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FOREWORD

Welcome to the fifth edition of Clinical Psychology Today. In these times of significant global change concerns have been raised about ‘fake news’ and the polarisation of views. In this context we may need, more than ever, the critical and analytic lens of good research and critical thinking from our discipline. Consequently, I’m delighted to introduce an edition in which research and critical analysis covers such a broad range of topics. The full life-span is covered from work with children, to adults and older adults, and encompassing disability and physical ill-health en route. It does feel like an edition in which there will be a paper of relevance to the work of most Clinical Psychologists.

The psychological impact of psoriasis is covered in a fashion that makes a persuasive case for the key role that Clinical Psychologists can play in medical settings. Similarly the powerful benefits of establishing creative and practical programmes for adolescents in CAMHs, of delivering key supports for siblings of individuals with an ASD diagnosis, and of mindfulness-based approaches for older adults, are convincingly set out in the following papers. Finally, a reflective piece questions whether significant philosophical differences between disciplines in adult mental health settings is a key underpinning to a lot of the difficult tensions with which Clinical Psychologists can be very familiar.

As ever, the hope is that these pieces will inform and challenge our thinking, supporting us to make the best difference that we can in the contexts in which we find ourselves.

Do if at all possible, – check out the accompanying podcast (available at https://soundcloud.com/user-811173165-185749227/cpt-muireann-mcnulty-dec-2019). It’s an engaging and really informative interview about schema therapy with one of its most experienced and key proponents – Dr. Muireann McNulty. It covers ‘*everything you ever wanted to know about schema therapy but were afraid to ask* ‘ !! At just over 20mins, it's a brief but fascinating insight into the model and its benefits.

Finally, heartfelt thanks need to go the key individuals who may the journal possible. As an entirely voluntary endeavour, the journal is fuelled by the passion, knowledge and goodwill of a board network of individuals. Particular thanks need to go to our reviewers (you know who you are!!) to the input of Ellen Ní Chinseallaigh and especially to the ongoing and wonderful editing work of Siobhán O’Neill to whom we are eternally grateful.

Wishing you a peaceful Christmas and hopeful and positive 2020!

Edition Editor: Pádraig Collins

RISE AND SHINE! INVESTIGATING THE EFFECTIVENESS AND FEASIBILITY OF A WELLNESS PROGRAMME FOR ADOLESCENTS IN A CAMHS SETTING

JOANNE KIERANS & MUIRÍOSA CONNOLLY

ABSTRACT

This non-randomised feasibility pilot study aimed to determine whether *Rise and Shine*, a 4-week wellness programme, is an acceptable and feasible group-based intervention for adolescents attending Child and Adolescent Mental Health Services (CAMHS). Rise and Shine promotes positive habits in relation to a number of areas of wellbeing particularly relevant during the adolescent period, including sleep, physical activity, diet, and consistent morning and night-time routines. Ten participants attending CAMHS for moderate anxiety and/or depressive symptoms were recruited and four completed the Rise and Shine programme. A mixed methods design was employed to obtain rich information on the experience of group participation for both participants and their parents. Moreover, information was sought on efficacy, cost, recruitment and retention, and acceptability to participants and parents. Despite limitations due to the low retention rate and brief measures applied, participants and parents rated the group experience positively and indicated that they would recommend the group to others. Important parameters were uncovered for further evaluation studies of the programme, including the need to spend time promoting the value of group-based interventions to service users during recruitment. Overall, findings

suggest that the programme is acceptable and feasible in terms of cost and practicality, and a useful recovery-focused supplement to individual support provided at CAMHS.

INTRODUCTION

Adolescence is a demanding developmental stage with rapid physiological growth, new levels of cognitive functioning and affective regulation, and new social roles and relationships to contend with.[1] Interacting pressures from sociocultural influences and modern-day lifestyles can lead to mental health problems and engagement in unhealthy behaviour. Recent figures highlight the pervasiveness of mental health problems in adolescence. In a large-scale study of European adolescents, 5.8% met criteria for an anxiety disorder and 10.5% for depressive disorder.[2] The My World Survey[3] (MWS) national study of youth mental health in Ireland found that significant proportions of the Irish adolescent population presented with above average levels of depression (30%), anxiety (32%), and stress (20%), ranging from mild to severe. Fostering positive health behaviours such as good sleep habits, physical activity and healthy eating during this key stage is particularly important in helping young people manage vulnerabilities to emotion and behaviour dysregulation.[4]

Sleep

Sleep quality has been negatively associated with anxiety and depression in adolescence.[5,6] The recommended level in adolescence is between 8 and 10 hours per night.[7] However, a significant proportion of young people in Ireland (38%)[8] and worldwide (53%)[9] fail to obtain this level. Although associations appear bidirectional, greater evidence points to sleep disturbance preceding the development of anxiety and depression in childhood and adolescence than the reverse.[5]

Physical Activity

Engagement in regular physical activity is associated with better mental and physical health and wellbeing in adolescence.[10,2] Although the recommended level is at least 60 minutes of moderate to vigorous physical activity daily,[11] only a minority (13.6%) of adolescents in Europe appear to reach this level.[2] The Health Behaviour in School-Aged Children study[12] (HBSC) in Ireland found that 61% of boys and 44% of girls met recommended levels. Engagement was much lower in females and decreased with age; almost 9 out of 10 girls (15-17 years of age) were not achieving recommended levels.

Nutrition

The field of research focusing on the relationships between overall dietary quality and mental health is relatively new, but dietary consumption is increasingly recognised as an important contributing factor in the development, management and prevention of specific mental health problems, including depression and attention deficit/hyperactivity disorder.[13] A healthy diet providing adequate amounts of complex carbohydrates, essential fats, amino acids, vitamins, minerals and water can promote a balanced mood and overall wellbeing.[13,14] However, Irish research shows that the amount of fruit and vegetables consumed by young people is relatively low and consumption of foods high in fat, salt and sugar is high.[15]

Wellness Programmes with Young Adolescents

To date, many interventions for young people with mental health difficulties have adopted similar approaches to those for adults, with the main goal of reducing specific clinical symptoms rather than addressing physical, social and occupational behaviours that contribute to overall wellbeing.[16,17] However, research demonstrating the value of recovery-focused programmes that aim to promote resilience and engagement in health behaviour is progressing. [18-22]

The Sleep Programme is a 5-week group programme aiming to promote positive sleep habits in young people.[8] In a recent evaluation with a nonclinical sample, sleep hygiene scores did not show significant improvement, but small increments on domains of sleep habits and sleep quality were evident.[8] Many participants reported the need to get more sleep and improve their sleep habits after having attended the Sleep Programme, suggesting its use as a means of enhancing understanding of sleep architecture and hygiene.

The Present Study

The need to promote positive social, vocational and physical functioning in managing mental health difficulties rather than traditional symptom-resolution approaches is increasingly acknowledged.[16] In fact, in response to the emergence of data highlighting the important role of health behaviours for the prevention and treatment of mood disorders, recent policy documents in Australia have made explicit recommendations to address these behaviours as a first step in adult clinical treatment.[23] The literature base for these recovery-focused interventions is more established for adult populations, and there are few interventions offered by child and adolescent mental health services that focus on optimising these skills and reducing modifiable risk factors such as poor sleep, diet, and physical inactivity.[24] The prevalence of mental health issues and low levels of engagement in health behaviours in adolescence indicates the need for multi-faceted programmes promoting health behaviours and wellness for adolescents presenting to clinical services, based on holistic, recovery-focused wellness models.

The purpose of the present study was to conduct a feasibility pilot study to evaluate the *Rise and Shine* wellness programme, in terms of its efficacy, acceptability and utility when delivered to adolescents within a CAMHS setting. Rise and Shine is a 4-week multidisciplinary group-based intervention aiming to increase awareness of the relationship between healthy lifestyle behaviours and positive mental health. Utilising a multi-faceted approach, the programme intends to equip participants with tools to promote these health behaviours and develop consistent routines.

The evaluation involved examining the applicability of the programme for this population and context in addition to its effect on a number of aspects of physical and psychological wellbeing. By adopting a mixed-methods design and involving participants and their parents, the aim was to capture rich accounts of participants' experiences and outcomes. Moreover, key information was sought on how the programme can be further improved and refined in terms of content, efficacy, cost, and acceptability to participants and parents.

METHOD

Participants

Participants eligible for study inclusion were adolescents aged between 13 and 16 years currently attending a CAMHS service for support with moderate mental health difficulties. Seven young adolescents (6 female and 1 male) attended the first session for the Rise and Shine group. From these, 4 participants (3 female and 1 male) completed the programme. All participants were Caucasian and lived in the local area. The primary reasons for participants' referrals to CAMHS were anxiety, low mood and previous suicidal ideation.

Design

Adopting a quasi-experimental, prospective design, there were three points of quantitative data collection: pre-programme, post-programme, and at 5-week follow-up. Qualitative data were obtained from structured interviews with participants and the open-ended questions and discussions with parents.

Measures: **Parent and participant rating scales:** The parent rating scale requires ratings using visual analogue scales from 1 to 10 of how well parents felt their child was functioning across a number of areas of living (e.g. "*How is your child's morning routine?*"). After each question, their comments were invited to obtain qualitative feedback. The participant rating scale consisted of a similar format with questions directed to them personally.

The Adolescent Sleep Hygiene Scale (ASHS). The Adolescent Sleep Hygiene Scale[8] is a 33-item self-report measure that assesses sleep practices theoretically important for optimal sleep. Higher scores reflect better success across dimensions of sleep hygiene.

The Paediatric Daytime Sleepiness Scale (PDSS). The Paediatric Daytime Sleepiness Scale[8] is an 8-item self-report measure assessing an individual's tendency to feel drowsy during waking hours. Higher scores reflect greater levels of daytime sleepiness.

Participant Interviews and Parent Group Discussion. Structured interviews were conducted with participants to explore their experience of the programme, their views on the most useful aspects, what could be improved, and any resulting lifestyle changes. Qualitative feedback was obtained from parents through group discussion in terms of perceived benefits and areas of improvement.

Programme: The Rise and Shine Group, The Rise and Shine programme consisted of four weekly 75-minute sessions and a 'booster' session involving parents and participants five weeks later. Each session addressed an area of wellbeing particularly relevant to the early adolescent period, including sleep, physical activity, diet, and the development of consistent morning and bedtime routines. A considerable amount of the content was adapted from *The Sleep Programme*[8] and other online resources.[13,25] In addition to focusing on increasing knowledge and implementing useful strategies for these areas of wellbeing, each session involved group-based activities, relaxation, home challenges, and reflections. The content of the programme is further described in Table 1.

Table 1: The Rise and Shine Programme

Programme Session	Session Content
Parent Session	Introduction from group facilitators Completion of outcome measures Completion of diary of a typical day Detailed overview of each group session Walking quiz Diary reflections Discussion of weekly home challenges and the importance of parental encouragement and support
Session 1	Introductions and an icebreaker activity Completion of outcome measures Detailed overview of each group session Generation of a group contract Weekly challenge Relaxation
Session 2 *Sleep*	Icebreaker activity Discussion of sleep experiences and sleep habits, the benefits of sleep and the effects of sleep deprivation Activity illustrating the links between sleep and emotional health Tips to promote sleep hygiene and develop a good, sustainable sleep routine Weekly challenge Relaxation

Session 3 *Physical activity, stress, and the importance of good routines*	Icebreaker activity Discussion of current levels of physical activity and sources of stress, the importance of physical activity Physical games to stimulate bodies and minds Activity: developing good routines through *the 3 Rs* (reminders, repetition, and reward) Weekly challenge Relaxation
Session 4 (Morning Session) *Healthy eating and nutrition*	Icebreaker activity Discussion of the food pyramid, nutrition and dietary requirements for adolescents Activity: how to make healthy choices in the shop Activity: making a healthy breakfast Weekly challenge Completion of outcome measures Relaxation
Booster Session (5 weeks later)	Icebreaker activity Discussion of the experience of participating in the group, what was learned and any changes made Activity: matching food pictures to shelves on the food pyramid and discussing nutritional value Activity: "balancing demands and resources" how to balance demands and create good routines and habits Completion of outcome measures Presentation of certificates of completion Relaxation

Procedure

Following a discussion of the programme and eligibility criteria with the CAMHS multidisciplinary team (MDT), an information pack was posted to the parents/guardians of 21 young adolescents containing programme information, a parental consent form and an adolescent assent form. Those who returned signed consent forms were then contacted by the lead researcher by phone and provided with further information.

A parent information session took place one week before the group commenced. Pre-programme evaluation measures were administered, followed by introductions, and a detailed overview of each group session. The key role parents would play in promoting healthier lifestyle behaviours and in supporting their child throughout the group was highlighted. Session 1 of the Rise and Shine programme took place the following week. Similar to the parent information session, pre-programme evaluation measures were administered before introductions, icebreakers and information regarding the content of subsequent group sessions were provided.

All subsequent sessions began with an icebreaker activity and a reflection of the previous week, and ended with setting weekly home challenges and relaxation. A flipchart was used throughout to take notes, illustrate points and generate discussion. Games were included that encouraged learning in relation to the topics covered, for example, playing 'Headbandz' with images of food to generate discussion on food groups and nutritional content, and games that encouraged movement and quick thinking to stimulate their bodies and minds (Figure 1). Session 4 took place in the morning and emphasised the importance of a healthy start to the day. Participants prepared healthy and tasty breakfasts, such as fruit smoothies, wholegrain toast and cereal. Post-programme measures were administered at the end of Session 4.

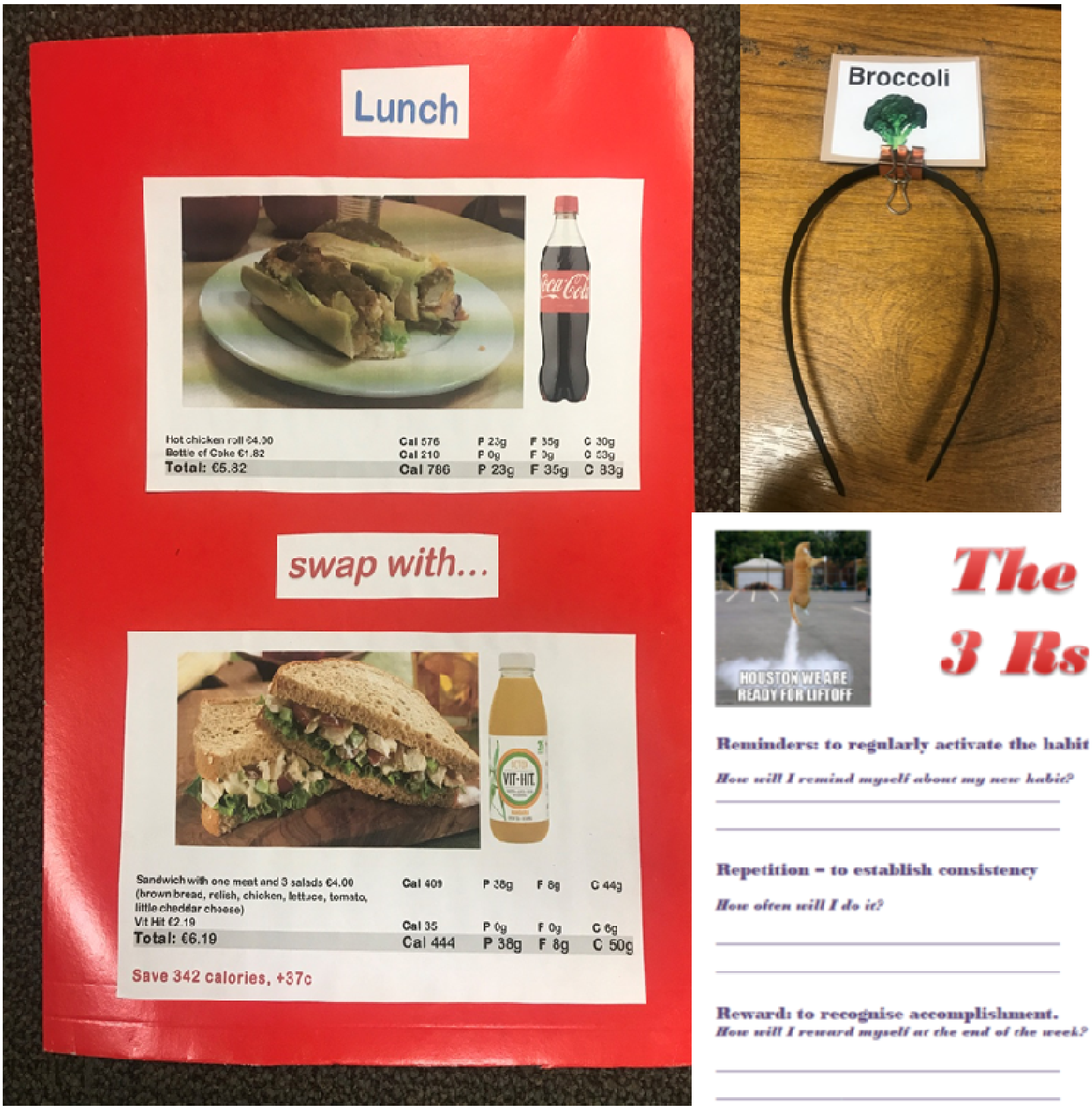
Throughout the following week, the structured interviews with participants were conducted. A booster session took place five weeks later for parents and participants, summarising the key elements of the programme and reflecting on the experience. Once more, participants and parents completed the set of measures at the end of this session. All were thanked for participating in the programme and evaluation. Sessions were facilitated by a psychologist in clinical training (the lead researcher), a senior clinical psychologist, and an occupational psychologist, all of whom were part of the MDT in CAMHS.

Data Analysis

Adhering to Patton's[26] method of process evaluation, both quantitative and qualitative change as a result of the programme was of interest. Multiple perspectives were sought as both parents and participants were involved in the evaluation. However, due to the small sample size and inadequate power, quantitative analyses were not permitted. However, descriptive statistics were generated and graphically presented in order to observe trends and possible changes in the examined variables.

The qualitative data was analysed using Patton's[26] suggested method of content analysis for process evaluation. The aim was to focus on the *process* as well as the evaluative feedback in order to determine how changes (if any) as a result of the programme were produced. This involved exploring, interpreting and reporting themes within the data that reflected the young adolescents' personal views and experiences of the group. Interview discussions were transcribed verbatim from audiotape shortly after each interview took place. The initial coding phase involved a label being attached to all elements of interest in the text and these codes were then grouped together and organised within a master-coding template based on the questioning route of the interview schedule. Conceptually-related codes were combined and renamed to represent a refined theme that encompassed a broad but specific pattern in the data.

Figure 1: Examples of the Rise and Shine Group materials



Lunch

Hot chicken roll €4.30	Cal 576	P 23g	F 35g	C 30g
Bottle of Coke €1.82	Cal 210	P 0g	F 0g	C 53g
Total: €5.32	**Cal 786**	**P 23g**	**F 35g**	**C 83g**

swap with...

Sandwich with one meat and 3 salads €4.00 (brown bread, relish, chicken, lettuce, tomato, little cheddar cheese)	Cal 409	P 38g	F 8g	C 44g
Vit Hit €2.19	Cal 35	P 0g	F 0g	C 6g
Total: €6.19	**Cal 444**	**P 38g**	**F 8g**	**C 50g**

Save 342 calories, +37c

The 3 Rs

Reminders: to regularly activate the habit

How will I remind myself about my new habit?

Repetition – to establish consistency

How often will I do it?

Reward: to recognise accomplishment.
How will I reward myself at the end of the week?

RESULTS

Participation and Retention Rates

From the 21 adolescents recruited, 10 consented to participate, demonstrating a low-moderate recruitment rate (48%). Reasons for declining included unavailability of the child or parent on the specified dates and lack of readiness or interest from the child. Of the 10 who agreed to participate, 7 parents attended the parent session and 7 adolescents attended the first group session. Four adolescents completed all group sessions, demonstrating a moderate retention rate (57%). Reasons for non-completion included the time commitment and prioritising schoolwork.

Quantitative Analysis

Parent Ratings

Observation of scores indicated that parents rated improvements in their child's functioning on all outcome variables following participation in the Rise and Shine group, and this effect was maintained at follow-up (Figures 2 & 3).

Figure 2: Mean scores for parents' ratings of of daily lifestyle activities at pre-group, post-post- group, and follow-up

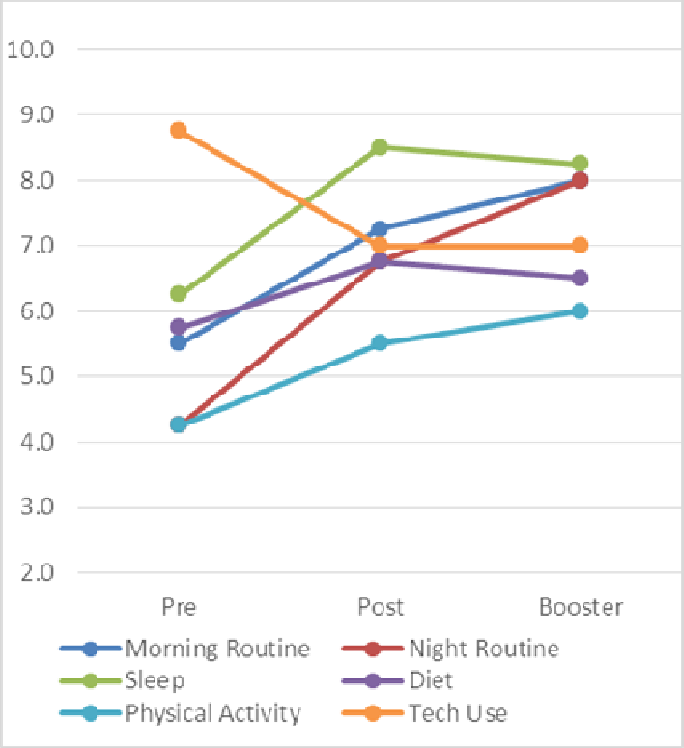
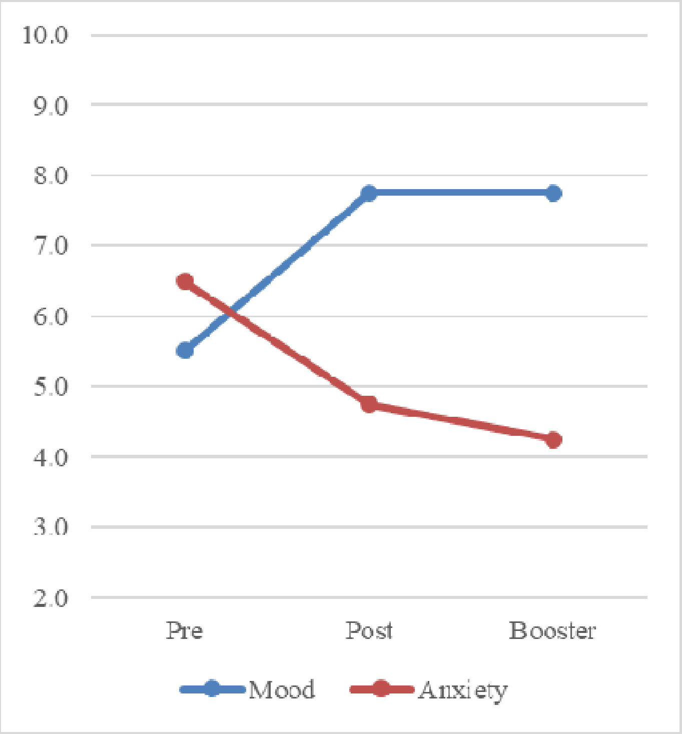


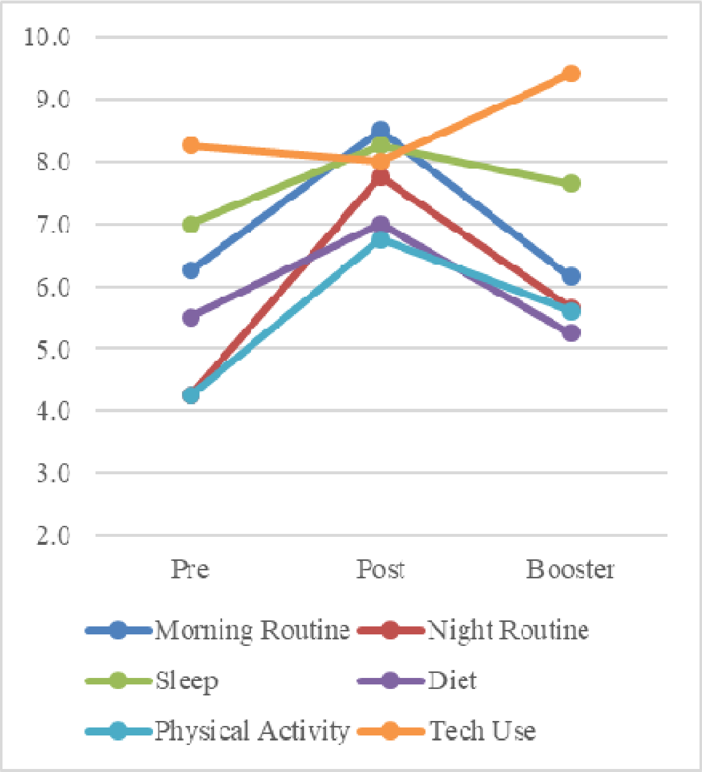
Figure 3: Mean scores for parents' ratings psychological functioning at pre-group, group, and follow-up



Participant Ratings

Examination of variables reflecting participants' daily living activities show that their morning routine, night-time routine, sleep, diet, and physical activity all appeared to show an improvement upon completing the group (Figure 4). However, levels appeared to revert close to baseline at follow-up and improvement was only maintained for sleep quality. Technology use was unchanged post-group and levels increased at follow-up.

Figure 4: Mean scores for participants' ratings of daily lifestyle activities at pre-group, post-group and follow-up



Improvements in ratings of psychological functioning were apparent post-group and were maintained at follow-up (Figure 5). Overall sleep ratings and sleep hygiene did not change as a result of completing the group and appeared to reduce slightly at follow-up (Figure 6). Daytime sleepiness declined across the three time periods. However, as there was an insufficient sample size to undertake more rigorous statistical analyses, no inferences to wider population conditions can be drawn.

Figure 5: Mean scores for participants' ratings of psychological functioning at pre-group, post-group, and follow-up

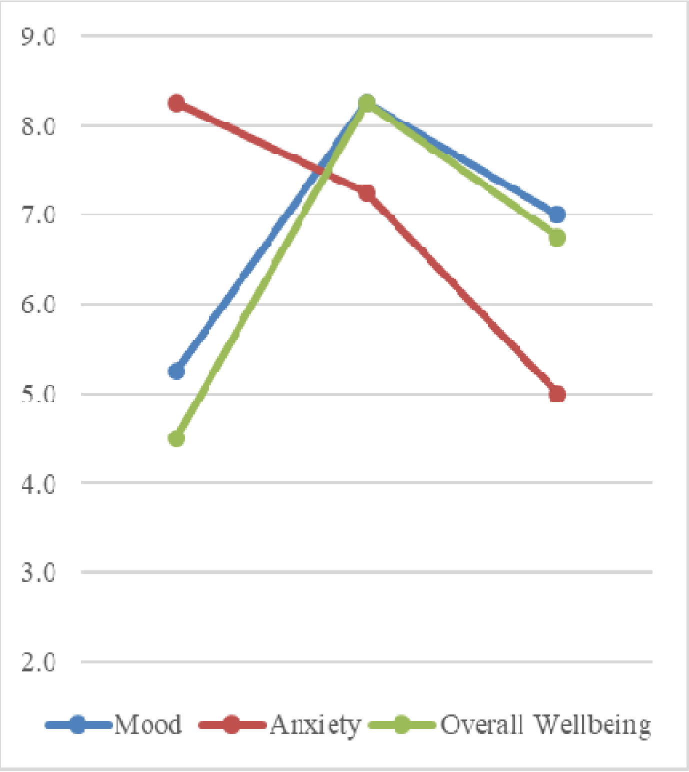
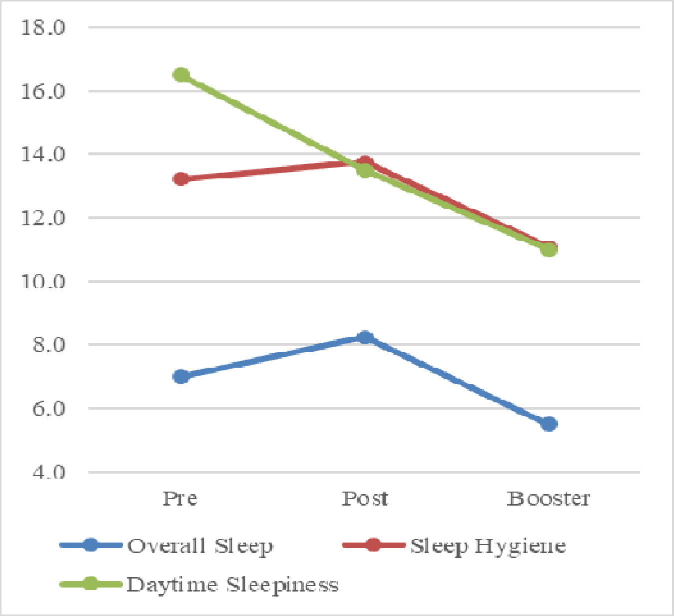


Figure 6: Mean scores of participants' ratings of sleep variables at pre-group, post-group, and follow-up



Qualitative Analysis

Parent Qualitative Feedback

Qualitative data obtained from the parent rating sheets and the group discussion were analysed. One parent thought the group was too short but, overall, parents felt topics were relevant and useful in providing their children with knowledge and increasing their focus.

> *"Very good group, great topics and engaged her very well. Information was clear and relevant."*

Improvements were noted in a number of areas, such as their child now taking responsibility to set an alarm and rise independently in the morning. All parents reported improvements in physical activity; with increased participation for some and increased knowledge and motivation for others. Technology use was an area that still required improvement, although one parent reported an improvement since participation in the group.

> *"It's much better. She'll put her phone up at ten and be in bed for half ten"*

In terms of psychological functioning, mood appeared more stable overall and anxiety levels were reported to have decreased. It was felt that the group was beneficial in helping participants manage the stress of the Junior Certificate mock exams.

Participant Interviews

From the content analysis, three overarching themes emerged from the dataset. Experiential aspects of participating in the group were merged to produce the 'group experience' theme; 'self-motivation' reflects personal accounts of efficacious aspects of the group; and 'programme feedback' reflects comments regarding programme content.

Group experience: The experience of the group brought both challenges and rewards for participants. Most presented with symptoms of anxiety and would generally find group participation difficult. One participant appeared surprised at how much she enjoyed previously feared activities (names anonymised) :

Louise: Em… well I did liked it, I liked the group. My first thoughts were, like when we were doing the icebreakers I was like 'Oh my God!' But as we got into it I properly joined in and I thought the group was very good.

When asked about the home challenges, it was noted that they were feasible and useful in encouraging daily reflection.

Nicola: Well I found it hard at first but then I decided to get into it and I found it easier. Actually surprisingly easy.

Parent involvement was noticeable for all participants; a number of parents appeared to benefit from reflecting on their own level of functioning in those areas and actively participated in activities with their child.

Eva: …My mom would help me with the sheets and we could see what time we went to bed and stuff

Nicola: …My mom said it made her think she never walks so she's going to do more walking and I will too.

Self-Motivation: In relation to the programme content, one participant noted that the learning was enjoyable as the topic was relevant and interesting. The format of interspersing the material with games helped him to retain the information.

Chris: But I do care about this because if you find it interesting and fun you do care.

Participants' insight in terms of the need to be ready and willing to make successful and sustained lifestyle changes was evident. It was apparent that they had personally applied acquired information and considered changes that could be made.

Louise: Em… well my diet is a lot better anyway. And I think it is more like the knowledge has helped me so I keep thinking about all the different things now.

They were aware that this was a more effective means of making lifestyle changes than being told what they should do by their parents.

Chris: If it's a challenge… eh a challenge to change a habit which I'm just not willing to do at the moment like they'd try and force me to do that challenge and like that wouldn't, I wouldn't be gaining anything by doing it. I'd just be getting a lot more angry and upset.

A number of lifestyle changes had been made by participants as a result of participating in the group, and these changes reflected every area of wellbeing that the course covered.

Louise: Yeah because I would never have to have breakfast before and I would just go to school but since the group now I'm like 'OK you have to have breakfast'. Yeah, it's good especially for exam time and stuff you need the energy.

Programme Feedback: Data that related to feedback regarding programme delivery and content were pooled together under the headings of 'useful aspects' and 'areas for improvement.' The subthemes and illustrative examples are presented in Table 2.

Table 2: Useful aspects of, and areas of improvement for, the Rise and Shine programme

Useful Aspects	Examples
Games	Louise: Em weirdly enough I probably enjoyed the icebreakers the most. Eva: Probably like the activities because we've never had anything like them before and it was different
Knowledge gained	Chris: It like opens the flood gates Louise: Like I think it's good to you know look back on things in the day and what you do and ways you can do better like.
Presentation of material	Eva: Yeah (presentations) were really good too, I liked the funny pictures Nicola: It was clear yes and I liked it Louise: Yeah, the handouts were handy yeah (laughs)
Group Format	Nicola: I really liked being in the group
Home Challenges	Eva: They were good. 'Cause I wasn't sleeping great and then you write it all down Nicola: Yeah I mean I did it once and then again and then after that it was just easier for me
Supplement to one-to-one support	Eva: We talk about it and I talk about the stuff I learned with her (keyworker)
Recommend to a friend	Louise: Yeah I would yeah, especially to people who have problems with their sleep or their diet and stuff, I definitely would, it would help them. Louise: Yeah like I'd say even for exam years they would really use it more… And the relaxation fits in with it all as well
Useful Aspects	Examples
Session content	Chris: I think that there should be something like, eh, a game first, serious talk, another game, serious talk, another game.
Group numbers	Nicola: Emm… maybe have more people there
Group length	Louise: Well it was grand but it went by so fast like so maybe a bit longer Eva: I think it was long enough, yeah

DISCUSSION

This preliminary investigation examined whether the Rise and Shine wellness programme could positively impact the wellbeing of adolescents experiencing moderate mental health difficulties. Furthermore, it sought to evaluate the feasibility of delivering the programme within a CAMHS setting. A mixed-methods design was employed in evaluating the programme to obtain feedback and detailed accounts of the process from all stakeholders involved.

In determining change in aspects of wellbeing, parents reported small improvements in their child's functioning and this was maintained at follow-up, although formal statistical analyses of these changes were not undertaken due to the small sample size. Similarly, participants rated improvements in their wellbeing post-group but these improvements were not maintained at follow-up for diet, physical activity and morning routines. More sessions and less time before the booster session may be required in order to consolidate the observed post-group changes. As the majority of participants were sitting their Junior Certificate mock exams during the five-week latency period, extra stress during this time is also an important factor to consider. Interestingly, perceived technology use had increased at the booster session from pre- and post-group levels and was reported by all parents as an issue. Indeed, technology use and academic pressure have both been cited as factors impacting adolescent sleep quality,[18] and may be important topics to specifically address in future applications of the Rise and Shine programme.

Participants' rated improvements that were maintained at follow-up for sleep, night-time routines, and psychological functioning variables. However, as the data was limited to descriptive statistics, no generalisations can be made and findings must be interpreted with caution. Nevertheless, trends look promising and coincide with previous research highlighting the association between sleep quality and psychological functioning.[5,19] Moreover, daytime sleepiness appeared to decline across the three time periods indicating that participants felt more alert during the day, possibly due to making changes in other areas of their daily living as a result of participating in the programme.

The qualitative data further elucidated observed trends, as parents discussed the group favourably. Participants also discussed many benefits of the group. Connections were made with other group members, and in turn, participants gained the confidence to engage in activities and contribute to discussions. The home challenges were also adhered to, encouraging personal reflections in relation to recommendations for optimal wellbeing. Participants reported a number of lifestyle changes as a result of participating in the group and seemed genuinely surprised to find the experience enjoyable. The experiential aspects of the programme – intrinsic motivation, reflective practice, and behaviour modification – were successful in fostering a sense of autonomy for participants in relation to their wellbeing and in considering health behaviours. The group-based format and collaborative parental involvement were paramount for these effects, coinciding with previous research on such programmes.[21] Indeed, participants reported that changes are more likely to be effective when they are not enforced by parents, indicating the benefit of their supportive role. Valuable feedback was also obtained from participants on useful aspects of the group and areas for improvement.

Strengths & Limitations

Innovative features of the Rise and Shine programme include: i) collectively discussing key information, ii) identifying and challenging barriers to change, iii) nurturing decision-making abilities, iv) supporting and respecting autonomy within a peer-supportive environment, v) involving parental support, and vi) providing opportunities to practice strategies at home. Moreover, it was clinically useful to see participants' functionality within a group environment and to feedback to their keyworkers. The evaluation coincides with recommendations relating to evidence-based practice[27] and CAMHS Standard Operating Procedures,[28] such as welcoming feedback from service users and acquiring the best available evidence to address clinical need. The engagement of the CAMHS MDT was a further strength, with psychology and occupational therapy collaboratively working from an integrated, holistic, recovery-based model. Indeed, its cross-disciplinary nature and relevance to overall mental health suggests that the programme could be facilitated by staff across the MDT.

This preliminary investigation also carries a number of limitations. The small sample size and brief rating scales greatly limits its ability to derive meaningful data. As inferential analysis was not permitted, the trends observed can only be used to describe the population under study. Unfortunately, retention rates were low-to-moderate reflecting the clinical realities of participation in group interventions. In surmising reasons for non-completion, further work in promoting the value of group interventions to service users and their parents may be warranted. This could include greater effort in promoting the value of group-based interventions to service users at the recruitment stage and providing testimonials from participants who have completed such programmes. The brief measures were selected with participant burden and participation in mind, restricting the depth of analysis and generalisability. Replication in other CAMHS settings would be beneficial with larger samples, incorporation of objective standardised outcome measures, and comprehensive interviews to permit greater interpretive-level analyses. Moreover, the evaluation did not include a control group and, although the reliability of the findings was increased through the prospective design, future work needs to explore randomising participants to intervention versus treatment as usual. Greater retention and randomisation would permit the power required for adequate quantitative analysis and the ability to generalise to wider adolescent clinical populations. An indication of inter-rater reliability could also increase the reliability of the qualitative data.

Implications & Conclusion

Notwithstanding the aforementioned limitations, preliminary findings suggest that the group was beneficial and demonstrates the feasibility of replication in other CAMHS settings. The positive psychology and holistic focus on social, vocational, and physical functioning coincides with the increased recognition of the need for recovery-focused approaches over traditional symptom-resolution models.[16,23] Cost-effective group interventions suitable for clinical settings have implications for addressing the problem of lengthy waiting lists in primary and secondary mental health services, and in the long-term, effective use of limited resources. Initial findings look promising for Rise and Shine in supplementing the prevention and treatment of adolescent mental health problems.

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PSYCHOLOGICAL IMPACT OF PSORIASIS ON IRISH PATIENTS: A CROSS-SECTIONAL EXAMINATION

AHMAD ALABDULKAREEM AND NICOLA RALPH

ABSTRACT

Skin conditions are a significant cause of disease burden globally. Psoriasis has been previously described as a model dermatologic psychosomatic disorder; it is a chronic inflammatory skin disease with a well-documented impact on patients' psychological wellbeing and results in higher levels of psychopathology when compared to other dermatologic conditions. Due to the paucity of data, there is a need to assess psychological wellbeing in Irish patients with psoriasis. The aim of this paper was to measure the prevalence of anxiety and depression among Irish patients with psoriasis, to correlate psychological morbidity with impact on quality of life, and with disease severity. This study was a cross-sectional study conducted at a tertiary referral hospital in Dublin using the Hospital Anxiety and Depression Scale (HADS) and Dermatology Life Quality Index (DLQI) questionnaires. Disease severity was assessed using Psoriasis Area Severity Index (PASI) scores. In total, 72 patients participated in this study, 38 males and 34 females. Psoriasis worsened quality of life in 79.2% of patients, 45.8% of patients (34.8-57.2%, CI 95%) were anxious, 20.8% (13-31.57%, CI 95%) were depressed, and 15.3% (8.8-25.3%, CI 95%) had comorbid anxiety and depression. Psychological morbidities were strongly correlated with a worse quality of life and were more likely in female and younger patients and in patients on topical treatments. Disease

severity was correlated with a worse quality of life but was not associated with psychological morbidities. Overall, there is a considerable need to routinely assess psychological wellbeing in all patients with psoriasis in Ireland. This will allow for comprehensive management and better overall health outcomes.

INTRODUCTION

Globally, skin diseases are ranked as the fourth leading cause of non-fatal disease burden expressed as years lost due to disability[1]. The contribution of mental health to physical disease burden has been stressed by the World Health Organization as they stated ''there is no health without mental health''[2]. This is particularly relevant to dermatology where it has been reported that as much as 60% of patients with skin diseases may show evidence of significant mental distress[3]. Psoriasis has been previously described as a model dermatologic psychosomatic disease where psychological comorbidities are well-documented and are uniformly higher when compared to patients with other forms of skin disease[4, 5].

Psoriasis is an immune modulated chronic inflammatory skin condition characterized by thickened, red, scaly lesions affecting 1-3% of the population in Ireland[6]. Psychodermatological research investigating the complex interplay between the skin and the mind in patients with psoriasis established a bidirectional relationship between the two. Psychological distress triggers disease flares, and worsening psoriasis further distresses patients[7,8]. Therefore, the National Institute for Health and Care Excellence recommends routinely assessing psychological well-being in people with chronic skin diseases including psoriasis[9].

In view of the paucity of data investigating the extent of the psychological impact of psoriasis on Irish patients, this study was undertaken with aims to measure the prevalence of anxiety and depression among Irish patients, to assess any potential correlations with disease impact on quality of life, and to correlate psychological morbidity with disease severity.

MATERIALS AND METHOD

This study was an observational cross-sectional study conducted at the department of dermatology of a tertiary referral hospital in Dublin. Adult psoriasis patients over the age of 17 attending the department's general clinics, systemic clinics, dermatology day-centre, and phototherapy units between February and April 2018 were invited to participate. All diagnoses were made by consultant dermatologists and for the purpose of this study their management plan was recorded as either topical, phototherapy, or systemic treatment. Patients with comorbid skin conditions, established psychiatric diagnoses, and patients attending the department's psychologist-led psychodermatology clinic were excluded. All participants were explained the purpose of this study and informed consent was obtained. This study was approved by the institutional ethics committee.

The Hospital Anxiety and Depression Scale (HADS) questionnaire was used to assess psychological well-being[10]. The HADS is a screening tool, which has high levels of psychometric validity and reliability, developed to assess the levels of anxiety and depression in patients. It has 14 items; 7 identifying anxiety and 7 for depression. According to the patient's answer, each item is scored from 0-3 giving a maximum score of 21 for either anxiety or depression. A score of 8/21 has been used as a cut-off point for both anxiety and depression[11].

The Dermatology Life Quality Index (DLQI) was used to examine perceived disease severity and disease impact on quality of life. The DLQI has ten questions covering symptoms, embarrassment, self-care, limitations of everyday activities, impact on intimate relationships, and effect of treatment on lifestyle. Each question is scored from 0-3 giving a maximum score of 30 where quality of life is maximally affected[12].

Psoriasis Area Severity Index (PASI) scores were documented to objectively account for disease severity. PASI is calculated by assessing the area of skin involved and the severity of disease pathology. Scores range from 0 (no active disease) to 72 (most severe form of psoriasis). A PASI score of more than 10 is considered to be severe psoriasis.

All data obtained was analyzed using Microsoft Excel 2013 software and OpenEpi. Tests used were ANOVA, Student's t-test, and Pearson's correlation coefficient. Prevalence rates were reported as percentages.

RESULTS

Table 1. Distribution of variables (gender, age, and treatment) among study participants (n=72) and their corresponding rates of psychopathology and mean quality of life (DLQI) scores.

Variable	Category	n	Anxiety n (%), 95% CI	P value	Depression n (%), 95% CI	P value	Mean DLQI score	P value
Gender	**Male**	38	*17* (44.7%), 30.1-60.3%	*0.78*	*7* (18.4%), 9.2-33.42%	*0.44*	*6.31*	*0.23*
	Female	34	*16* (47%), 31.5-63.3%		*8* (23.5%), 12.4-40%		*8.26*	
Age	**≤30**	16	*9* (56.25%), 33.2-76.9%	*0.28*	*4* (25%), 10.2-49.5%	*0.58*	*9*	*0.27*
	>30	56	*24* (42.9%), 30.8-55.9%		*11* (19.6%), 11.3-31.8%		*6.7*	
Treatment	**Photo-therapy**	31	*14* (45.2%), 29.2-62.2%	-	*7* (22.5%), 11.4-39.8%	-	*9.65*	0.018*
	Systemic	23	*7* (30.4%), 15.6-50.9%	-	*4* (17.4%), 7-37.1%	-	*4.52*	
	Topical	18	*12* (66.7%), 43.8-83.7%	-	*4* (22.2%), 9-45.2%	-	*6.56*	

Table 2. Overall rates of psychopathology - defined as a cutoff score of 8/21 or more on the relevant HADS section- among study participants, n=72.

Psychopathology	Mean HADS Score (SD)	Range	N	%	Confidence Interval, 95%
Anxiety	7 (4.6)	0-18	33	45.8%	34.8-57.2%
Depression	4.9 (4.1)	0-18	15	20.8%	12-21.57%
Comorbid Anxiety and Depression	-	-	11	15.3%	8.8-25.3%

Cohort characteristics

Seventy-two psoriasis patients with a mean age of 44.3 years (range, 17-77 years) participated in this study. Thirty eight males (52.8%) and thirty four females (47.2%) were included, of which 31 (43%) were being managed with phototherapy, 23 (32%) were on systemic drugs, and 18 (25%) were on topical agents.

Overall, the mean DLQI score reported was 7.2 (standard deviation, 6.8). Based on DLQI scores, 57 patients (79.2%) stated their quality of life is impaired by their psoriasis. In 23 patients (31.9%), the detrimental effect of psoriasis was not pronounced whereas for the other 34 patients (47.2%) their quality of life was either largely or extremely affected by their disease.

Influence of demographic variables on psychopathology and quality of life

Female participants scored more highly in terms of anxiety (47% vs. 44.7, p=0.78) and depression (23.5% vs. 18.4%, p=0.44) and reported a worse mean DLQI quality of life score (8.26 vs. 6.31, p=0.23) when compared to male patients [Table 1].

Psychopathology and impact on quality of life

Overall rates of psychopathology observed among study participants show that 45.8% of patients scored above the clinical cut-off for anxiety, 20.8% for depression, and 15.3% from both anxiety and depression. These findings, however, did not reach statistical significance.

While age did not correlate directly with either total HADS anxiety or depression scores, patients aged 30 and younger had slightly higher rates of anxiety (56.25% vs 42.9%, p=0.28) and depression (25% vs 19.6%, p=0.58) when compared to older patients. Similarly, the younger cohort of patients were more likely to have their quality of life negatively impacted by psoriasis (DLQI score 9 vs. 6.7, p=0.27) [Table 1]. Nevertheless, these differences were not of statistical significance.

Patients' age was negatively correlated with their perceived disease severity and its impact on their quality of life as measured by DLQI scores, r= -0.2, p=0.08, which approached the level of statistical significance.

Table 3. Correlation study (r coefficient and p value) between quality of life (DLQI) scores and other study variables.

Variable	r	P Value
Age	-0.2	0.08
HADS Anxiety Score	0.3	0.01
HADS Depression Score	0.4	0.000
PASI	0.4	0.002

Association of quality of life with psychological morbidity

Mean DLQI scores in patients with scores above the clinical cut-off for anxiety on the HADS (mean DLQI = 9, range 0-29) was significantly higher than the mean DLQI scores of patients without (mean DLQI = 5, range 0-24), p=0.02. Likewise, patients above the clinical cut-off for depression on the HADS had higher mean DLQI scores (DLQI = 12, range 0-23) when compared to patients who were not (DLQI = 6, range 0-29), p=0.01. DLQI scores were strongly correlated with both HADS depression scores (r=0.4, p=0.000) and HADS anxiety scores, (r=0.3 p=0.01) [Table 3].

Associations between disease severity, quality of life, and psychological morbidity

Overall, mean PASI scores among study participants was 4.64 (standard deviation, 4.27) and there was no correlation between PASI scores with neither HADS anxiety nor depression scores. However, PASI scores were strongly correlated with DLQI scores (r=0.4, p=0.002) [Table 3].

As demonstrated in Table 1, patients with a relatively less severe form of the disease managed with topical treatments were much more likely to score above the clinical cut-off for anxiety (66.7%) compared to patients treated with more advanced treatment modalities like phototherapy (45.2%, p=0.06) and systemic agents (30.4%, p=0.000).

Patients managed with systemic agents were also least likely to score above the clinical cut-off for depression (17.4%), however the differences in depression rates when compared to patients on topical treatments (22.2%) or phototherapy (22.5%) were not statistically significant, p=0.5.

Similarly, patients on systemic agents had the lowest mean DLQI score of 4.52, compared to 9.65 for phototherapy patients and 6.56 in patients on topical treatments, with the differences among the three groups being statistically significant, p=0.018 [Table 1].

DISCUSSION

This study found that about one in every two Irish patients with psoriasis suffers from anxiety, significantly higher than the European reference values for anxiety among the general public of 14%[13]. Similarly, about every fifth patient with psoriasis is clinically depressed when compared to only 7% of the population[13]. A review estimated that about half of all patients with clinical depression suffer from other comorbid mental disorders most commonly anxiety, about 3-4% of the population, which is considerably less than the prevalence rate of 15.3% among Irish patients with psoriasis observed in this study[14]. These high rates have significant relevance to routine clinical practice given the prevalence of psoriasis in Ireland[8].

While it is difficult to interpret previous published research due to the varying inclusion criteria of patients, psychopathology scales used, lack of control groups and dependency on population reference values, a 4994-participant study investigated the prevalence of anxiety and depression among patients with skin diseases across 13 European countries, not including Ireland. It reported an anxiety prevalence rate of 17.2% overall and 22.7% among patients with psoriasis and a depression rate of 10.1% overall and 13.8% in psoriasis patients[15]. These rates are in accordance with several other studies from different countries that estimated anxiety rates to be between 12%-30% and depression rates of 10-24% among their participants[9, 16-19]. Despite the partial overlap between those findings and the rates reported in this study, psychological distress among Irish patients appear to be higher. Other studies, however, have reported far higher rates of anxiety and depression of up to 50-80% among their study participants[20, 21]. While the tertiary population of patients included in this study may, to an extent, explain the higher prevalence of psychological comorbidities, the cross-sectional nature of this study combined with the chronic natural history of psoriasis suggest these findings may be an underestimation.

In this study, higher prevalence of psychopathology has been observed among female participants and in younger patients. Furthermore, there was a negative correlation between age and quality of life scores. While this correlation was only nearing statistical significance (r=-0.2, p=0.08), it highlighted that the younger the patient, the more likely they are to suffer a worse quality of life as a result of their psoriasis. The limited number of patients and the slight difference in anxiety and depression rates observed in between the demographic variables of gender and age may have reduced the statistical significance. Nevertheless, these findings are consistent with the majority of published research, which have found that the greater importance placed by young people on their appearances possibly influenced the greater psychological distress caused by their psoriasis [22,23]. Therefore, gender and age may both have an influential role in predicting the susceptibility of patients with psoriasis to psychological distress.

The bidirectional relationship between the skin and the mind creates a vicious cycle whereby disease flares and psychological distress are closely intertwined. The associations observed in this study between patients' subjective perception of disease impact on their quality of life and their psychological wellbeing provide further evidence. While this study did not interview patients and explore their attitudes toward their disease or their coping mechanisms as part of assessing their mental wellbeing, it showed that screening patients for anxiety and depression provides a tool that may help recognize patients whose quality of life is more severely affected as a result of their psoriasis.

Disease severity as measured objectively by area of skin involved and the extent of skin pathology (PASI) was significantly associated with a worse quality of life; however, there was no associations with psychological morbidity. This is consistent with available evidence and it could be due to patients presenting only with a localized yet highly exposed or sensitive area of skin involved, and hence PASI scores would be inappropriately low despite the stigmatizing aesthetic nuisance patients would have among other symptoms[24, 25]. PASI scores also do not take into account nail involvement which has been associated with more severe forms of the disease and correlated with higher levels of psychological distress[26].

In terms of treatments, patients are usually initially managed with topical treatments especially if their disease is localized, hence it may be argued that patients on topical agents are likely the least experienced with disease presentation and have relatively less severe pathology. If lesions become unresponsive and refractory, more advanced treatment modalities include phototherapy or systemic and other biologic therapies are utilized. In this study, a markedly higher rate of anxiety has been observed among patients on topical treatments with about two thirds of patients being above the clinical cut-off for anxiety on the HADS tool when compared to 30.4% of patients managed with systemic drugs. While the same trend has also been seen with depression rates, the differences were not as statistically significant. Similarly, patients on systemic therapy had the lowest mean DLQI score of 4.52 which differed significantly from the mean DLQI scores of 9.65 for patients managed with phototherapy and 6.56 for patients on topical treatments. These findings have been previously highlighted in a study where Spanish patients on systemic drugs had better psychological wellbeing and quality of life compared to patients on topical treatments[27]. Therefore, higher levels of psychological distress and a worse quality of life may be attributed to the novelty of disease pathology among patients on topical treatments and their possible lack of practical experience with disease flares. This is in contrast to patients on more advanced treatment modalities, who may have possibly developed a degree of acceptance of their disease. Moreover, the nature of the treatments, their efficacies, and their varying delivery methods which affect the amount of time and effort patients' spend interacting with their disease may all be compounding factors; multiple daily applications of topical agents are often needed compared to a few weeks of phototherapy, or only weekly/biweekly administration of systemic drugs. Overall, there appears to be a role for an early intervention of a psychological nature; a low intensity, brief, psychoeducational intervention offered to everyone upon diagnosis with escalation plans available if needs be. For this to be realized and for patients' health outcomes to be improved, regular input from clinical psychology through specialist psychodermatology clinics should be incorporated within the standard practice of dermatology.

This study gave an insight as to the extent of the co-occurrence of psychological morbidity and psoriasis among Irish patients and assessed the negative impact this had on quality of life. The sample size was however limited and the cross-sectional nature of this study did not allow for assessing the therapeutic benefits of treatments and their potential effects on mental health. Length-time bias was not a concern given the natural history of psoriasis. However, larger scale and longitudinal qualitative research with patients, to assess how psychopathology and attitudes towards disease can change over time, is necessary to better assess the magnitude of psychological comorbidities and how to best manage patients holistically.

CONCLUSION

Psoriasis is a chronic inflammatory skin condition with significant impact on psychological wellbeing that often goes under-recognized and unassessed. Patients with psoriasis suffering from anxiety and depression have evidently worse quality of life when compared to patients with better mental wellbeing. This study shows that Irish patients also suffer from relatively higher levels of psychological distress when compared to patients elsewhere in Europe. Similarly, female and younger patients appear to be more susceptible to mental distress. Severity of disease pathology was not correlated with psychological morbidities further highlighting the underpinning issues of personal attitudes, coping mechanisms and stigmatization. This study supports available evidence investigating the complex interplay between psoriasis and mental wellbeing, and by extension, quality of life. While the concept of psychodermatology is still evolving, there is a need to incorporate its principles within routine clinical practice.

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RECOMMENDATIONS FOR THE IMPLEMENTATION OF THE SIBSHOP PROGRAMME IN IRELAND

LORRAINE O’CONNOR, EMMA STACK AND MARIA GOMES

ABSTRACT

Autism spectrum disorder (ASD) emerges in early childhood and is characterised by atypical neurodevelopment resulting in impaired social communication and rigid and repetitive patterns of behaviour. Once thought to be relatively rare, there has been a worldwide increase in the prevalence of children diagnosed with ASD. Figures have risen from 2 to 6 in 10,000 children in epidemiological studies prior to the 1990s to current estimates of up to 260/10,000 or 2.6%[1]. In an Irish context, the most recent figures estimate a prevalence rate of 1.5% in a national school population aged 6-11 years[2]. Increased rates of ASD have resulted in a growth in research pertaining to ASD and its social and psychological impact on immediate family members. Currently, Sibshops have different criteria in terms of group size, age range, frequency and duration of groups, focus on a specific disability and therapeutic approach. This article will introduce five key recommendations to be implemented in future Sibshops based on these criteria.

INTRODUCTION

Autism spectrum disorder (ASD) is a behaviourally defined neuro-developmental disorder associated with the presence of social communication deficits and restricted and repetitive behaviours[3]. The incidence and prevalence of ASD have increased over the last 20 years[4]. This increase has directly resulted in an increase in the research topic of ASD and its impact on family members. The birth of a child with a disability or chronic illness, or the discovery that a child has an impairment, has a profound effect on the family. The family system model[5], ecological model[6], transactional model[7] and developmental systems model[8] suggest that as one family member is affected by a disability or disease, each family member, in turn, must individually adjust to the impact of that disability or disease[9]. Previous research has identified the significance of the sibling relationship. Hartup[10] refers to the sibling relationship as the first peer relationship in life. He theorised that a) close peer relationships are crucial for social development during childhood and b) social interaction varies across relationships according to the extent of reciprocity and emotion involved.

Siblings of children with ASD are believed to confront unique challenges. These include encountering negative reactions from the public due to the stereotypical, repetitive and unpredictable behaviour of the child with ASD despite a typical physical presentation which may mask underlying cognitive and developmental deficits[11, 12]. Several studies have reported greater behavioural and emotional problems in siblings of children with ASD, including higher scores on depression measures and greater internalizing and externalizing problem behaviours, in comparison to siblings of children with another disability or no disability[13-16]. In response to the identified difficulties faced by siblings of children with ASD, sibling support groups have emerged in recent years.

The original Sibshop programme was founded by Don Meyer and Greg Schell in 1978. Sibshops refer to sibling groups that incorporate Meyer and Schell's original model. Sibling support groups generally have the same goals as Sibshops, but may not adhere to Meyer and Schell's original model for implementation of the group[17, 20, 21]. As the fundamental features are similar, the terms Sibshops and sibling support groups will be used interchangeably throughout this article. The programme was designed to engage typically developing children and encourage them to make an impact on the lives of their siblings with a disability[17]. The target population was initially children between the ages of 8 to 13 years old. Since the programme's inception, services' implementation of Sibshops has varied. Some disability services offer one- or two-hour workshops over a period of 8 to 10 consecutive weeks[18,19] while others conduct less frequent (monthly or biannually) day-long 'events' for siblings[17, 20, 21]. Sibshops also differ in terms of the age range they target, the group size and whether they focus on a specific disability or disabilities in general. Data collected in 2012 estimates that 340 Sibshops were taking place across eight countries[20]. The common thread across all Sibshops appears to be the inclusion of both an informational component and a social component. The informational component educates children on the socio-emotional implications of their siblings' disability on themselves and their immediate family members. Furthermore, the social component enables children to share their concerns and help each other problem solve the challenges they may be experiencing.

Evaluations of the efficacy of Sibshops provide encouraging findings. Zona and his colleagues[22] found positive changes in sibling relations as measured by the Sibling Need and Involvement Profile (SNIP)[23]. The area of greatest improvement was children's awareness of their siblings' developmental delay which illustrates that implementation of the educational component of the programme was successful. A sibling support group conducted in an Irish context[21] found similar advances in sibling involvement as well as overall improvements in family relationships. Participants valued the opportunity to meet other siblings of individuals with a developmental disability, to become more knowledgeable about their siblings' disability, and to openly discuss the feelings and challenges they are experiencing. Dailey's[20] evaluation indicates that parents are equally pleased with the outcomes of the Sibshop programme. Parents report that the programme was a positive experience for their child; allowing them to feel like they were not alone and that their feelings were being recognised. They observed positive changes in terms of their child's attitude and knowledge about their sibling's disability. Both parental and sibling satisfaction with the programme is a promising finding as it aligns with the family-centred approach to service delivery.

Family-centred practice is an empowering approach to service delivery that involves supporting, involving and engaging with all family members as opposed to only the child who requires support and intervention. It recognises that the wellbeing and development of each family member and the family as a whole are critical to the wellbeing and development of the child[24]. Family-centred practice is one of the six guiding principles of the National Children's Strategy[25]. The Health Service Executive (HSE) child disability services, who provide assessment and intervention for children with complex developmental needs, strive to implement a family-centred approach to service delivery. In addition to a family-centred approach, the HSE disability services endeavour to work on an interdisciplinary and interagency basis. These collaborative approaches are valuable as they increase communication effectiveness among team members and build a sense of partnership and teamwork. Improved communication and collaboration results in ameliorations in the overall care and support that each child and their family receives[26].

Fifty-one per cent of the children registered with a school age disability service in the Mid-West of Ireland are diagnosed with ASD, with a further 25% of children having a query of ASD. While we do not possess statistics for other school age disability services in Ireland, we suspect these figures are relatively representative of national figures. As ASD is thought to account for a large proportion of presentations in child disability services in Ireland, many services provide family support in the form of programmes, such as 'EarlyBird' and 'Understanding Autism'. These programmes, usually conducted by an interdisciplinary team, aim to empower parents in guiding their children's social communication and positive behaviour in everyday life. Despite the known challenges experienced by siblings of children with ASD, sibling support groups are not as widely available as parental support groups in Ireland. Unfortunately, due to factors including the increase in demand for school age disability services[27], such services are struggling to meet the needs of families. As parents are not only family members of children with a disability but usually also their primary caregivers and legal guardians[28], training and support for parents appears to be prioritised above training and support for siblings. In light of research indicating the potential advantageous impact of Sibshops on siblings' attitude, knowledge and engagement with their brothers or sisters with a disability, it is thought that sibling support groups would be beneficial for overall family relationships.

The purpose of this paper is to make recommendations on best practice for delivery of the Sibshop programme to siblings of children with ASD in Ireland. Thus far, services have varied in terms of their approach to conducting the Sibshop programme. We aim to make recommendations for best practice that are empirically or theoretically supported.

RECOMMENDATIONS FOR BEST PRACTICE

The following five recommendations, summarised in Table 1, expand on Meyer and Schell's original model by providing more concrete guidelines for implementation of the Sibshop programme. These recommendations are based on theory, research and best practice guidelines. These guidelines, provided by the National Co-ordinating Group for the programme 'Progressing Disability Services for Children & Young People'[24], include adopting a family-centred, interdisciplinary and interagency approach.

Group Size

Previous sibling support groups have varied in terms of group size, some groups being as small as three participants with others as large as 52 participants[17, 20]. According to Meyer and Vadasy[29], the Sibshop programme should generally not exceed 12 participants to help ensure group cohesion. Small groups make it possible for programme facilitators to provide individualised attention and instruction, leading to a more meaningful experience for the participants. Pollock, Hamann, and Wilson's study[30] found that learning through discussion appears to be more beneficial in small groups than in large-class settings. Small-group settings allow for more frequent participation, offer fewer opportunities to disengage mentally from the discussion, and consequentially further students' engagement compared to a large-class setting. Ideally, support groups that are offered to siblings of children with ASD should be limited to a group size of 8 to 12 children. Undoubtedly, many child disability services are under-resourced[31] and may not have the option of coordinating multiple small-group Sibshops. In this case, it is advised that services invite all interested siblings to the Sibshops and split them into smaller subgroups to facilitate discussion and engagement.

Age Range

In recent years, sibling support groups have varied immensely regarding the range of participants' ages. The Sibshop programme has been conducted for children ranging from the ages of 8 to 14 years old[18], 4 to 14 years old[20], 6 to 16 years old[19] and 7 to 12 years old[22]. Such variation in age is not advisable. Age range should be restricted considering the significant cognitive development individuals experience during late childhood and early adolescence[32]. The information and activities in the Sibshop programme are tailored to siblings at the late childhood developmental stage. Research suggests that children's understanding of ASD is largely dependent on his or her level of cognitive development[33]. Steinberg wrote that information processing, reasoning and expertise develop markedly during early adolescence[32]. As such, it would be pertinent to arrange Sibshops by age group so as to ensure that participants are at a similar stage of cognitive development. Therefore, it is advised that individuals in late childhood attend separate groups to those in adolescence. The impact of ASD on a sibling will also change as their cognitive skills, as well as their socio-emotional skills, develop throughout the lifespan. As per the original model introduced by Don Meyer and Greg Schell, it is recommended that the age range should be limited to 8 to 13 years old. If a service wishes to provide support to teenage siblings, it is advised that the content of the Sibshop programme be adjusted and the Sibshop for teenagers occur distinctly to the Sibshop for younger children. In relation to younger children who do not meet the age criteria proposed above it is advised that parents should act as the support system. In order to provide such parents with the skills required for supporting their younger children, it is recommended that groups such as ‘Understanding Autism’ and ‘EarlyBird’ equip parents with adequate training and resources.

Frequency and duration of groups

Sibshops tend to vary in terms of how frequently they occur and the duration of the group. The frequency of a support group is an important factor to consider. Some children who may be encountering a wide range of issues, or are introverted[18], may feel that the support group should occur more frequently. It is proposed that the Sibshops run for 8 to 10 consecutive weeks. This would give ample time for children to 'warm-up' to each other, to ‘be themselves’, and to become comfortable sharing their thoughts and feelings with each other[18]. The duration of the support group is a further important factor for consideration. Moyer and Gilmer[34] suggest that young children are built for action rather than sitting still for a period of time; therefore, it can be theorised that younger children may not benefit from discussion based Sibshops. Older children may have a slightly longer attention span and may be able to withstand a longer discussion centred on their thoughts, feelings and experiences[35]. It is advised that for children between the ages of 8 to 13 years old, the Sibshop last for one hour. Both the duration and frequency of a group are contributing factors to the rapport between child and practitioner being constructed. Rapport can be defined as “a positive emotional connection”[36(p13)]. A recent study by Crary[37] suggests that the longer one spends communicating, the stronger the interpersonal connection becomes[38]. This finding supports the recommendation of short but regular support groups as opposed to day-long, infrequent events. However, it is important to highlight that both the duration and frequency of Sibshops and their impact on the efficacy of the group has not been empirically investigated to date. Future research is required in order to gain greater insight as to what is the optimal duration and frequency for such groups.

Focus on specific disability

The original Sibshop programme was designed to support siblings of children with life-long mental and/ or physical impairments that appear before adulthood i.e. developmental disabilities. Over time, the specific groups of siblings that the programme has targeted has grown. Some services have expanded their service delivery, holding Sibshops for siblings of children with developmental disabilities such as neurological conditions, learning disabilities or developmental delay, mental health diagnoses, and medical conditions such as cancer or diabetes[20]. It is believed that siblings of children with developmental disabilities will encounter different challenges to siblings of children with chronic medical conditions. With regards to the latter, Fleary and Heffer found that for the sibling living with a chronically ill brother or sister, there can be negative effects on their social functioning (their ability to maintain trusting social relationships) in late adolescence[39]. It is important to note that even within the category of developmental disabilities; siblings are likely to experience different challenges depending on the specific diagnosis. Notwithstanding other characteristics, clinical markers of ASD include poorly integrated verbal and nonverbal communication, reduced facial expressions, poor eye contact and reduced sharing of interests[40]. As a result, siblings of children with ASD may experience unique difficulties when interacting with their sibling. To ensure that the programme is tailored to the specific challenges children are experiencing, we recommend that separate Sibshops are conducted for siblings of children with different diagnoses.

Therapeutic approach

The primary goals of the Sibshop programme are to a) educate children on the challenges associated with their siblings' disability and b) provide a supportive environment in which they can discuss the challenges they are experiencing[21]. To guide children in problem solving, it may be helpful to discuss their thoughts and feelings related to their experiences. Cognitive Behavioural Therapy (CBT) is a therapeutic approach that aims to improve how one feels and behaves by challenging and changing unhelpful thoughts. Research suggests that implementation of a CBT approach when working with children and adolescents results in reduced anxiety, anger, irritability and physical aggression and increased coping skills and emotional awareness[41, 42]. Based on this research, it is likely that adopting a CBT approach to the Sibshop programme would be advantageous to the emotional wellbeing of the siblings. It is understood that CBT training is not compulsory for all professionals involved in the school age disability team. Subsequently, there may not be CBT trained professionals available to deliver the sibling support group. However, where possible, it is advised that a professional with CBT training delivers the group as research suggests this approach may carry added benefits for the siblings.

It is important to consider that in the case of Sibshops, the CBT approach would be implemented within a group setting. Meyer, Vadasy and Fewell[43] highlighted that siblings of children with a disability may experience negative emotions related to their sibling including anxiety, guilt, embarrassment and resentment. For example, children may have anxiety around their peers' reactions to their sibling with ASD or who will provide care and support to their sibling in the future[12, 43.] Irvin Yalom[44], who has researched group psychotherapy extensively, noted that group therapy aids in cultivating strategies to manage the anxiety and tension that may be triggered by having a sibling with a disability.

Table 1: Summary of recommendations

Group Size	8-12 children
Age Range	8-13 years old
Frequency & Duration	8-10 consecutive weeks, one hour in duration
Focus on specific disability	Yes, Autism Spectrum Disorder
Therapeutic Approach	Cognitive behavioural

CONCLUSION

The need for support services for the child with ASD and their immediate family members has increased in recent years as a direct consequence of the increase in the prevalence of ASD. This article outlines five key recommendations to be implemented when carrying out future Sibshops in Ireland. Along with the suggestions introduced in this article, it is advised that Sibshops continue to implement both an interdisciplinary and interagency approach to ensure ample communication and collaboration among team members and consequentially improving the overall level of care and support that each child and their family receives. Currently, parental support groups for ASD generally lack information regarding the sibling relationship and the importance of Sibshops. It is suggested that going forward support groups offered to parents, for instance, 'Early Bird' and 'Understanding Autism', highlight a) the impact that ASD has on siblings and b) how Sibshops can provide support to siblings of children with ASD. The literature on Sibshops is generally positive; it indicates improvements in siblings' knowledge of ASD, their family relationships and social support following attending the support group. However, such evidence is sparse. Thus far, there appears to be considerable variation in how services implement the Sibshop programme (i.e. how frequent the workshops are, what age child can attend, how many can attend). We hope to pilot the above recommendations when implementing the Sibshop programme in our school age disability service. Our objectives are to a) measure the efficacy of this model of service delivery and b) enhance the existing literature on this topic. In conclusion, we predict that the implementation of the Sibshop programme with the above recommendations will be beneficial for families attending disability services throughout Ireland.

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LIVING IN THE MOMENT: THE PSYCHOLOGICAL BENEFITS OF MINDFULNESS BASED COGNITIVE THERAPY FOR OLDER ADULTS

MARY-FRANCES MCCAFFERTY & CATHERINE LEE

ABSTRACT

Mindfulness Based Cognitive Therapy (MBCT) is a group-based treatment which simultaneously combines mindfulness practice with elements of Cognitive-Behavioural Therapy. Previous literature suggests that there is limited research investigating the benefits of MBCT for older adults; despite preliminary evidence suggesting cognitive, emotional, physiological and psychological benefits. This study aimed to add to and address this gap in the literature by exploring the experiences and perceived benefits of MBCT as a therapeutic intervention for adults (N=7) who attend an older adult mental health service. The study employed a repeated-measures, mixed-methods design. The quantitative phase examined older adults' perceived levels of depression, self-compassion, stress, mindfulness use and quality of life.

Administration of measures at baseline and following eight weeks of MBCT indicated improvements across all areas. The qualitative phase employed semi-structured interviews and used thematic analysis to examine older adults' experiences of participating in the group. Participants retrospectively viewed their experiences positively, and highlighted their perceived benefits of engaging in an MBCT group. Post-group, participants reported continued mindfulness use, both regularly and as a responsive technique.

Findings suggest that MBCT may be a beneficial psychological intervention for older adults. Recommendations for further research and practice are discussed within the context of therapeutic interventions for older adult mental health service users.

INTRODUCTION

The act of being mindful is purposefully paying attention to our lives: moment by moment, on purpose and without judgement.[1] Mindfulness develops a connectedness between the mind and the body, and focuses on an individual's abilities as opposed to difficulties, making it an empowering activity. Mindfulness evolved from the Buddhist tradition of meditation, is over 2,500 years old and is secular in nature. Research shows that the average person spends only 53% of their time in the present moment, with the remainder spent ruminating about the past or focusing on the future.[2] Mindfulness increases our capacity to bear witness to internal pain.

Treatment options for recurrent depression in adults under the age of 65 recommend MBCT.[3] MBCT is a group based treatment which simultaneously combines mindfulness practice with elements of Cognitive-Behavioural Therapy (CBT).[4] There is evidence that MBCT is an effective treatment for depression relapse prevention, with studies showing its effectiveness for those who have experienced three or more episodes of depression.[5,6] MBCT has also shown benefits for adults currently experiencing depression [7] and has been associated with an increased quality of life.[8]

Previous literature suggests that there is limited research investigating the benefits of MBCT for older adults despite preliminary evidence suggesting cognitive, emotional, physiological and psychological benefits.[9] Older adults can face various difficulties associated with the ageing process, such as health concerns, bereavement and social isolation.[10] Mindfulness training has been suggested as a powerful approach to ageing healthily.[11] When practised correctly, it can reduce personal suffering for each individual, including those experiencing acute psychological problems.[12] However, there is a gap in published research, with the majority of mindfulness research focusing on middle-aged adults. Considering that mindfulness focuses on developing a connectedness between the mind and the body, it may be beneficial for older adults who experience both physical and psychological health problems. Previous studies have suggested that mindfulness-based therapies show promising results in reducing levels of depression, stress and anxiety in older adults. [13] Therefore, it would be beneficial to provide mindfulness skills training to older adults, in order to investigate its potential for improving their general wellbeing.

Aims

This study aimed to add to the current research base and address the aforementioned gap in the literature by investigating older adult mental health service users' experiences and perceived benefits of MBCT as a therapeutic intervention.

More specifically this study aimed to:

1. Investigate whether participation in mindfulness groups improves older adults' quality of life, self-compassion, depression, stress and mindfulness use;
2. Evaluate the experiences and perceived benefits of older adults' participation in a mindfulness group.

METHOD

Design

This study employed a repeated-measures, mixed-methods design. The quantitative strand of the study examined participants' perceived levels of depression, self-compassion, stress, mindfulness use and quality of life at baseline and following eight weeks of MBCT. Qualitative data was collected via semi-structured interviews and thematic analysis was used to examine participants' experiences of taking part in an MBCT group.

Participants

Participants were older adult service users who attend a Mental Health Service (N = 7). The group consisted of four females and three males. All participants were aged between 68 and 75 (mean age: 72; SD: 2.67). Eligible service users were given information about the nature of the group and its subsequent evaluation. All participants met with the group facilitators (Senior Clinical Psychologist and Assistant

Psychologist) for a suitability screening. All participants had a psychiatric diagnosis (anxiety and mood disorders) and were deemed suitable to partake in the group by their Consultant Psychiatrist. Individuals with poor verbal communication skills or a hearing impairment were excluded, as were those with a neurocognitive disorder.

Measures

The following quantitative measures were used to collect information:

- The Geriatric Depression Scale (GDS).[14]
- The Quality of Life Scale (CASP-19).[15]
- The Five Facet Mindfulness Questionnaire Scale (FFMQ).[16]
- The Perceived Stress Scale (PSS).[17]
- The Self-Compassion Scale (SCS).[18]

Procedure

The course involved attendance at eight weekly sessions for a duration of two hours. The MBCT course was based on the manual, "Mindfulness-Based Cognitive Therapy for Depression". [4] The content of the group consisted of psychoeducation combined with experiential mindfulness-based activities. The group involved various mindfulness practices while additional activities were given to work on at home, in order to practise incorporating mindfulness into daily life. Mindfulness diaries were given to record this and verbal feedback was given from participants each week.

Participants completed questionnaires pre-intervention and post-intervention. Semi-structured interviews were conducted within two weeks of the final group session. Interviews were recorded and transcribed by the researchers.

A realist inductive approach, a data driven approach to analysis which reports on the experiences of participants without trying to fit an existing coding frame or follow prior theoretical conceptions, was taken to analyse the transcripts. This was done in line with Braun and Clarke's [19] guidelines for thematic analysis. Therefore, the procedure was (1) data familiarisation, (2) generation of initial codes, (3) searching for themes, (4) reviewing themes, (5) naming themes, and (6) report production.

RESULTS

Quantitative data analysis (see Table 1) showed improvements in mood, as measured by the GDS (pre-group: mean = 7.14, SD = 5.27; post-group: mean = 5.14, SD = 3.44), increased levels of self-compassion, as measured by the SCS (pre-group: mean = 11.19, SD = 2.11; post-group: mean = 11.63, SD = 2.08), reduced stress levels, as measured by the PSS (pre-group: mean = 22.43, SD = 3.31; post-group: mean = 17.71, SD = 8.28), increased mindfulness use, as indicated by the FFMS (pre-group: mean = 107.14, SD = 19.26; post-group: mean = 124.00, SD = 17.94), and improvements in quality of life, as measured by the CASP-19 (pre-group: mean = 33.14, SD = 8.86; post-group: mean = 35.57, SD = 8.89). Although improvements were seen across all measures, results should only be viewed as illustrative, due to the limited sample size.

Table 1: Mean scores pre-group and post-group (including Standard Deviation)

Measure	Pre-Group		Post-Group	
	Mean	SD	Mean	SD
Geriatric Depression Scale	7.14	5.27	5.14	3.44
CASP-19	33.14	8.86	33.57	8.89
Five Facet Mindfulness Scale	107.14	19.26	124.00	17.94
Perceived Stress Scale	22.43	3.31	17.71	8.28
Self-compassion Scale	11.19	2.11	11.63	2.08

For explanatory purposes, the themes that arose from the data have been grouped into the following headings:

1. Expectations for the group
2. Overall group experience
3. Benefits of MBCT
4. On-going journey

Sub-themes that were identified within these themes will also be described.

1. Expectations for the group

Participants reported seeking an alternative treatment option to medication and stated that they hoped to gain skills that they could use to help themselves in times of distress. Other participants reported feeling curious regarding the concept of mindfulness.

Hope for an alternative to medication

Participants' responses indicated that they entered the group hoping for a treatment that could be used as an alternative to medication *("I was just looking for something that wasn't medication that might help").* Others discussed the possibility that MBCT might be a useful component to be added to their treatment plan *("Nobody wants to be on medication forever, so I was looking for something extra that might help me in those agitating moments").*

Tools to add to personal resources

Participants reported that they sought skills they could develop independently and draw upon in times of distress *("I was just looking for some technique that might help me to get over those moments by myself").* The empowering aspect of gaining self-help skills was appealing to participants who wished *"to find some technique that I could use on my own".*

Curiosity

Participants reported feelings of curiosity regarding the concept of mindfulness *("I wasn't nervous. More curious. What were we going to do? What was it all about? So it was more curious … 'cause I love doing new things"*). Some participants had reportedly heard about mindfulness in the media, which sparked an interest into learning more about it *("I had heard about it, but I had no idea what mindfulness was and I was very curious to find out how to practise mindfulness and what it was all about").*

2. Overall group experience

Participants reported a sense of universality, cohesion and hope as a primary experience felt from attending the group. Another theme that emerged was the acquisition of knowledge and the diverse skills learned. Finally, participants reported an overall experience of learning to become more mindful and fully present.

Universality, cohesion and hope

According to the participants, participation in the group provided a sense of universality for older adults who recognised that they are not alone in terms of their mental health struggles. This allowed them to normalise their personal journey and difficult thoughts and feelings. Participants reported valuing the views and opinions of other participants *("Each one of us had a different perspective on* *it”).* Group discussions were an important aspect of the group, and the compassionate atmosphere of group members was highlighted *(“Everyone helped each other”).* Other individuals highlighted the openness of group members as insightful and valuable *(“There was raw honesty”).* Hearing the trials and triumphs of others appeared to provide hope for participants who were also going through a difficult period in their life *(“It was inspiring to hear all the people telling their difficulties”).*

Acquisition of knowledge

Participants reported that they acquired new knowledge during the MBCT group. For some individuals, the concept of eating mindfully resonated with them as a way to incorporate mindfulness into their everyday life *(“To have a sultana in your hand for a few minutes and then eventually put it in your mouth. This is new. So I definitely did take that from the group, the mindfulness eating”).* Other participants found the cognitive-behavioural teachings insightful *(“It was all the different teachings about how thoughts are different to facts, and how your thoughts can affect how you feel. For me, that was felt in my tummy”).* The application of these new skills in other areas of people’s lives was also highlighted *(“It was nice to go home and try it out then”).*

Getting into the mindful body

Participants described in detail their experiences of attempting to be more mindful and live in the present moment. While participants reported the difficulties associated with practising mindfulness, they acknowledged the benefits they experience when mindful *(“Trying to stay in the moment is hard, but very good. I have a tendency to go away but it’s about focusing on anchoring myself to my breath when that happens”; “You get to a state of mind, you get to slow down”).* Others found support in hearing similar struggles of other group members *(“I was asking other people and people have distractions like I have”).*

3. Benefits of MBCT

Participants found that the MBCT group has improved their ability to calm their thoughts and bear witness to painful emotions, as well as to be in the present moment. An increased awareness of the importance of practising gratitude and self-compassion was highlighted. Acceptance of the ageing process, as well as using MBCT as an alternative to medication, also emerged as a sub-theme.

Practice of being in the present moment

Participants reported that the MBCT teachings have allowed them to become more attuned to the present moment *("It's about trying to keep yourself where you are. I have a tendency to go away").* Other participants reflected on the "mindful eating" teachings and highlighted how it has taught them to be more present in everyday activities *("Last week I was just eating for the sake of it and then I thought "mindful eating". Slow down. Enjoy even two or three spoonful's"; "The thought, food! Now, what else can I be making myself aware of? Fabric? Can I be mindful about fabric?").* Participants reported using mindfulness skills to calm their minds *("If I'm beginning to feel anxious in a particular situation, I do the three minute breathing. Doing that has got me so that I can stand there, rather than running out of there").*

Increased self-compassion and gratitude

Participants reported that following the MBCT group, they have experienced increased feelings of self-compassion, and are more aware of the importance of self-care. Participants viewed their newly acquired mindfulness skills as an important self-care tool in their on-going recovery *("If you're not feeling good, I would recommend mindfulness for that reason. I would recommend it even if you are feeling good"; "Mindfulness has a lot of benefits in terms of looking after yourself").* Mindfulness practice has allowed participants to become more aware and grateful in the present moment *("Stopping for a moment and appreciating everything").* One participant stated that mindfulness has allowed her to be more present with her grandchildren *("I was with my grandkids, and realised that in the past I've always been somewhere else in my mind. And all of a sudden I was so grateful to be in the moment with them").*

Acceptance of the challenges of later life

Participants reported finding mindfulness helpful in coping with the ageing process. One participant explained that mindfulness has helped her to accept the complex difficulties associated with growing older *("At 65 you've been through most of your life, whether you like it or not. At my age illness and death are facing us and looking* *us in the face. Being able to accept things that I can't change was an eye-opener for me").* Another participant found mindfulness helpful in coping with the bereavement of her husband *("Yeah, I use it at swimming. I always used to swim with my husband and obviously he's not there now but I just went into the mindfulness. I just floated in the water, looked up to the sky and I used it there").*

A viable alternative to medication

Following the mindfulness group, several participants viewed mindfulness as more beneficial than taking medication *("It does outweigh for me taking medication … normally I'd be popping the pills down to try and calm down the legs").* Others stated that a benefit of MBCT is that they now have another option to draw upon that is not just medication *("Mindfulness is now another option for me").*

4. On-going journey

Post-group, participants reported that they hope to adopt mindfulness into their daily lives. Two perspectives were provided by participants of their intentions for future mindfulness practice; practising mindfulness every day and in response to a difficult situation.

Everyday mindfulness

Participants reported that mindfulness is a practice that, over the eight week course, they have incorporated into their everyday life *("It's become a habit").* One participant explained that mindfulness has been able to ground her each day *("It is part of my day because it's something to hold onto and I haven't had something before to hold onto").* Other participants reported that they will practise mindfulness everyday as they view it as an important and vital component of their mental health *("Mindfulness is very, very important. It's like brushing your hair or brushing your teeth").*

Responsive mindfulness

Participants recognised the benefits of practising mindfulness as a response to stressful periods. One participant explained that *"If I feel stressed in the morning I do it. I will keep on doing it".* Another participant highlighted the relief of having these skills ready to use if their mood deteriorates *("And I have it now, so that I can use it, whenever, please God that I won't ever go down that far again, but I can use it now at any stage").*

CONCLUSION

The results of this exploratory investigation indicated that MBCT appears to be a beneficial and positive psychological intervention for older adults attending an older adult mental health service. These preliminary findings suggest an improvement in the quality of life, self-compassion, depression, stress levels and mindfulness use following an eight week MBCT group. Qualitative findings highlighted the perceived benefits of an MBCT approach for older adults. As MBCT is recommended as a treatment option for recurrent depression in adults under the age of 65, [3] this study suggests that MBCT should also be considered for older adults with similar mental health difficulties. Findings of this study are in line with other preliminary research conducted on the benefits of mindfulness practice for older adults.[9,11] In terms of its clinical application, considerations should be made regarding incorporating MBCT into the treatment plans of older adults attending an older adult mental health service. This would provide this population with an additional treatment option, granting more autonomy and choice for service users.

There are various limitations to this current study which warrant mentioning. Due to the sample population and the recommended group size, the study's sample size is small, and findings should be taken as illustrative rather than representative. The sample consisted of a purposefully selected sample in one area of Ireland. Social desirability may have been a confounding factor as the researchers were known by the participants. Furthermore, participant bias may have been a confounding factor as participants self-selected for participation in the group and may have been more open to the intervention and change than other service users. No data was collected from a control group, and thus, no between-group comparisons can be made. It is difficult to ascertain the extent to which participants used mindfulness between sessions and therefore to make reliable inferences as to any relationship between improvements made and regularity of mindfulness practice.

Future research should take various routes. In order to gather reliable quantitative data, future studies should look at using a larger sample size. Longer post-group interviews (e.g. six months post-group) would provide valuable information on whether mindfulness practice and the benefits achieved from it, is maintained. The benefits of providing refresher groups should be ascertained, as well as establishing the cost-effectiveness of running groups within a health service setting. As this study looked only at older adults attending an older adult mental health service, the benefits of MBCT should be assessed for older adults in other settings (e.g. care homes), in order to assess its worth across differing populations. The role MBCT could have as an alternative to or in conjunction with medication should be discussed and assessed in more depth.

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THE IMPOSSIBLE TASK: ARE IRISH CMHTS SET UP TO FAIL?

PÁDRAIG COLLINS

ABSTRACT

Tensions within the functioning of Irish Community Mental Health Teams (CMHTs) have been alluded to in the small body of published literature on teamwork in Irish mental health services. Such literature commonly recommends a range of measures to enhance teamwork, but fails to explore how issues of power and how the conflicting paradigms that underpin different practitioners' work may preclude the implementation of such measures. This paper discusses how the conflicts that can arise in CMHTs may often be framed as between particular personalities but may be better understood as primarily arising from profound philosophical differences, and therefore preferred praxis within teams. Key amongst these issues is that of defining the team's 'task', along with the structure, processes and governance required to complete such a 'task'. It is argued that understanding the differing forces that operate when different ideologies clash, including that of how power is exercised, may help illuminate the nature of these conflicts and empower us to find better solutions.

BACKGROUND

It has been almost a decade now since the Mental Health Commission (MHC) published its key document on teamwork: "Teamwork Within Mental Health Services in Ireland" (2010)[1]. Since then a small body of Irish published literature, including one large study, has attended to this topic. In essence, these discussions have focussed on issues such as resourcing, mainly the under-resourcing of certain disciplines, disciplines' satisfaction with their role and the impact of blurring or stereotyping of roles[2,3] and the challenges of integrating a recovery ethos in multidisciplinary teams (MDTs)[4]. Deady[5] noted that of 32 MDTs studied "none agreed on structure, formulation, and practice of their MDT". A paper by Twomey, Byrne & Leahy[6] re-iterated the key points in the MHC document around the key need for the correct ethos, structures and processes for positive teamworking. An earlier large-scale study by De Búrca, Armstrong and Brosnan[7] had similarly highlighted the reality that the majority of teams did not have a full multidisciplinary complement, did not measure performance/outcomes, that 'reflexivity' was rare in busy teams, and that the majority of team activity occurs at a unidisciplinary level primarily by biomedical (nursing/medical) practitioners. The authors made a range of recommendations amongst them an emphasis on the need for 'clarity of purpose, shared goals and performance capability […] that translate into key performance indicators' (pg.8).

The review by Maddox[2] of the broader international literature highlighted the many diverse challenges experienced by practitioners in multidisciplinary mental health teams. The majority of Irish papers, however, have focussed more on certain key drivers of positive teamwork (e.g. having a 'Shared Vision and Goal' - as recommended by De Búrca et al.) while highlighting the absence of these features in teams across the country. It seemed important, therefore, to explore in greater detail *why* it may be that many Irish teams continue not have a 'Shared Vision & Goal" and consequently struggle to develop the resulting agreed structures and processes that are necessary for effective teamwork. An analysis that explores the issues of power (defined simply as 'influence over the actions of others'[8]) and contested paradigms within CMHTs may provide some helpful understandings in this regard, and illuminate the nature of the challenges inherent in bringing about the changes promoted by previous documents. The focus therefore of this paper is less on the already acknowledged deficits in teamworking highlighted by previous research or on recommending additional measures to foster positive teamwork, as the original MHC document more than adequately highlights these. The focus here is rather a further critical analysis of the some of the key forces that continue to preclude such teamworking and may continue to do so unless directly understood and faced.

A CONTESTED TASK

The ingredients for highly effective teams have been well discussed within the broader organisational literature (e.g. Mickan & Roger, 2000[9]). One commonly accepted feature of such teams consists of having a consensus on what is the 'task' ('shared mission') of the team. Having a shared sense of what is the 'job' or 'common goal' of the team is crucial to the creation of processes and structures by which this task can be achieved. However, where the 'task' is contested, where no consensus exists on what is the key job of the team, then the legitimacy of any leadership, structure or processes put in place to achieve such a task will invariably come under challenge.

Within mental health teams starkly different conceptual paradigms of mental distress co-exist which naturally result in often different understandings of what is the 'task' of the team. Within a standard biomedical model mental disorders can be best understood as biological illnesses of the brain and nervous system, of largely genetic origin, at times triggered in the individual by environmental stressors. In such a model such diseases are best understood and treated at a biological level (commonly through the use of psychotropic medication but also by in certain cases through ECT or surgical intervention). The task is to diagnose through categorising the reported cluster of symptoms into the correct diagnostic category and 'treat' using the best evidence-based treatments for this disorder resulting in the alleviation or elimination of symptoms.

Certain psychological models (e.g. trauma-focussed understandings of mental distress[10, 11]) would reject the concept of the 'diseased brain' conceptualising the behaviour, and reported affect and cognitions, as the natural consequences of a brain acting as it's designed to do in response to specific environmental experiences. I.e. an individual traumatised by childhood physical abuse, bullying in school and assaults as an adult may naturally develop high levels of anxiety and hypervigilance around others, which could be construed as 'paranoid thinking'. The 'task' then becomes one of fostering healing and the development of more positive and beneficial patterns of thinking through therapy and fostering more benign and interpersonally supportive environments within the person's life.

Certain social models[12, 13] of mental disorders point to the ever-changing nature of diagnoses and how marginalised individuals consistently have differences construed as pathology (e.g. the presence of homosexuality in previous diagnostic manuals, the admission of unmarried mother in Irish asylums, the placing of political dissidents in psychiatric institutions abroad). They would look at the disproportionately high level of 'mental illness' among the poor and disadvantaged and challenge whether these difficulties are best understood as occurring within the individual, rather than the natural consequence of individuals suffering from social, economic and power inequalities in unjust societies. The 'task' then becomes one of highlighting injustice more broadly, de-pathologising the individual, supporting them to acquire basic resources (housing and money) and subsequently the power (both individually and collectively) to materially alter their well-being and live a freer life.

These differing paradigms may be understood as partially a natural consequence of different training systems wherein different understandings are privileged and different identities formed. However, if these different identities are core to a practitioner's value to a team, then any attempts to obfuscate such differences (e.g. in developing a single team approach) may lead to practitioners feeling that their worth to the team is being threatened.

The problematic nature of biopsychosocial / holistic approaches

Attempts to bridge these quite different understandings of mental distress (with the resulting different 'tasks' that follow) have arisen through the promotion of a 'biopsychosocial' or 'holistic' approach (the latter commonly including spiritual needs in addition to biological, psychological and social) to service delivery. Such models have commonly taken an 'additive' approach to mental health services i.e. support for 'biological' needs *and* support for 'psychological' needs *and* support for 'social' needs. An 'all must have prizes' approach, which superficially appears to attend the diversity of needs with which service users present. However, two difficulties immediately arise with this: (1) Conceptually defining a need as either biological or psychological is highly problematic. Without subscribing to Cartesisan dualism (that the mind exists in a separate space from the brain) then effectively such models could be seen as making a philosophical 'category error'. I.e. it holds that the mind and brain are physically different objects rather the same entity viewed through two different paradigms (one psychological and one biological). Rather than the sparking of neurons *causing* thinking, the sparking of neurons *being* thinking. If therefore we are talking about how two paradigms conceptualise the same difficulty, rather than two separate areas of need, then this leads to the second difficulty. (2) The question of power. If the same entity can be understood in different ways (e.g. anxiety as the phenomenological experience of fear and frightening thoughts, and simultaneously as the hyperactivation of the sympathetic nervous system) then which understanding is privileged? Discourses dominated by biological understandings may naturally lead to biological interventions and the prioritisation of resources to facilitate this. Different paradigms can certainly co-exist and enrich each other in teams. However, when attempting to understand why certain decisions are made about resource allocation or treatment type, it seems necessary to acknowledge that the paradigm espoused by the practitioners with greatest power within a team commonly triumphs. Consequently, helpful discussions on the use of "biopsychosocial' models by CMHTs may need to explicitly attend to the conceptual difficulties therein as well as consider how power operates within the team.

THE CHALLENGE OF CONTESTED LEADERSHIP

Socio-historical influences may help explain why certain professions currently occupy positions of leadership within CMHTs but they may also help our understanding of why such leadership invariably remains contested. At a paradigmatic level, the legitimacy of leadership based on biomedical expertise will necessarily be challenged by professions for whom biomedical understandings and knowledge do not trump psychosocial (and vice versa). It is in keeping with this to note (as reported by De Búrca et al.)[7] that conflict between nursing and medical practitioners is reported as less pronounced than between psychological and psychiatric.

Clinical hierarchies are ubiquitous in healthcare delivery (e.g. a consultant physician overseeing a junior doctor). However, the legitimacy of such hierarchies derives from a consensus that the individual in the superior position has greater knowledge and expertise in a domain that the individuals in the inferior position. When such a consensus does not exist in a cross-disciplinary context e.g. a psychiatrist attempting to clinically oversee a social work intervention, the legitimacy of such a hierarchy and consequently the adherence to such a hierarchy falls. A managerial system which attempts to implement clinical hierarchies without the consent or agreement as to its legitimacy, from those involved, invariably gives rise to problematic team functioning.

Such tensions also operate within a broader social and legal setting of importance, given the role of ‘public protection’ historically held by mental health services. The organisational attempt to exclusively place one discipline as ‘clinical leaders’ within CMHTs poses significant challenges as a consequence of disciplinary conflicts already discussed. In addition any attempt to hold clinical leads as exclusively clinically responsible for service users clashes with the legal reality that all disciplines remain personally responsible for their own clinical actions. I.e. at any disciplinary hearing, civil case or criminal proceedings, no one discipline has no legal power to grant immunity from prosecution to other disciplines. Consequently, regardless of their wishes in this regard, all professionals remain personally, ethically and legally clinically responsible for their own actions with service users. The impact of this legal reality is that professionals of all disciplines cannot simply defer to clinical leads and thereby dispense with any personal clinical responsibility but need, in contrast, to act at all times in keeping with their ethical, professional and legal responsibilities. However, in multidisciplinary CMHTs, individual professional's determination of what is appropriate (ethically and professionally) will again be largely determined by their disciplinary background, and their definition of the 'task' of the service, returning us once more to areas of potential conflict for the team.

CONTESTED STRUCTURE AND PROCESSES

It unsurprisingly follows from the above, that the structures and processes that teams put in place necessarily will be both (a) an expression of where power between competing paradigms currently exist within the team and (b) a forum within which these contested perspectives will play out. Furthermore, in the absence of accepted broader forces to adjudicate decisively on these conflicts, in one direction or another, individual teams will be left to largely battle this out separately in each area. However, the individual solutions that particular teams may come up (whether functional or otherwise) will continuously be open to question when professionals come into to contact with colleagues in other teams. This may leave professionals in the invidious position of operating in teams where no sustainable conclusion to the phase of 'storming' (cf: Tuckman[14]) can ever by fully arrived at, given the competing forces both internal and external to the team.

HOW WE GOT HERE AND THE FORCES THAT SUPPORT THE "STATUS QUO".

The socio-historical background to the development of community mental health teams in Ireland bears briefly alluding to. As discussed in more comprehensive detail elsewhere (e.g. Bentall[15, 16], Pilgrim and Rogers[17, 18]) societal beliefs that mental distress represented 'moral failure' -with those involved therefore needing to be hidden or punished - were displaced by ideas of mental disorders as 'medical ailments'. These therefore required 'care and treatment' by medical practitioners, aided in this task by nurses, predominately in large asylums (for most of twentieth century). An informal 'social contract' whereby medical practitioners took on the role of 'public protection' (acquiring legal power to detain individuals to 'protect' the public from those deemed 'mad') facilitated this process and was further reinforced when 'care in the community' became the norm for mental health service delivery. Concurrently, broader societal forces over the last 50 years continued to shape our understandings of mental distress, with psychological and social understandings gaining greater credence. This in turn led to the emergence of different disciplines, informed by such paradigms, and the insistence of their presence in community mental health teams. However, the emergence of teams with social workers, psychologists and OTs is a relatively recent phenomenon (cf: Vision for Change[19]) and has brought with it the natural contesting of the 'task' of the team as explored above. However, the preponderance of biomedical staff in mental health services, has resulted in a biomedical culture (medical hierarchies, medical paradigm of mental distress) remaining the dominant culture within teams[7], even while broader society embraced more diverse social and psychological ideas.

THE BROADER "PUSH-AND-PULL" FORCES TOWARDS CHANGE FACED BY CMHTS

A sociological power-based analysis (cf: Pilgrim, 2003)[20] would argue that professional 'guilds' naturally develop in healthcare domains. In this perspective guilds focus on the promotion of the interests of their own discipline first. In practical terms this would mean that as new interventions gain credence then particular disciplines will argue that they, and they alone, can safely oversee or provide such interventions, and demand the need for additional resources, or colleagues of their discipline, to achieve this. The more powerful the discipline within a system the more able it is to make this argument and protect pre-existing power structures. Similarly competing disciplines will attempt to use the introduction of new initiatives/ interventions as a means of enhancing their own standing and power within the system. Consequently, from this analysis, individual CMHTs will constantly face external disciplinary forces placing tension on the cohesion of the team.

Other forces impacting on teams would include the changing nature of the service user's relationship with the mental health service provider. The Recovery movement has challenged the relatively disempowered nature of service users within the system and demanded a great say for service users and those that support them[21]. This has included insisting on representation on management teams and a greater emphasis on particular types of interventions (e.g. talking therapies and family engagement). These forces of change again may challenge pre-existing relationships and power structures within the mental health system.

Similarly, as Irish society's views of mental distress and its alleviation continue to develop so does its expectations from its mental health services. It remains, therefore, to be seen whether the current system can successfully adapt within its current power structures to these evolving demands, potentially through implementing relatively minor adaptations in the type of service provided. Or, in contrast, whether these broadening paradigmatic understandings within society will see more radical changes (in leadership, in definitions of the 'task' of CMHTs, in the use of resources, in the nature of responses to mental distress) to the structures of, and services delivered by CMHTs.

CONCLUSION

This paper outlines how differing perspectives of mental distress exist within Irish CMHTs. It argues that while these different perspectives can enrich each other they also naturally give rise to conflict and tensions within teams. It explores how attempts at developing common conceptual overarching models have been problematic and have been insufficient to resolve these tensions. The result being that the issue of power and how it's exercised within a CMHT comes to the forefront. Consequently, an analysis of power and its manifestations, including the ideas and belief systems – the 'paradigms' – that underpin the exercise of such power, is crucial to understanding the current functioning of mental health teams within Ireland. It also explores how these tensions have invariably resulted in the key foundations of functional teamwork (i.e. an agreed task, and consensus around the nature of authority and leadership within the team) remaining highly problematic.

Tensions within community mental health teams are often viewed by those within teams as unique to that region or to the constellation of personalities within the particular team. However, many of the sources of such tensions may be much broader than the specific teams and lie in fundamental existential questions about the nature of mental distress, the nature of our response to this, the 'task' of CMHTs and in the distribution of power broadly with mental health services in Ireland. An open acknowledgement of these 'structural fault lines', how such unresolved tensions may mean that CMHTs can be 'set up to fail', may liberate individual practitioners from personalising the difficulties they face. It may also make them more powerful to affect real change where required.

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Clinical Psychology Today: Noticeboard

WHO IS CLINICAL PSYCHOLOGY TODAY?

Clinical Psychology Today is a collection of Clinical Psychologists (staff grade, senior grade, assistant and trainee) passionate about creating a forum in which our profession can share ideas. The publication is overseen by an editorial steering group, from which two members, in rotation, take up the edition editor and deputy editor role. The steering group is: Pádraig Collins, Malie Coyne, Sean Foy, Eoin Galavan, Patrick McHugh, Ruth Melia, Olive Moloney, and Charlotte Wilson. The journal is also supported by a broader editorial network consisting of Clinical Psychologists across all grades, including Heads of Service, from each region of Ireland who generously give of their expertise.

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Clinical Psychology Today publishes peer-reviewed articles on issues of interest to Clinical Psychologists in Ireland. The ISSN number is 2565-5698. The application for SCOPUS registration is pending. Articles of interest may include:

- Articles discussing and analysing the key issues affecting the Clinical Psychology profession in Ireland.
- Articles exploring the 'lived experience' of being a Clinical Psychologist in Ireland today (the frustrations and joys of this work).
- Reports on new service innovations in your area (new services / particular groups or new services you've run) of interest to Clinical Psychologists.
- Articles on the experience of early career Psychologists and their view of the profession, its development, and the training of the next generation of Psychologists.

For further information on submissions (e.g. recommended style guide) contact us directly at clinicalpsychologytoday@gmail.com

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With thanks!!

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