive (e.g. intelligence, attention), social (e.g. communication) and adaptive (e.g. problem solving and decision making)[5] deficits related to prenatal alcohol exposure[9]. Thus, the term Alcohol Related Birth Defects (ARBD) was later coined to describe the cognitive and behavioural deficits that manifest as a result of prenatal alcohol exposure in the absence of any physical characteristics[9,11]. In recent years, 'FASD' has been introduced as a non-diagnostic descriptive term to refer to the diagnosable conditions associated with prenatal alcohol exposure, including FAS and ARBD[12]. However, in the absence of physical features, FASD can often be overlooked or misdiagnosed[13, 14] and consequently has been professed as a 'hidden disability'[15].

## PREVALENCE/DIAGNOSIS

There is currently no national register to capture the number of people with FASD in Ireland[1], thus the exact prevalence is unknown[16]. However studies on self-reported alcohol consumption throughout pregnancy have revealed that alcohol use is prevalent and socially pervasive among pregnant women in Ireland[10,17]. For example, a study of women who attended

the Coombe Hospital in Dublin between 1987 and 2006 found that 79% of Irish women reported alcohol consumption during pregnancy[18], while the Screening for Pregnancy Endpoints research (SCOPE)[17] study reported a similar figure of 80%. Interestingly, The Growing Up in Ireland (GUI)[19] study reported a significantly lower rate of alcohol consumption during pregnancy, ranging between 20-40%. Unfortunately, recent research published in the Lancet [4] reflected the accuracy of the higher figures, as Ireland ranked among the top five European countries with the highest level of alcohol consumption during pregnancy, as well as consequent cases of FAS. However, it is estimated that FAS comprises only 10-15% of all FASD cases and has the most explicit diagnostic criteria[13], while up to 75% of people with FASD present with no characteristic dysmorphic features and may go undiagnosed[20].

It has been postulated that the worldwide prevalence of FASD may escalate in the coming years due to an increase in binge drinking, consumption of alcohol during pregnancy and a growing rate of unplanned pregnancies[17,21]. Despite this projection, there is currently no standardised assessment, diagnostic service or treatment pathway available for individuals with FASD in Ireland[14, 20]. Therefore health professionals in an Irish context are encouraged to utilise a range of international diagnostic systems to guide their assessment. A plethora of diagnostic guidelines for FASD have been

developed such as the 4-digit diagnostic code[22], the Canadian Guidelines[23] and the revised guidelines of the Institute of Medicine[24]. Most of these classification systems are multifaceted[25] as a multi-disciplinary approach is considered best practice to accurately assess and interpret the wide range of outcomes that define FASD[22, 24, 26]. However, because no universal list of symptoms has been established for FASD, these varying diagnostic systems may lead to contradictory outcomes[26]. To address this lack of diagnostic clarity, diagnostic criteria for cognitive and behavioural effects associated with prenatal alcohol exposure have recently been introduced to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE) is included under the appendix section entitled 'conditions for further study'[11]. The DSM-5 criterion for ND-PAE requires confirmation of prenatal alcohol exposure and impairment in three domains, including neurocognitive functioning, self-regulation and adaptive functioning [11, 25, 26]. Although there is considerable overlap in the criteria for FASD diagnostic instruments and ND-PAE, a review by Sanders and colleagues (2017) found that ND-PAE was less sensitive in identifying clients with FASD. Therefore, it is suggested that health professionals adopt a multi-disciplinary approach to accurately assess and interpret the wide range of outcomes that define FASD[22, 24, 26].

As part of a multidisciplinary assessment, it is recommended that health professionals incorporate questions about prenatal alcohol and substance use into their assessment procedure[26]. Social desirability bias and stigma can affect self-report measures of alcohol consumption during pregnancy[27]. Therefore, stringent clinical protocols in healthcare settings are required to ensure accurate screening. A proposal calling for alcohol testing throughout routine pregnancy check-ups was recently passed at the annual conference for the Irish Medical Organization (IMO)[28]. This measure aims to reduce the incidence of FASD in Ireland and provides medical professionals with the opportunity to intervene in cases where alcohol is being consumed during pregnancy[29]. However, while educating women on the risks of prenatal alcohol exposure is important, FASD prevention strategies should aim to address and eliminate factors contributing to alcohol use during pregnancy, rather than reinforce notions of individual and personal responsibility and blame[30].

## PRIMARY AND SECONDARY DISABILITIES

Individuals with FASD may present with both primary and secondary disabilities. Primary disabilities refer to the impaired mental functioning that directly results from prenatal alcohol exposure, such as deficits in cognition, social skills and adaptive behaviour as well as attention/ hyperactivity[26]. For example, impairments associated with executive and adaptive functioning are hallmark deficits of FASD[31]. Executive function deficits can contribute to impulsivity, impaired planning, emotional regulation and memory, as well as a diminished ability to learn from consequences[26]. In addition, deficits in adaptive functioning can impair an individual's communication, socialisation and mental capacities to deal with everyday challenges[31].

Although FASD is a common cause of intellectual disability [5] it has been reported that up to 86% of individuals with FASD have an IQ within the normal range. However, their academic ability, communication, living and adaptive behaviour skills are often below their IQ levels. For example, a person with an IQ of 80 may have a math IQ of 70, socialisation skills of 65, and adaptive behaviour skill of 60[32]. Despite this, there tends to be a reliance on standardized intelligence tests in the assessment of clients with suspected FASD, which fail to detect cognitive deficits associated with the condition[33]. Thus, in instances where intellectual capacities are not diminished, cognitive deficiencies are usually present which can limit an individual's ability to perform everyday tasks. It is therefore suggested that adaptive behaviour composite scores may be better predictors of outcomes than IQ[12].

In addition to primary disabilities, individuals with FASD are at risk of developing secondary disabilities[33], which

are not present at birth but occur as a result of FASD and could presumably be ameliorated through greater understanding and appropriate interventions[32]. Examples of secondary disabilities include mental illness (e.g. mood disorders), behavioural disorders (e.g. ADHD, Conduct Disorder, Oppositional Defiant Disorder), substance use disorders, academic difficulties and employment issues[26]. Rates of secondary disabilities are significantly high in individuals with FASD, particularly throughout adolescence and adulthood[34]. In fact, it has been estimated that up to 94% of people with FASD have experienced at least one mental health problem throughout their life, 60% have encountered trouble with the law, 50% have been confined in jail or a psychiatric treatment facility, 49% have engaged in inappropriate sexual behaviours and 35% have had issues with drug or alcohol abuse[33, 34].

## KEY ISSUES FOR CLINICIANS

Many of the symptoms associated with FASD are similar to mental health disorders[26]. However, as FASD is not considered a psychiatric condition, it is often overlooked by mental health professionals and can therefore be misdiagnosed as a co-occurring mental health condition. Co-occurring disorders with FASD can create obstacles to appropriate treatment, as it is postulated that various mental health disorders that are more readily diagnosed will be

observed in clients with FASD and thus become the primary diagnosis in determining treatment. For example, attention deficits and hyperkinetic activity associated with FASD may be misdiagnosed as Attention Deficit Hyperactivity Disorder (ADHD) by medical professionals, and therefore treated with inappropriate treatment methods. The most common misdiagnosis and co-occurring mental health conditions in children and adolescents with FASD include ADHD, autism spectrum disorders, substance abuse disorders and conduct disorder[12]. Although these diagnoses may fit the client's behaviour, they often don't fully accommodate their difficulties, and clients are more likely to develop secondary conditions when their individual needs are not recognised or adequately supported[33]. Furthermore, failure to identify FASD can be detrimental to the client's treatment, as clients with FASD and a co-morbid disorder are more likely to have adaptive behaviour problems compared to those diagnosed with a mental health disorder and no FASD[12]. It is also important to note that research identifying associations between mental health symptoms and FASD purportedly contains a number of methodological limitations such as referral bias and influence of uncontrolled cofounders[35].Therefore, while there is concern for FASD being misdiagnosed as another disorder, there is also risk for a false positive FASD diagnosis when this relationship is overestimated[36]. Given the complexity in the classification of FASD, it

is crucial that psychologists are familiar with the common symptomatology of FASD in conjunction with typical comorbid disorders, in order to ensure clients benefit from a suitable treatment approach.

## TREATMENT APPROACH

Although some professionals are concerned about the stigma attached to a FASD diagnosis[37], a true diagnosis has been identified as a protective factor as it allows for early intervention and suitable supports[8]. Treatment of clients with FASD can be challenging. Given the variability in physical and behavioural outcomes[2], individuals with FASD present with a unique profile and often respond differently to treatments when compared to those with other neuro-developmental disorders[20]. However, there are a number of steps psychologists can take in order to communicate with clients with a suspected FASD and maximize the effectiveness of treatment[33].

Communication of an FASD diagnosis should be carried out in a manner that minimizes any potential harm to the client and their relationship with their mother. Thus, the clinician should ensure that the client understands how FASD can be caused inadvertently, including the mother's lack of knowledge around negative effects of alcohol, difficult life circumstances or mental health issues. It is imperative that information is shared with the client in a developmentally appropriate manner, using age-appropriate language,

as communication can be challenging with this population[38]. For example, there is often a marked discrepancy between an individual's ostensibly high verbal skills and their ability to communicate effectively[39]. Psychologists should therefore ensure that they use simple, concrete language and avoid complex questions that may result in individuals with FASD responding with factually incorrect responses or becoming emotionally unavailable[26, 31]. Role plays using different reactions and outcomes have also been identified as an effective tool in helping clients with FASD communicate and learn about cause and effect[26, 39].

In addition to communication impairments, learning and memory deficits associated with FASD necessitate the use of consistency and repeating information in order to establish a sense of control and predictability. Furthermore, clients with FASD have a tendency to be talkative and charming, which can lead psychologists to overestimate their competence and comprehension of intervention goals. Thus, it is advised that information is repeated and the individual with FASD demonstrates their knowledge of the intervention or question asked by explaining it in their own words[31].

The environmental context is also very important to consider when treating individuals with FASD. For example, it is postulated that this population are conducive to learning in a stable environment with minimal change in order to minimize anxiety that can impede the

therapeutic process[26]. It is therefore recommended that mental health practitioners simplify routines, arrange shorter appointments and establish achievable short term goals to facilitate the individual's needs[39].

Finally, it is important to consider the propriety of various therapeutic approaches in supporting clients with FASD. For example, insight-based therapy and group therapy may not be appropriate for clients with FASD as they find it difficult to relate to other's feelings[39]. However, individual therapy that incorporates modelling, coaching, and skill-building has been identified as being of greater pertinence to this client group[26, 39]. International evidence-based interventions in the domains of parenting, attention, self-regulation and adaptive functioning have proved to be successful in supporting people with FASD[21]. Therefore, in conjunction with strategies focused on the individual, it is also important to involve the client's family, where appropriate, in order to educate them about the condition and provide them with strategies to support the individual living with FASD[40]

## CONCLUSION

FASD is a growing concern in Irish society. Considering the suggested high prevalence of FASD in Ireland[4], it is likely that psychologists come into frequent contact with individuals who are impacted by the condition[31]. However, given the overlapping symptoms and co-morbidity with other psychiatric conditions, identification and assessment can be challenging, often resulting in missed diagnosis and misdiagnosis. Psychologists can play an invaluable role in a multi-disciplinary assessment and treatment of clients with FASD[26]. Thus, there is a need to increase awareness of FASD among psychologists in Ireland in order to increase the likelihood of accurate identification and diagnosis as well as creating an understanding around the various challenges and deficits faced by individuals with FASD throughout every day life[31].

## ACKNOWLEDGMENTS

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# THE EFFECT OF THE THERAPEUTIC ALLIANCE ON PSYCHOTHERAPY OUTCOMES

## PATRICK MCHUGH



## ABSTRACT

The therapeutic relationship has been theorised as a core process across many psychotherapies, from a focus on transference within psychoanalysis[1] to the humanistic concept of the 'real relationship' examining the authentic and personal client-therapist relationship[2]. While different models vary in their conceptualisations of the relationship, the therapeutic or working alliance has emerged as a pan-theoretical construct. The most common definition of the therapeutic alliance includes an affective bond between the client and therapist, as well as their agreement on the goals and tasks of therapy[3]. The current review will evaluate the contribution of the therapeutic alliance to adult psychotherapy outcomes, including an examination of recent meta-analyses and implications for clinical practice.

## THE RISE OF COMMON FACTORS

Common factors are processes shared by all or most therapies, such as the therapeutic relationship, empathy and expectations about treatment[4]. There has been an increasing focus on common factors since Lambert's review in 1992 examined the various influences on psychotherapy outcomes[5]. It was estimated that 15% of the variation in outcomes could be attributed to specific therapeutic techniques, with a larger 30% of the variance attributed to common factors (most of the remaining variance was explained by extra-therapeutic factors). A subsequent review by Wampold concluded that treatment factors as a whole accounted for 13% of the variance in outcomes, with the therapeutic alliance identified as the most effective component[6]. Such findings are consistent with the contextual model which proposes that therapy operates within a social context, with the relationship between the client and therapist forming the foundation of all therapeutic processes [7, 8].

## THE ALLIANCE-OUTCOME ASSOCIATION

While narrative reviews of the literature have indicated an influential role of the therapeutic alliance, meta-analyses are required to establish the alliance-outcome effect with accuracy. One of the most recent and comprehensive meta-analyses examined 295 independent studies with more than 30,000 clients from the years 1978 to 2017[9]. An overall moderate correlation of .278 was observed between the therapeutic alliance and clinical outcomes, explaining approximately 7.7% of the variation in clinical outcomes. The magnitude of the relationship is largely consistent with previous meta-analyses which have observed associations in the range of .28 to .29[10, 11]. As such, the association is robust and does not appear to be influenced by the type of meta-analytic strategy.

The meta-analysis of Flückiger et al. (2018) included an analysis of the alliance-outcome effect across various moderators (see Table 1 for effect sizes across moderators). A number of the variables analysed showed no moderating effect, including the type of therapy, alliance measure and the rater of the alliance. The alliance-outcome association also showed no significant difference for internet-based therapies (r = .257, k= 23). The type of client group did show a moderating effect. Those with substance abuse disorder and eating disorder showed a lower alliance-outcome association relative to other presentations. With regard to the type of outcome measure used, the alliance showed a lower association with measures of dropout and risk. However, these measures tended to be used in treatment studies of substance use disorder and therefore the lower association may be a consequence of the client group. Another factor showing a moderating effect was the time the alliance was measured, with measurements later in therapy showing a stronger association with outcomes than earlier measures. As will be discussed, this difference may have implications when considering the directionality of the alliance-outcome association.

The role of the alliance in preventing dropout represents an important consideration, given that those who fail to complete therapy show worse outcomes than completers[12, 13]. Furthermore, dropout can have a negative impact on service functioning and the morale of staff[14, 15]. As previously discussed, the meta-analysis of Flückiger et al. (2018) showed a small association between the alliance and dropout, although this effect may have been confounded by the large number of substance use disorder studies underlying the effects. A previous meta-analytic review with a more diagnostically varied client group has also examined this question, analysing 11 studies with 1,301 cases[16]. A moderate alliance-dropout relationship was observed (d = .55, r = .27), with larger effects for therapies of longer duration and within inpatient settings. This appears to be of a similar magnitude to the effect of the alliance on symptom

reduction. As such, the alliance appears to have a robust and wide-ranging effect across clinical outcomes.  However, the magnitude of the association may not be

high enough to suggest that the alliance has a role in all therapeutic processes, as would be predicted from the contextual model[7, 8].

Table 1: Summary of alliance-outcome effect sizes across moderators[9].

| Moderator | ES *(n)* | ES *(r)* | Moderator | ES *(n)* | ES *(r)* |
|---|---|---|---|---|---|
| **Alliance Measure** | | | **Alliance Rater** | | |
| WAI | 150 | .24 | Client | 223 | .25 |
| CALPAS | 34 | .22 | Therapist | 40 | .22 |
| HAq | 33 | .26 | Observer | 66 | .22 |
| **Client Group*** | | | **Outcome Measure*** | | |
| Anxiety | 23 | .24 | BDI | 44 | .28 |
| Depression | 54 | .26 | SCL | 58 | .23 |
| Borderline PD | 9 | .32 | Risk | 35 | .17 |
| Substance Use | 29 | .14 | Dropout | 27 | .18 |
| Eating Disorder | 11 | .15 | IIP | 16 | .22 |
| **Type of Treatment** | | | **Measurement Time*** | | |
| CBT | 72 | .20 | Early | 182 | .22 |
| IPT | 9 | .28 | Middle | 51 | .21 |
| Psychodynamic | 57 | .24 | Late | 41 | .30 |

Note. BDI = Beck Depression Inventory, CALPAS = California Psychotherapy Alliance Scale, CBT = Cognitive Behavioural Therapy, HAq = Helping Alliance Questionnaire, IIP = Inventory of Interpersonal Problems, IPT = Interpersonal Therapy, SCL = Symptom Checklist, WAI = Working Alliance Inventory.

* Statistically significant moderator

## THE DIRECTION OF THE ALLIANCE-OUTCOME ASSOCIATION

As research on the alliance-outcome association is correlational, the directionality of the association cannot be established[17].  The potential for outcomes to influence ratings of the alliance is plausible, with the finding that the alliance-outcome association is greater

when the alliance is measured later in therapy supporting this influence[9] (i.e., when the alliance and outcome are measured closer in time).  As the alliance is typically measured early in therapy, an alliance to outcome effect is more probable.  However, it is possible that early symptom improvement acts as a confounding variable by influencing both the early alliance and final outcome.

A number of studies have sought to address this methodological limitation by controlling for early symptom improvement. While a non-significant effect of the alliance has been found in some of these studies[18, 19], the majority have observed the alliance-outcome association to persist[20, 21]. This includes a study of 646 clients in primary care which found that the alliance predicted symptom improvement session to session, controlling for prior symptom change[22]. The meta-analysis by Fluckinger et al. (2018) also included a sub-analysis examining the alliance-outcome association for 66 studies which controlled for both client demographics and early symptom change. No statistically significant difference was found in these studies between the overall alliance-outcome correlation (r = .25) and the partial-correlation controlling for confounds (r = .22). Thus, the existing evidence is supportive of an alliance to outcome effect, although the mechanisms underlying a direct causal pathway have yet to be established.

## COMPARING THE ALLIANCE WITH OTHER COMMON FACTORS

The magnitude of the alliance-outcome association has been described as moderate based on general effect size criteria for the behavioural sciences[23]. However, it is also necessary to evaluate the effect of the alliance relative to the effects of other therapeutic factors observed in meta-analyses. For example, some common factors show larger effects, such as goal consensus and collaboration each explaining 11% of the variation in clinical outcomes[24]. Other common factors have explained variance similar to the alliance, such as empathy[25] (9%) and genuineness/congruence[26] (6%); lower effects have been observed for treatment expectations[27] (1.4%), specific treatment techniques and adherence[28, 29] (< 1%). The alliance would therefore appear to be moderately effective in the context of other common factors. However, it is difficult to make an accurate comparison across common factors as many will have a high degree of shared variance[30]. There is also evidence to suggest that the therapeutic alliance facilitates the effects of other treatment factors, consistent with the contextual model. For example, it has been found that early expressions of empathy by the therapist result in a stronger alliance, which subsequently has a direct positive effect on outcomes[31, 32]. Thus, the association between empathy and outcomes[25], as previously referred to, may be partly mediated through the therapeutic alliance. There is also evidence to suggest that the alliance mediates the link between treatment expectations and clinical outcomes[33, 34]. Although it is difficult to isolate the nature of such interactions, the alliance does appear to have a role in facilitating the effects of other common factors.

## INFLUENCE OF THERAPIST AND CLIENT FACTORS

In examining the factors that contribute to a positive alliance, much research has examined the influence of therapist and client factors. One study attempted to compare the contribution of the therapist and client to the alliance-outcome association[35]. It was found that therapists who formed stronger alliances had better outcomes, with client variability in the alliance having no influence on outcomes. Furthermore, the better outcomes of some therapists were explained by their ability to form stronger alliances. The influence of therapist factors was further supported by a meta-analysis which found that a lower client to therapist ratio within a study (an indicator of therapist variability relative to client variability) was a moderator of the alliance-outcome association[36]. Thus, some therapists appear to have alliance-enhancing characteristics which result in better outcomes for their clients. In comparison, some clients may form better alliances but this does not appear to impact outcomes.

Therapists who form stronger alliances tend to be those viewed by their clients as warm, empathetic, trustworthy, confident and friendly[37]. Qualitative research can be particularly valuable in this area, identifying the more subtle alliance-enhancing behaviours of therapists. For example, clients have described how therapist behaviours such as good eye contact, smiling, self-disclosure, encouragement and personalisation of

therapy can contribute to the alliance[38, 39]. In contrast, alliance-hindering factors include superficial, critical and non-responsive behaviours, a cold/detached interpersonal style and therapists with a high personal burden[40-42]. These barriers to the alliance would appear to be associated with a lack of therapist empathy.

As previously discussed, client factors have not been shown to influence the alliance-outcome association[35, 36]. Furthermore, there has been far less consistency in identifying client factors that contribute to the alliance. However, one relatively reliable client predictor of the alliance is that of a secure attachment style, with this finding supported by meta-analyses[43, 44]. Other less reliable client predictors of the alliance include dependent personality characteristics[45], and a higher level of interpersonal problems has been associated with a greater scope to improve the alliance over time[46]. Client factors showing a negative association with the therapeutic alliance include hostile/dominant interpersonal problems and maladaptive defence mechanisms[47, 48]. However, with the exception of attachment style, the results overall do not present a consistent picture of clients most likely to develop a strong alliance.

## THE ALLIANCE AS A DYADIC AND DYNAMIC PROCESS

Despite the alliance being conceptualised as a dyadic process[3], there is limited research on the interaction between the

client and therapist. As there is only a moderate correlation between client and therapist ratings of the alliance[49] (r = .36), variation in their level of agreement may influence outcomes. For example, greater similarity of alliance ratings have been associated with greater symptom reduction, although initially this appeared specific to high alliance dyads[50]. However, a more recent study also observed this effect for low alliance dyads, suggesting that agreement on alliance difficulties can provide a basis for therapeutic effects[51]. Such results would support the value of therapists being attuned to the ongoing nature of the therapeutic relationship.

Another dyadic dimension of the alliance to consider is its development over time, in particular how changes in the 'state alliance' influences outcomes[52]. For example, a recent study using dyadic multilevel monitoring found that therapist-client congruence in alliance ratings did not predict symptom reduction, but greater convergence in alliance ratings over time did show an effect[53]. Furthermore, another study showed that time-specific improvements in client's alliance ratings were predictive of both clients' and therapists' rated outcomes in the following session[54]. Such research supports the value of measuring the alliance as a dynamic process. It also suggests that therapists need to be concerned not only about the current alliance, but also its development over time.

## ALLIANCE RUPTURES

It has been proposed that ruptures to the alliance are an inevitable part of psychotherapy, with the management of these ruptures a key determinant of outcomes[55]. Ruptures can range from 'withdrawal' associated with silences and non-compliance to 'confrontation' associated with anger and dissatisfaction. Where ruptures are not effectively managed, the therapeutic alliance will deteriorate and client outcomes will be poorer[56, 57]. However, when ruptures are effectively managed, it can contribute to positive outcomes and provide the client with greater insight on how they relate to others[58].

There is evidence to suggest that the process of 'rupture and repair' can have therapeutic effects. For example, clients who show a 'U' or 'V' shaped pattern of high-low-high alliance tend to have more positive clinical outcomes than those with a stable alliance or a linearly improving alliance[59-61]. Early rupture repair dynamics in therapy have also been associated with the strengthening of the alliance over time[51]. Quantifying the effect of this process, one meta-analysis found that rupture-repair episodes had a moderate correlation with client outcomes[62] (r = .24), although the reliability with which rupture-repair episodes were measured was questionable (based on fluctuations in alliance measures). There is also some evidence that alliance-focused therapy, which includes rupture resolution training,

leads to better client outcomes[62-64]. With such research however, it is difficult to distinguish the effects of rupture resolution training from the more generic alliance-building techniques.

## HOW VALID IS THE ALLIANCE AS A CONSTRUCT?

Despite the therapeutic alliance having a robust association with outcomes, there remains a question about the validity of the construct itself. For example, there is still a lack of consensus about the mechanisms underlying the therapeutic benefits of the alliance[65]. It could be argued that the alliance is simply a label for a range of highly correlated therapeutic processes that have distinct influences on outcomes (e.g., goal consensus, affective bond, empathy). Indeed, one meta-analysis showed a strong association of the alliance with empathy (r = .50) and genuineness (r = 59), potentially suggesting many shared processes within these constructs[30]. A second critique of the alliance is the proposal that the goal/task consensus component is measuring compliance rather than collaboration[66]. There is some evidence to support this idea as those with submissive or dependent personality types tend to have stronger alliances with their therapists[45, 67]. Another challenge to the alliance comes from the concept of the 'real relationship', defined as the personal and genuine relationship between the client and the therapist[68]. While this real relationship is proposed as distinct from the therapeutic

alliance[69], the high level of shared variance would question this difference[70]. Thus, there are many challenges to the construct of the therapeutic alliance and future research needs to go beyond basic alliance-outcome associations.

## CLINICAL IMPLICATIONS

Research on the therapeutic alliance needs to be considered in terms of its implications for clinical practice. As meta-analyses have established that the alliance is one of the leading therapeutic processes, it needs to be given extensive focus during clinical training. While evidence-based alliance training has yet to be developed, a number of recommendations for such training can be made from the existing research. First, alliance-enhancing behaviours need to be given focus in training, including techniques to facilitate empathy, warmth and an environment of psychological safety. Second, there is a need to develop skills that can adapt to the dynamic nature of the alliance, including rupture resolution. Lastly, techniques relating to goal consensus and collaboration should be given particular focus during alliance training, given the large therapeutic effects of these processes.

A limited number of studies exist which have evaluated alliance-enhancing techniques in practice. In one of the initial studies, a small group of therapists were trained in alliance promoting activities,

such as collaboratively reviewing goals and displaying empathy[71]. Moderate to large effect sizes for increases in the alliance were observed (therapists acted as their controls), although the difference was non-significant due to the small sample size. There is also some preliminary evidence to support alliance-focused training[64, 72]. Such training has a particular emphasis on rupture resolution, but also involves teaching therapists to actively monitor the relationship, to identify their own contribution to the relationship and to utilise their own feelings. This training has been shown to enhance therapist-client interpersonal processes, including reduced client dependence, increased client responsiveness and increased therapist affirmations and expressiveness. These improved therapeutic processes have in turn been associated with better treatment outcomes[72]. Such preliminary research is encouraging in translating alliance-enhancing skills into improved clinical outcomes.

An additional way the alliance may be enhanced is through explicit monitoring of the relationship. For example, there is emerging evidence to suggest that clients whose therapists overtly check-in on the alliance have better outcomes[73]. Furthermore, the alliance-outcome association is stronger for therapists who receive feedback on the alliance[74]. Such monitoring of the alliance may aid in the identification of misalignments and ruptures[75] and is a core process of feedback-informed treatment[76]. However, questionnaire-based monitoring should

only be used in combination with observational skills which can identify less conspicuous aspects of the alliance (e.g., withdrawal type ruptures associated with excessive compliance).

## FUTURE RESEARCH

As meta-analyses have consistently established the effect of the therapeutic alliance, the focus of future research should move beyond simple alliance-outcome correlational studies. In this respect, there is a need for research to focus on how the dyadic and dynamic nature of the relationship contributes to outcomes. The use of the actor-partner interdependence model may be valuable here, statistically examining bidirectional effects within interdependent relationships[77]. Such research can be supported by qualitative research methods and single case studies which provide a more detailed description of these dynamic processes. Another line of future research is the validation of measures which assess the process of alliance rupture and repair. Efforts have been made to develop such measures and may have an important role in guiding clinicians through the resolution process[78].

## CONCLUSION

The therapeutic alliance has been shown to have a moderate and robust effect on clinical outcomes across a range of

treatment contexts. While the effect of the alliance is consistent, it is also complex with dyadic and dynamic influences. The alliance-outcome association has undergone robust testing, although the exact processes underlying the association remain unclear. The alliance is likely to have a curative effect in itself, but also a mediating or facilitative effect for other common factors. Whether the concept of the alliance survives in its current form is unclear, although the underlying processes will undoubtedly be the subject of future attempts to enhance psychotherapy outcomes.

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# THE PREVALENCE OF MENTAL HEALTH DIFFICULTIES PRESENTING TO AN IRISH CMHT

PÁDRAIG COLLINS AND DAVID FEELY

## ABSTRACT

**Objectives:** To attend to the paucity of research on the profile of presentations cared for by Irish Community Mental Health Teams (CMHTs) by undertaking an audit of the difficulties of service users on the caseload of one CMHT.

**Methods:** All CMHT members were asked to score each individual on their caseload using a 40-item inventory of common presenting difficulties. These difficulties covered common mental health diagnoses (e.g. depression), common social difficulties (e.g. housing, financial) and common psychological difficulties (e.g. low self-esteem, interpersonal conflict). The needs of 400 of the 601 service users on the team's caseload are reviewed in this manner.

**Results:** Of mental health diagnoses, depression and anxiety disorders were most frequently represented. A large percentage of service users (e.g. 41%) presented with distress related to interpersonal conflict. Substance abuse was also highly prevalent (17.5%). High levels of complexity and co-morbidity was noted with 63.5% being scored as having difficulties in three or more domains.

**Conclusions:** The audit of this CMHT provides data on what presentations are being managed by an Irish CMHT. The audit highlights service implications related to the provision of support for interpersonal and social difficulties and also recommends the development of bespoke care pathways for individuals with high levels of need in multiple domains. Further research in other CMHTs is required to determine the generalisability of these results.

## INTRODUCTION

Despite the expenditure of significant resources in the provision of healthcare through community mental health teams (CMHTs) in Ireland we have little to no published data on what presentations are being seen by community teams. In 2017

the predominant disorders evident in *inpatient* admissions to Irish mental health services were depression (25%), schizophrenia (20%), mania (11%) and alcoholic disorders (7%)[1]. Inpatient admissions have fallen by over 88% since 1963 representing a transition towards community mental health teams[1]. This transition has been more recently facilitated by the key policy document 'A Vision for Change'[2] which stressed the need for integrated, community-led, multidisciplinary teams to meet the mental health and wellbeing needs of the Irish population[3].

The need for well-resourced and effectively run community mental health care is highlighted by the direct cost of mental health problems in Ireland being estimated at over €3bn[4]. The proposed role of the CMHT is to provide a comprehensive package of secondary mental health care within a specific geographic area[5]. However, there is currently a dearth of national data on the prevalence of mental health conditions amongst service users served by these teams. One Irish study compared referrals from primary and secondary care to CMHT psychologists[6]. It was found that between 36 - 54% of service users were referred for the treatment of a mood disorder, 41 – 46% for an anxiety disorder, up to 12 % for a psychotic disorder, up to 9% for an eating disorder and up to 4% for an impulse control disorder. Of the service users sampled, 26% had at least one comorbid disorder[6]. This study highlights the

diversity and complexity that exists in the caseloads of psychologists working in Irish CMHTs.

A UK study by Greenwood and colleagues (2000) investigated the prevalence rate of disorders in a CMHT in South London serving a population of 1651 service users[7]. It was found that schizophrenia (28.6%), depression (23.6%), and anxiety disorders (11.1%) were the most common diagnoses. Other UK studies investigated the prevalence rate of personality disorders presenting to CMHTs. It is estimated that between 40 – 52% of service users within these CMHTs suffered from at least one personality disorder[8,9]. Research has also indicated that up to 44% of CMHT service users had experienced some form difficulties arising from drug and/or alcohol use over the previous year[10].

In light of the lack of published data relating to an Irish context, the aim of this current study was to profile the caseload of a CMHT in Ireland in order to determine the prevalence and types of mental health difficulties amongst the service users seen by this team.

## METHOD

*Setting*

A CMHT serving a population of approximately 24,000 people and covering a wide geographical area in Ireland's midland region was chosen for the purpose of this study. This is largely a rural area,

but includes two larger towns. In this area it has been estimated that 1 in 3 referrals to local GPs present with symptoms of psychological distress[11]. The CMHT was a multidisciplinary team comprised of 1 clinical psychologist, 1 social worker, 3 psychiatrists (1 consultant, 2 NCHD), 2 community mental health nurses, 1 CBT therapist and 1.5 occupational therapists.

*Analysts*

Each team member was asked to fill in the audit form for each service user for whom they were the keyworker (all service users had one named keyworker, thereby preventing double-scoring) using the guidance outlined below. Consequently the full range of disciplines participated in the audit. The presentations of 400 service users (aged 18+) who were on the CMHT caseload were consecutively analysed. This constituted 66% of the total team caseload (n=601). The presentations of the remaining 201 service users were not analysed due to time constraints on the audit. A randomised sample (n=15, random number generator) of these 201 service users was later analysed and revealed a profile of presentations similar to that of the large sample.

*Audit Items*

The audit items (36) were based on the topics covered by the large-scale Psychiatric Morbidity survey carried out in the UK (Office of National Statistics[12]). This study was chosen as a guide as it was the closest published example of a study that covered diagnostic and non-diagnostic

mental health categories. On piloting, CMHT clinicians requested an additional 4 items relating to forensic issues which were added. (Full list of items available on request from corresponding author).

*Threshold Judgements:* The psychiatric morbidity UK survey involved lay interviewers surveying individual members of the public, followed, for a subset, by clinical interviews. For the purpose of this audit, skilled mental health professionals scored individuals on a caseload with which they would be very familiar. The professionals were advised, for diagnostic categories (e.g. depression, personality disorder), to score an item (present/absent) if a formal diagnosis had been previously given. As such team members were not required to make any new diagnostic decisions but simply apply pre-existing diagnoses in relation to formal mental disorders. For non-diagnostic categories e.g. 'distress arising out of poor financial situation', the professionals, who were highly experienced mental health practitioners, were advised to score an item as present if it met the DSM V (2013) threshold of clinical significance i.e. "causes clinically significant distress or impairment in social, occupational or other important areas of functioning" [13].

International best practice guidelines on ethical approval (i.e. UK National Research Ethics Service[29]) were consulted indicating that standard internal service audits of this nature did not require additional external ethical approval.

## RESULTS

*Service Users*

The sample of service users included 170 (42.5%) males and 230 (57.5%) females. The age range was 17 – 88 years. The vast majority of the sample was of a White-Irish ethnicity. Detailed information on non-Irish ethnicity was not collected.

*Disorder Specific Analysis*

229 service users (57.25%) were rated as having problems associated with depression or anxiety, with 89 (22.25%) individuals rated as having difficulties with both depression and anxiety. 96 people (24%) were rated as experiencing problems associated with psychosis and 69 people (17.25%) with substance abuse. Meanwhile, 53 people (13.25%) were rated as presenting with bipolar disorder, 51 people (12.75%) with a personality disorder, 26 (6.5%) with an eating disorder, and 26 (6.5%) with Post Traumatic Stress Disorder (PTSD). Table 1 presents a summary of the prevalence rates for each of the different disorders experienced by the service users sampled.

Table 1: Prevalence rates of the different disorders experienced by the service users.

| Presenting Difficulty* | No. of Service User's Affected | % of Service User's Affected |
|---|---|---|
| Depression | 178 | 44.5% |
| Anxiety Disorder | 140 | 35% |
| Psychosis | 96 | 24% |
| Substance Abuse | 69 | 17.25% |
| Bipolar Disorder | 53 | 13.25% |
| Personality Disorder | 51 | 17.75% |
| PTSD | 26 | 6.5% |
| Eating Disorders | 26 | 6.5% |
| OCD | 21 | 5.25% |
| Total | 400 | |

Note. PTSD = Post Traumatic Stress Disorder, OCD = Obsessive Compulsive Disorder. * A high degree of co-morbidity of disorders was found and is discussed below.

*Interpersonal Difficulties*

164 service users (41%) were scored as experiencing some category of interpersonal difficulty. This figure is broken down further in Table 2 below.

*Social/ Environmental Difficulties*

61 individuals (15.25%) were scored as experiencing financial problems, 53 individuals (13.25%) as the victim of childhood abuse, 45 individuals (11.25%) as having problems associated with housing issues, 39 individuals (9.75%) as experiencing poor physical health. These figures are presented in Table 3 below.

Table 2: A breakdown of the interpersonal difficulties experienced by the service users.

| Category of Interpersonal Difficulty | No. of Service User's Affected | % of Service User's Affected |
|---|---|---|
| Couple/Family Conflict | 125 | 31.25% |
| Bereavement/ Grief | 23 | 5.75% |
| Interpersonal interaction/ attachment | 21 | 5.25% |
| Deficits in social skills | 20 | 5% |
| Difficulties understanding the behaviour of others/ "Mentalisation" deficits | 16 | 4% |
| Total | 205 | |

Table 3: A breakdown of the social/environmental difficulties experienced by the service users.

| Category of Social/Environmental Difficulty | No. of Service User's Affected | % of Service User's Affected |
|---|---|---|
| Financial | 61 | 15.25% |
| Childhood abuse | 53 | 13.25% |
| Housing | 45 | 11.25% |
| Poor Health | 39 | 9.75% |

*Level of Complexity*

354 (88.5%) scored as having more than one source of mental health distress (e.g. depression *and* financial difficulties), with 62 service users (15.5%) presenting with 6 or more needs. This information is presented in Table 4 below

Table 4: The number of service users scoring 1 – 6 + needs.

| No. of Items/Needs Scored Per Service User (n=400) | | |
|---|---|---|
| 1 | 46 | 11.5% |
| 2 | 100 | 25% |
| 3 | 98 | 24.5% |
| 4 | 62 | 15.5% |
| 5 | 32 | 8% |
| 6 or more | 62 | 15.5% |

## DISCUSSION

We know little from the published research to date on what types of mental health difficulties present to Irish Community Mental Health Teams or the prevalence of specific psychosocial difficulties. Effective resource allocation and utilisation requires some knowledge of the types of difficulties with which CMHTs are faced. This research aimed to attend to this deficit in our knowledge by engaging in an initial audit of one CMHT and examining not only the prevalence of specific mental health disorders but to also look more broadly at the diverse social and

psychological difficulties that commonly present at a CMHT.

*Diagnostic Prevalence Rates*

In keeping with a large body of research regarding the high prevalence of depression[14], depression was the most prevalent difficulty scored by team members with 178 (89 with depression alone, 89 with depression and anxiety) out of the 400 (44.5%) sampled service users. Similarly, the recorded high levels of anxiety disorders also mirror international research in this area[15].

Somewhat less prevalent than expected are ratings of Personality Disorder (12.5%). This is in keeping with research in prevalence rates in a community sample[16] but with a clinical sample one could have expected a higher prevalence. This may be influenced by the continuing stigma associated with the diagnosis of personality disorder and therefore, at times, a potential bias towards using a possibly less stigmatising diagnosis (e.g. depression). It may also reflect inadequate assessment for personality disorder. To address this limitation, recent discourse in mental health has called for a move away from diagnostic categories towards a formulation based framework of understanding people's distress[17].

The rates of PTSD are in keeping with other research with clinical samples but this may itself be an underestimate of its true prevalence (see Zinmmerman & Mattia, 1999, for discussion)[18]. The rates scored for psychotic symptomatology

(24%) are comparable to those found by the Greenwood et al. (2000) UK study for Schizophrenia (28%) with the recording of mood lability/ bipolar disorder symptomatology somewhat higher than the Greenwood sample (13.25% vs. 8.2%), possibly due to additional individuals in the Greenwood sample with significant mood lability being assigned a "schizoaffective" diagnosis (2.9%)[7].

*Psychosocial difficulties prevalence rates*

Of particular interest, due to a dearth of similar research in this area, are the results relating to the types and prevalence of psychosocial difficulties with which individuals present to a CMHT.

It has been long recognised that individuals commonly present with a mental health condition at a time of transition or major stress in their life[19, 20]. What is striking from this sample is the degree to which interpersonal difficulties may represent the source of such stress with 41% of the sample being scored as experiencing these difficulties. Acknowledging that professionals will be not be aware of such conflict in service users' lives, this figure may significantly underestimate the prevalence of such difficulties. These results highlight the importance for clinicians to ask about important relationships during assessment. The level of such difficulties may also support the role of therapies with an explicit interpersonal focus e.g. Interpersonal Therapy for Depression[21] or Behavioural Family Therapy for Psychosis[22].

It is noteworthy that a significant proportion of service users were rated as having a variety of different social difficulties such as housing (11.25%), finance (15.25%) and also that wellbeing issues, such as poor health (9.75%) also prominently feature. These results support the importance of the provision of support to service users around social difficulties. This finding is consistent with research over the last four decades (e.g. from Brown & Harris, 1978 to Murali & Oyebode, 2004)[23, 24] highlighting the importance of social difficulties in the aetiology and maintenance of mental health difficulties.

The levels of childhood abuse reported were significant (13.5%) but again, however, may represent a large underestimate cognisant that many such victims do not report to professionals their experience of abuse[25]. Consequently, further assessment of adverse childhood experiences may also be indicated in future research.

*Complexity and co-morbidity*

A high level of co-morbidity was noted in particular in relation to depression and anxiety with as large a number of service users being rated as suffering from a combination of these difficulties. It is also noteworthy that across the different diagnostic and psychosocial domains that the vast majority of service users (63.5%) were rated as having difficulties in 3 or more areas. This indicates a level of complexity that justifies the utilisation of a

multidisciplinary team service to meet the range of needs and complexity of presentations.

The results also indicate a significant minority of individuals (15.5%) with a high level of need having 5 or more domains scored as areas of need. There may be some utility in teams identifying these cases for specialist review and care coordination. Other jurisdictions have developed "complex cases" teams and/or specialist service (e.g. assertive outreach, rehabilitations and recovery, personality disorder services) as well as bespoke care pathways to attend to the needs of these individuals. This model of resource allocation acknowledges that where these cases are cared for within a generic CMHT model, there is the potential of this minority of presentations to take up a significant proportion of the CMHT resource, and that generic teams or generic care pathways may not always meet the specific needs of these complex presentations. Other case-load weighting models use measures of complexity to allocate fairly across the team the number of highly complex presentations with which each team members may be asked to work, thereby ensuring that service users are not being seen by team members overwhelmed by a caseload of highly complex presentations.

Conversely, the significant minority of service users (36.5%) scoring as having difficulties in only one or two domains may indicate that their remains a large proportion of service users whose needs could potentially be met with a well-developed primary care service. A "stepped-model" approach whereby service users receive the intensity of support required by their difficulties (as distinct from all service users being referred to a generic secondary care mental health team) may provide the best clinical and economic use of limited resources. Certain Primary Care Psychology services (e.g. the Access to Psychological Therapies Ireland service[26]) currently provide evidence-based psychological treatments for individuals presenting with conditions such as depression and anxiety on a 'stepped-care' basis. There may be a role for primary care practitioners, in partnership with secondary care CMHTs, in guiding GP referrals in this regard.

*Care Clusters*

The results also potentially indicate that there may be a usefulness in developing "care clusters" either around diagnostic criteria (e.g. "affective disorders", "bipolar and psychotic disorders" and "personality / complex presentations") or perhaps more helpfully around the broader biopsychosocial pattern of needs presenting (i.e. by using a clustering tool such as the "Mental Health Clustering Tool"[27] which is a further elaboration of the HoNOS; 'Health of the Nation Outcome Scale'[28]). Such clustering may allow the development of specific specialist skills and services within a CMHT as bespoke care pathways are developed and clinicians develop specialist interests.

*Limitations*

The scoring of psychosocial difficulties as 'present' or 'absent', while facilitating a large scale audit, may belie the complexity of such difficulties which tend to exist along a spectrum. The rural nature of the population may present a profile that differs from that seen in more urban areas. Service users might themselves, if consulted, have defined their difficulties using terms or categories different from those utilised in this audit.

*Implications for Service Provision and Future Research*

These results indicate the importance of interventions focused on attending to interpersonal and social difficulties, as well as clinical symptomatology. It highlights that a sub-cluster of service users may present with high levels of biopsychosocial need and requires specialist input. It outlines the potential utility of a stepped care model of service provision. Finally, it identifies the need for more comprehensive research on the demands placed on standard CMHTs and the most effective interventions that might be offered by those teams

This study provides some helpful indicative data on the type of presentations attending a particular CMHT. While manualised, structured clinical interviews of each individual service users by trained researchers might provide a more rigorous dataset (and could be a focus of future research) few CMHTs have access to such resources. Nevertheless, it is incumbent

upon all health services to audit the difficulties with which they are working to ensure their resources are being used in the best ways possible. This audit represents a first step in this direction and explicitly includes those psychosocial difficulties (e.g. financial problems, interpersonal conflicts) which are central to the work of CMHTs but commonly absent in diagnostic-led audits.

## CONCLUSION

An analysis of the presentations to a rural Irish CMHT was undertaken. Members of the multidisciplinary CMHT scored individuals on their caseload using a 40-iterm inventory which outlined common clinical diagnoses, as well as psychological and social difficulties. The results are outlined in detail and their potential implications discussed. Further research could usefully attend to exploring this area further including the use of additional tools such as structured clinical assessments to determine whether these results generalise to other Irish CMHTs (especially those in urban areas). Such data could increasingly inform the practice of CMHTs and ensure that their resources and skills are being best utilised to meet the needs of their communities.

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